Insufficient Staff & Lack of Enforcement Limit D.C. Restaurant Oversight

November 19, 2026

A report by the Office of the District of Columbia Auditor



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Office of the District of Columbia Auditor

Insufficient Staff & Lack of Enforcement Limit D.C. Restaurant Oversight

The District of Columbia's Department of Health (DC Health), through its Division of Food, plays a critical role in protecting public health by overseeing the safety of the District's food supply. In fiscal year (FY) 2025, DC Health was responsible for inspecting approximately 6,500 food establishments which include delicatessens, bakeries, candy manufacturers, grocery stores, retail markets, ice cream manufacturers, restaurants, wholesale markets, mobile vendors, and hotels. ODCA's audit assesses the completion of inspections and relevant enforcement actions for the 2,605 restaurants that required inspections in FY 2025.

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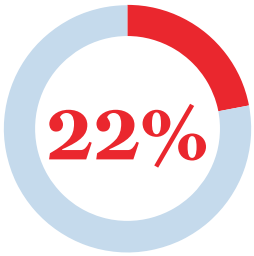
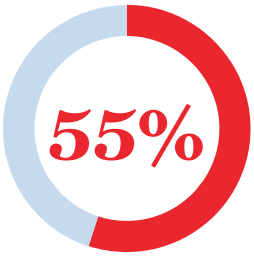


Amount of the 7,249 required routine inspections for restaurants DC Health conducted.



Number of restaurants that received no routine inspections.

543

The average number of inspections completed per Sanitarian in FY 2025; FDA recommends a range of 280-320 per year.



Amount of complaints investigated on time.



Amount of $264,400 in fines generated that were open, unpaid, and not progressing ($227,700).

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Executive Summary

Office of the District of Columbia Auditor

Why ODCA Did This Audit

ODCA conducted this discretionary audit to evaluate the District of Columbia Department of Health's (DC Health) effectiveness in safeguarding public health through its oversight of the District's restaurants.

What ODCA Found

In fiscal year 2025, DC Health completed only 22% of the routine inspections required by its risk-based schedule for restaurants. The primary cause of the low completion rate was insufficient staffing. ODCA found that although program management was, in several instances, able to effectively prioritize work and complete some core functions, the lack of resources negatively impacted many key operations.

Food Code violations were verified for correction or resulted in enforcement action only 55% of the time and the fining process (Notice of Infractions) was ineffectively implemented. Additionally, limited reporting capabilities and data quality challenges hindered program management's ability to make agile decisions and properly assess its work.

Collectively, these issues reduced DC Health's effectiveness in safeguarding the District's food supply.

What ODCA Recommends

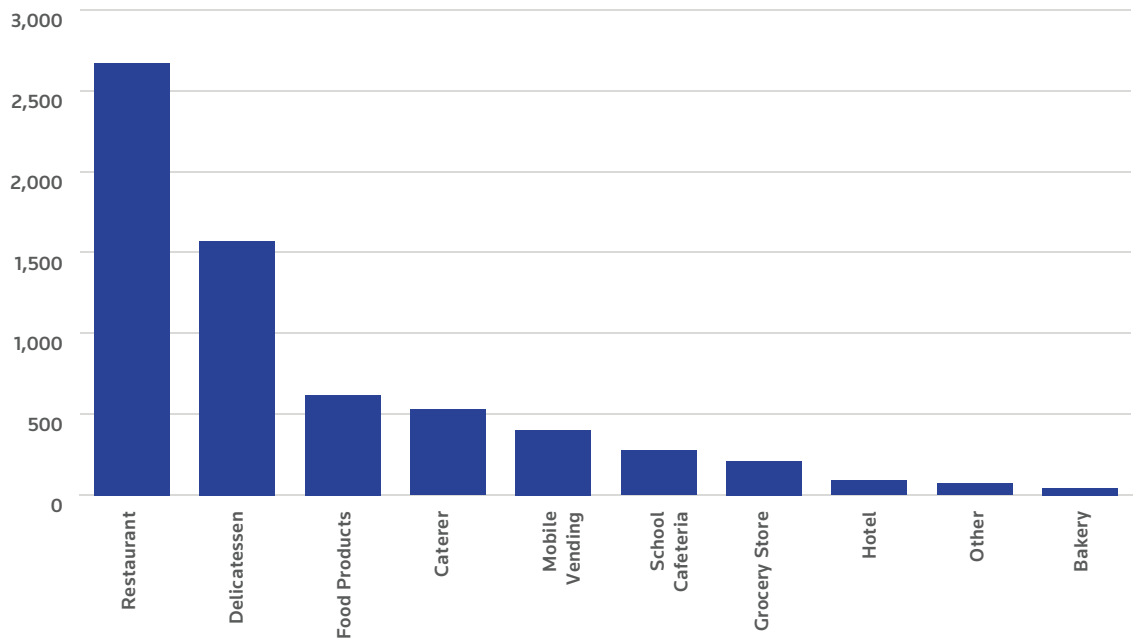
- DC Health should periodically review best practices for inspection frequency and if necessary, modify the risk-based schedule to establish more sustainable routine inspection requirements that remain consistent with the FDA Model Food Code and support broader, more consistent inspection coverage.
- DC Health should create and implement a staffing plan that identifies the personnel levels needed to complete routine inspection requirements in accordance with the risk-based inspection schedule.
- DC Health should develop, implement, and document updated policies and procedures related to violation enforcement, the Notice of Infraction process, restoration inspections, and inspection frequency updates based on past performance.
- DC Health should strengthen its reporting capabilities, and establish processes with the Office of Administrative Hearings, and the Department of Licensing and Consumer Protection to obtain data relevant to its work.

Background

The CDC estimates that 48 million people get sick from a foodborne illness each year, leading to 128,000 hospitalizations, and 3,000 deaths. The District of Columbia's Department of Health's (DC Health) Division of Food plays a key role in limiting the spread of foodborne illness and safeguarding the health and safety of residents and visitors by overseeing the safety of the District's food supply. The Division enforces the District's Food Code, derived from the Food and Drug Administration (FDA) Model Food Code and uses a risk-based schedule to determine inspection frequency for each food establishment. The risk level for each establishment is primarily determined by the menu and scope of its operations.

In fiscal year (FY) 2025 DC Health was responsible for inspecting approximately 6,500 food establishments which include delicatessens, bakeries, candy manufacturers, grocery stores, retail markets, ice cream manufacturers, restaurants, wholesale markets, mobile vendors, and hotels, as seen in Figure 1.

Figure 1: Food Establishments by Type



Source: ODCA analysis of summary data provided by DC Health.

ODCA's audit is focused on inspections of the 2,605 restaurants that required inspections in FY 2025. See a breakdown of the restaurants by risk level in the table in Figure 2.

Figure 2: FY 2025 Restaurants by Risk Level

Risk Level	Total Restaurants	Required Routine Inspections per Year
High Risk #5	8	5
High Risk #4	145	4
Moderate Risk #3	1,850	3
Moderate Risk #2	602	2
Low Risk #1	0	1

Source: ODCA analysis of data from DC Health's Digital Health Department (DHD) system and the Risk-Based Inspection Schedule provided by DC Health.

Inspections are pass-fail, and the results of each inspection are available to the public online.[1] The primary types of inspections performed by DC Health are referred to as routine, follow-up, and complaint based. Inspections may be announced or unannounced depending on the type of inspection. Routine inspections, which are the most common and whose frequency is set by the establishment's risk level, are unannounced.

At routine inspections Sanitarians will identify themselves as members of the Division of Food and inform the person in charge of the purpose of their visit. The Sanitarian will invite the person in charge to accompany them on the inspection and review the findings with them after the inspection is complete. (See Appendix A, page 44, for an example of the inspection form. Results of all restaurant inspections are available on the DC Health website at https://dc.healthinspections.us/?a=Inspections.) The goal of each routine inspection is to ensure that "no imminent health hazards or out-of-control risk factors are present." In instances when a violation of the Food Code is identified and the establishment cannot immediately correct it on site, DC Health will conduct a follow-up inspection to verify that the issue has been corrected.

In addition to follow-up inspections for code violations, DC Health can fine establishments by issuing a Notice of Infraction, or in instances where imminent health hazards or other extenuating factors are present, DC Health can issue a summary suspension, which immediately ceases all operations at an establishment. If contested or not immediately paid, the resolution of fines is managed through a process with the Office of Administrative Hearings. If the establishment was summarily suspended, then it must correct all violations that led to the suspension and pay a fee to schedule a restoration inspection.

1 Inspection reports can be found here: https://dc.healthinspections.us/?a=Inspections.

Objective, Scope, and Methodology

Objective

The objective of this audit was to determine if DC Health properly conducted and documented all required [routine/complaint] food safety inspections, and if DC Health appropriately enforced all food safety inspection violations at restaurants.

Scope

The audit scope covers inspections of restaurants from October 1, 2024, through September 30, 2025 (FY 2025).

Methodology

To conduct this review, we:

- Reviewed relevant District of Columbia Municipal Regulations (DCMR).[2]
- Reviewed Division of Food Operations and Procedures Manual, as well as other training and policy related materials.
- Reviewed, merged, and analyzed data from the Digital Health Department (DHD) system, the Division of Food's inspection management system.
  - Inspection logs from all restaurant inspections in FY 2025 and FY 2024.
  - All license records.
  - Violation Count Report for all violations documented on inspections of restaurants in FY 2025.
  - Analyzed all restaurant complaints from FY 2025.
- Reviewed summary data including but not limited to licensed food establishments, yearly inspections, and complaints, that DC Health is required to maintain according to DCMR, to compare with ODCA analysis and provide additional information related to non-restaurant inspections.[3]
- Conducted interviews with staff from the Division of Food, DC Health, and the Office of Administrative Hearings.
- Observed Sanitarians conducting inspections at five different establishments.
- Reviewed payment reports from DC Health's Salesforce payment system.
- Reviewed Notice of Infraction (NOI) data from the Office of Administrative Hearing's eCourt system.
- Reviewed Division of Food data on Notice of Infractions as well as relevant training documents.
- Reviewed performance oversight documentation from FY 2024 and FY 2025.
- Reviewed all available Quality Assurance Reports used as part of staff evaluations in FY 2025.

2 Title 25 of the District of Columbia Municipal Regulations are referred to as the "Food Code".
3 25-A DCMR § 4407.4.

- Assessed the internal controls of DC Health's food establishment inspection program by examining control activities related to Food Code violation enforcement, risk management related to complaints and changes to inspection frequency based on establishment performance, external reporting on program activities and individual inspections, as well as management's efforts to establish a structure and delegate responsibility to achieve the program's objectives.

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards (GAGAS). Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Audit Results

DC Health completed only 22% of the routine inspections required by its risk-based schedule at restaurants in FY 2025.

The DCMR chapter covering food "Inspection and Correction of Violations" outlines the program's food establishment inspection requirements. It states that DC Health "shall inspect a food establishment based on a written risk-based inspection schedule that is uniformly applied throughout the District."[4] This risk-based schedule is determined primarily by the types of food and preparation methods used at an establishment, but it may be adjusted based on other factors such as past noncompliance or whether the population served is more susceptible to foodborne illness (e.g., hospitals).

DC Health's risk-based schedule and number of inspections associated with each level are as follows:

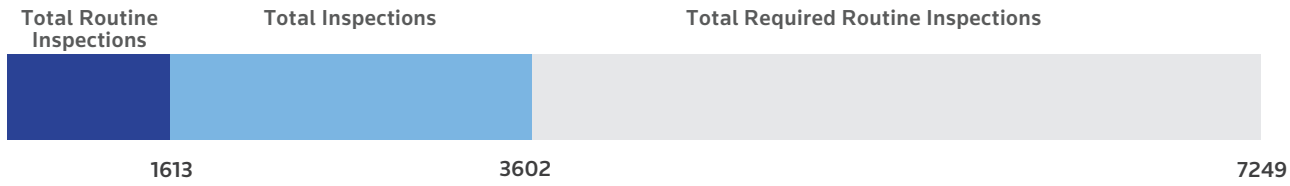
% of Restaurants	Risk Level and Description
0.3%	**High Risk #5 - 5 routine inspections per year** Extensive handling of raw ingredients. Food processing at the retail level (such as, smoking and curing; reduced oxygen packaging for extended shelf-life).
5.6%	**High Risk #4 - 4 routine inspections per year** Extensive handling of raw ingredients. Preparation processes include the cooking, cooling, and reheating of potentially hazardous foods. A variety of processes require hot and cold holding of potentially hazardous foods. Food processes include advanced preparation for next-day service. This category would also include those facilities whose primary service population is immunocompromised.
71.0%	**Moderate Risk #3 - 3 routine inspections per year** Extensive handling of raw ingredients. Preparation process includes the cooking, cooling, and reheating of potentially hazardous foods. A variety of processes require hot and cold holding of potentially hazardous food. Advance preparation for next-day service is limited to two (2) or three (3) items. Retail food operations include deli and seafood departments, establishments doing food processing at retail.
23.1%	**Moderate Risk #2 - 2 routine inspections per year** Limited menu (one (1) or two (2) main items). Prepackaged raw ingredients are cooked or prepared to order. Retail food operations exclude deli or seafood departments. Raw ingredients require minimal assembly. Most products are cooked/prepared and served immediately. Hot and cold holding of potentially hazardous foods is restricted to single meal service. Preparation processes requiring cooking, cooling, and reheating are limited to one (1) or two (2) potentially hazardous foods.
0.0%	**Low Risk #1 - 1 routine inspection per year - (No Restaurants)** Primarily prepackaged not potentially hazardous foods. Limited preparation of hot dogs and frankfurters; and mobile ice cream operations.

Source: ODCA analysis of data from DC Health's Digital Health Department (DHD) system.

4 DCMR 25-A § 4400.1.

DC Health only conducted 1,613 routine inspections of the required 7,249 (22%) in FY 2025. While 45% of restaurants received at least one routine inspection, only 81 restaurants out of 2,605 (3%) received all their required routine inspections, as seen in Figures 3, 4, and 7.

Figure 3: Routine and Total Inspections Conducted Compared to Required Routine Inspections



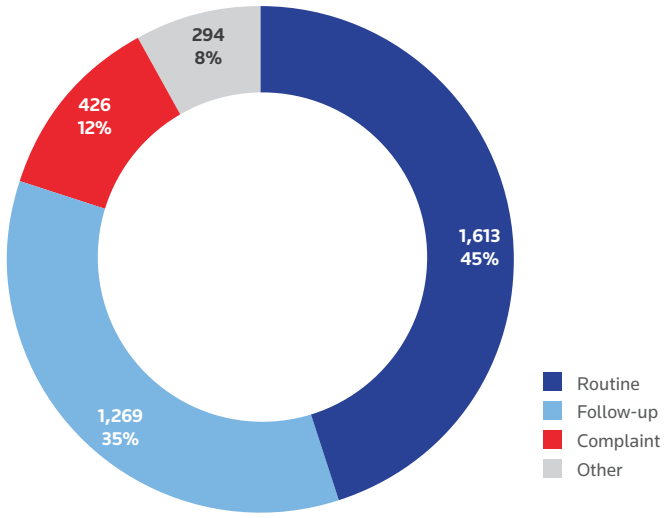
Source: ODCA analysis of data from DC Health's Digital Health Department (DHD) system.

The breakdown by risk-level for the establishments that received all their required routine inspections based on the risk schedule is as follows:

- High Risk # 5 = 0 out of 8 (0%) received all five routine inspections.
- High Risk #4 = 1 out of 145 (1%) received all four routine inspections.
- Moderate Risk #3 = 29 out of 1,850 (2%) all three routine inspections.
- Moderate Risk #2 = 51 out of 602 (8%) two routine inspections.

In FY 2025 DC Health conducted 3,602 total inspections, comprised of 1,613 (45%) routine inspections, 1,269 (35%) follow-up inspections, 426 (12%) complaint inspections, and 294 (8%) other types of inspections shown in Figure 4.

Figure 4: FY 2025 Inspections Conducted by Type



Source: ODCA analysis of data from DC Health's Digital Health Department (DHD) system.

Even when including all inspection types, the average inspection completion rate at each risk level was still under the required number of routine inspections. See Figure 5 for a risk-level breakdown of average total inspections and average routine inspections:

Figure 5: Average Total & Routine Inspections by Risk Level

Risk Level	Average Required Routine Inspections Completed	Average Total Inspections Completed
High Risk #5	2.4 (Required = 5)	4.4
High Risk #4	1.1 (Required = 4)	2.4
Moderate Risk #3	0.6 (Required = 3)	1.4
Moderate Risk #2	0.5 (Required = 2)	1.0

Source: ODCA analysis of data from DC Health's Digital Health Department (DHD) system and the Risk-Based Inspection Schedule provided by DC Health.

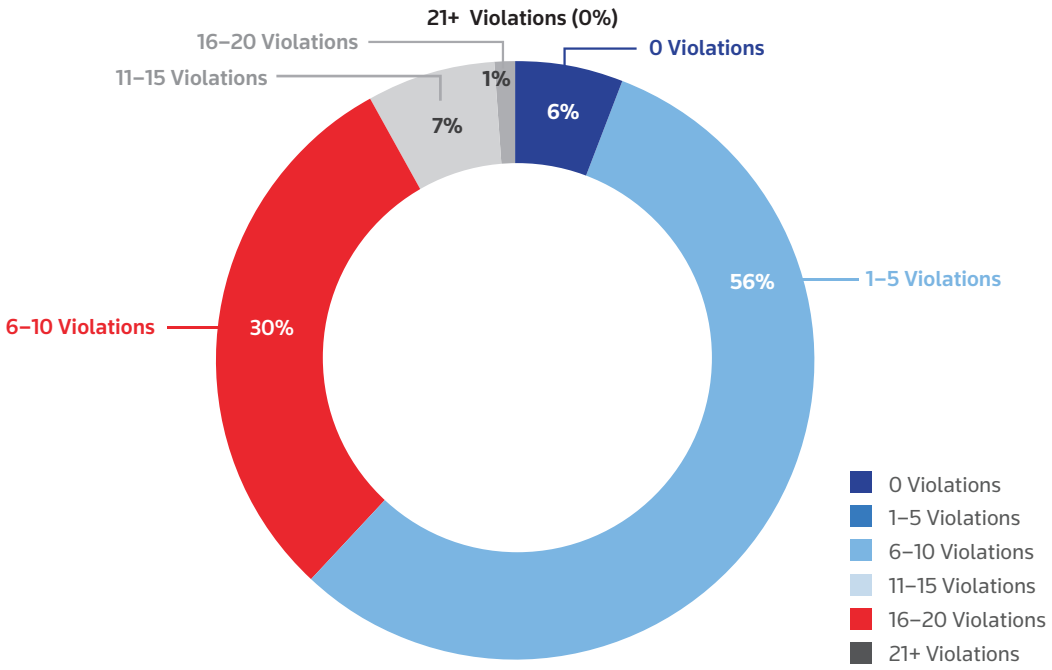
The primary cause of DC Health's failure to conduct all required routine inspections is inadequate staffing. In FY 2025, DC Health reported employing 13 Sanitarians and 1 investigator in the Division of Food. When looking at the total inspections for all establishment types (including delicatessens, bakeries, candy manufacturers, grocery stores, retail markets, ice cream manufacturers, restaurants, wholesale markets, mobile vendors, and hotels) the average annual output for each Sanitarian was 543 inspections per year. The FDA Voluntary National Retail Food Regulatory Standards recommends a range of 280-320 inspections per year per inspector/Sanitarian.

Such a heavy workload may lead to inconsistent and lower quality inspections and place additional strain on program management as they attempt to lead an overextended program.

Adding to this issue is the high rate of follow-up inspections. In FY 2025, 35% of the 3,602 inspections conducted were follow-ups (compared to 45% of routine). In examining violation counts at inspections, ODCA found that 94% of routine inspections resulted in at least one violation as detailed in Figure 6.[5]

5 In checking violation count totals from the Violation Code Analysis Report in DHD against inspection reports, ODCA found that in instances where the same violation was cited multiple times in the same inspection, the report only counted it as one violation instead of multiple violations. This means that the total violation counts associated with each inspection, and the associated averages, are likely slightly higher than listed in this report. In multiple inspections reviewed by ODCA, each report had one violation that occurred twice so the total number of violations for each inspection was one higher than is recorded in this report. ODCA could not make adjustments for all inspections so it chose to continue to use the counts established in this report and reference them as a minimum that could be higher.

Figure 6: Percent of Routine Inspections by Violation Count



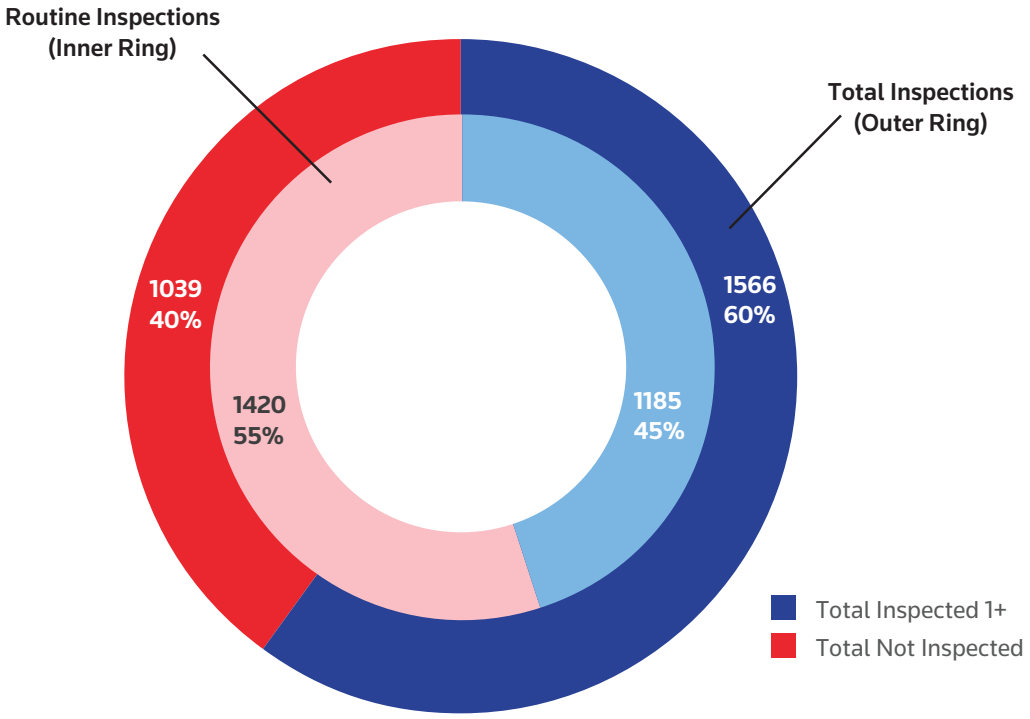
Source: ODCA analysis of data from DC Health's Digital Health Department (DHD) system.

DC Health has indicated they attempt to correct violations on site (COS) to reduce the need for follow-up inspections, but in a sample of inspections that resulted in at least one violation, only 6% of inspections had all violations corrected on site. Additionally, from the same sample, 17% of the inspections had violations that did not require a follow-up inspection, resulting in an approximate follow-up rate of 70%.[6]

DC Health's risk-based inspection schedule also requires a high number of routine inspections, ranging from one to five per year. In contrast, other jurisdictions using risk-based schedules typically require inspections every other year to twice per year, or one to three times per year. Insufficient staffing combined with the high number of required routine inspections has greatly limited the coverage of DC Health's food inspections across restaurants. In FY 2025, 40% of restaurants received no inspections, and 55% received no routine inspection, as seen in Figure 7.

6 Core violations do not require verification of correction.

Figure 7: Restaurants Inspected at least Once (Routine and Total Inspections)



Source: ODCA analysis of data from DC Health's Digital Health Department (DHD) system.

Each inspection is an opportunity for DC Health to educate industry personnel on their responsibilities and legal requirements for food establishments in the District. When inspections are infrequent or delayed, these opportunities for knowledge sharing decrease, increasing the likelihood that establishments will violate the food code.

DC Health falling far short of its required inspections means the public is not sufficiently protected from potential foodborne illnesses. With only 3% of restaurants receiving all required inspections, 22% of required routine inspections completed, and 40% of restaurants not receiving any type of inspection, there is an increased risk that unsanitary conditions or other factors contributing to foodborne illnesses are not being identified or addressed.

After the end of our audit scope, DC Health informed ODCA that they implemented a new risk-based schedule as of March 2026. This new schedule reduced the number of yearly required routine inspections for risk-levels 1-4. While this change is in line with Recommendation 1 below, ODCA recommends DC Health periodically conduct this review to continuously improve its ability to safeguard the District's food supply and ensure it is keeping up with best practices.

Recommendations

1. DC Health should periodically review best practices for inspection frequency and if necessary, modify the risk-based schedule to establish more sustainable routine inspection requirements. Any adjustments should remain consistent with the FDA Model Food Code, ensuring public health protections are maintained while enabling broader and more consistent inspection coverage across the District's food establishments.
2. DC Health should create and implement a staffing plan that identifies the personnel levels needed to complete timely routine inspection requirements in accordance with the risk-based inspection schedule.

DC Health did not consistently enforce all Food Code violations in FY 2025. In a sample of inspections with violations, only 55% resulted in either corrective action or additional enforcement action.

Sanitarians identify and record all priority, priority foundation, and core violations in an inspection report. Priority items directly reduce foodborne illness risks through quantifiable controls, such as cooking, cooling, and handwashing. Priority foundation items directly support the implementation of priority items, such as training, equipment, record-keeping, and labeling. Core items include but are not limited to general sanitation, operational controls, and general maintenance.

Priority and priority foundation violations must be corrected within five days of the inspection. DCMR states, "After receiving notification that the licensee has corrected a violation of a priority item or priority foundation item or HACCP [Hazard Analysis Critical Control Points] Plan deviation, or at the end of the specified period of time as stated in § 4410.2, the Department shall verify correction of the violation, document the information on an inspection report, and enter the report in the Department's records."[7]

For core violations which must be corrected within 14 days of the inspection, DCMR does not require verification of correction.[8]

In a sample of 40 inspections that had at least one priority or priority foundation violation, the violations were not fully enforced in 45% (18 out of 40) of the inspections. Seven did not have a follow-up inspection, and 11 inspections identified repeat violations that did not result in additional enforcement actions.

Of the 55% (22 out of 40) that had all violations enforced, three had all violations corrected on site, 14 had all violations corrected at the follow-up inspection, and five locations were issued a Notice of Infraction (NOI).[9]

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7 25-A DCMR § 4411.2.

8 25-A DCMR § 4412 contains information on violations of core items and their time frame for correction but contains no subsequent section on verification on documentation of correction which is found in DCMR 25-A § 4411.2 for priority and priority foundation violations.

9 The Division of Food Operations and Procedures Manual allows an establishment to correct certain violations while the inspector is on site. Immediately remediating issues also helps to reduce the number of follow-up inspections that DC Health is required to conduct.

In instances where a follow-up inspection occurred, the average time from initial inspection to follow-up was 42 days, with a range of six to 122 days. While the establishment is given a timeframe to correct mistakes, DC Health staff noted in interviews that they cannot verify if the violation was corrected until the end of the five-to-14-day window but that often the follow-up occurs later than that.

Many of the factors affecting routine inspection completion rates are also present in DC Health's violation enforcement. In FY 2025, follow-up inspections accounted for a significant portion of the Division's workload (35% of all inspections). With DC Health staff conducting nearly twice as many inspections per person as recommended by the FDA and still completing less than 25% of routine inspections required each year, it is evident that the staffing shortages are a primary reason the Department fully enforced violations from only 55% of inspections.

From an enforcement and policy perspective, DCMR and DC Health policies require specific timelines for licensees to correct violations but do not have written requirements for the timeframe in which a follow-up inspection must occur. DC Health staff indicated they try to complete follow-ups in a timely manner but that sometimes the follow-up is delayed.

On a positive note, the violation enforcement data shows clear evidence of workload prioritization. Follow-up inspections occurred in 30 out of the 37 inspections requiring follow-up (81%), which is a far higher rate of completion than the 22% of required routine inspections. This showed that DC Health was able to mitigate some of its capacity-related challenges by prioritizing follow-ups of known violations.

Even with a higher follow-up rate for known violations, the low overall enforcement rate can foster a culture of non-compliance. Although DCMR establishes penalties for non-compliance, the absence of fully defined, and consistently applied enforcement policies and procedures is likely a factor contributing to the high rate of violations found at inspections.

With nearly half of inspections resulting in violations without steps taken to verify that all issues were corrected, the public is not adequately protected from known risks that could lead to foodborne illness.

Recommendation

3. DC Health should develop and implement changes to the Division of Food Operations and Procedures Manual for the timeframes to conduct follow-up inspections and when to issue Notice of Infractions for restaurants that fail to comply with the food safety requirements.

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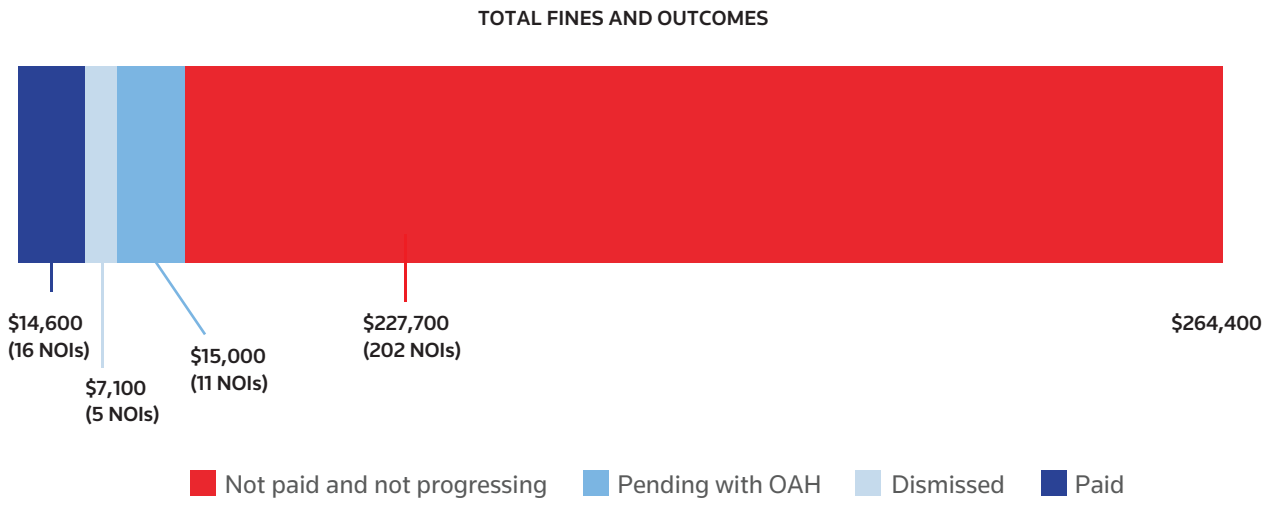
202 of the 234 Notice of Infractions generated in FY 2025 by the Division of Food at DC Health remain unpaid and are not part of proceedings at the Office of Administrative Hearings. This indicates that DC Health lacks a reliable and consistent process for managing Notice of Infractions, rendering them an ineffective enforcement mechanism.

DCMR states that "Civil fines, penalties, or related costs may be imposed against any food establishment, owner, or person in charge for violation of any provision of this Code."[10] Fine totals range from $50 to $2,000 for first time offenses for Class 1-5 infractions.[11]

DC Health generated 234 Notice of Infractions (NOIs) in FY 2025 totaling $264,400, of which 202 totaling $227,700 remain open, unpaid, and not part of proceedings at the Office of Administrative Hearings (OAH). The full breakdown of the NOIs can be seen below and in Figure 8.

- 16 fines totaling $14,600 were paid.[12]
- 5 fines totaling $7,100 were dismissed by OAH.
- 11 fines totaling $15,000 were pending OAH determination or payment.
- 202 fines totaling $227,700 are open, unpaid, and not progressing as part of OAH proceedings.

Figure 8: Total Fines Issued in FY 2025 and Status of Fines



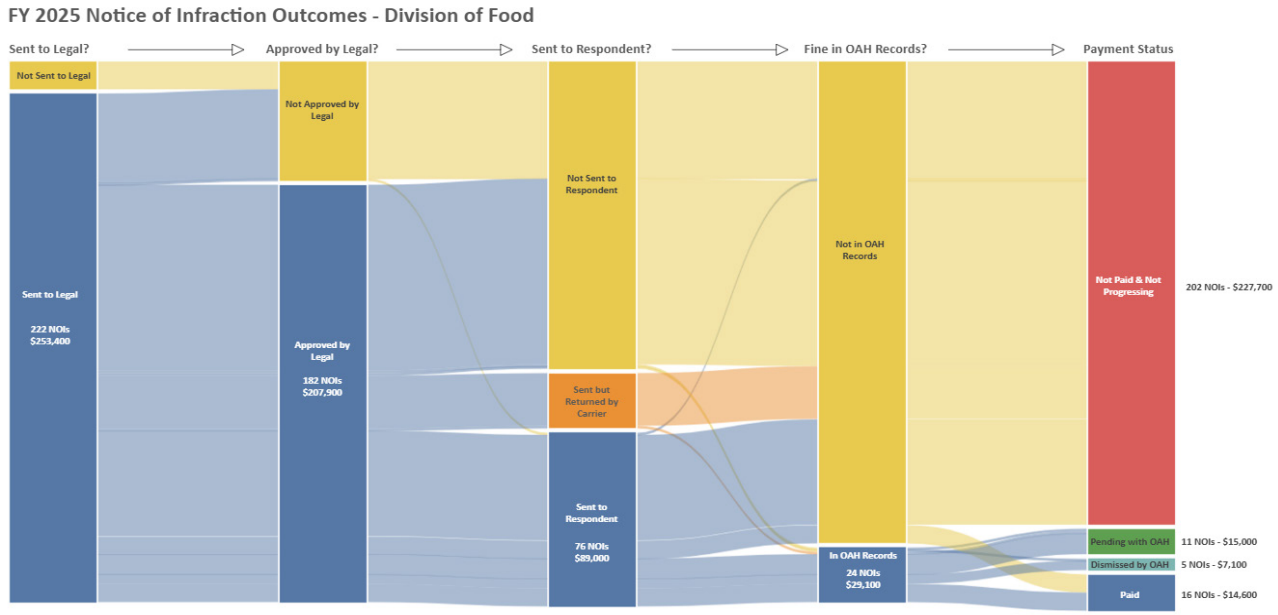
Source: ODCA analysis of data from DC Health's internal spreadsheet-based Notice of Infraction trackers, DC Health' Salesforce payment system, and OAH's eCourt system.

To determine the status of each NOI and why so few had been paid, ODCA analyzed data from DC Health's internal spreadsheet-based NOI trackers, DC Health's payment system, and OAH. Figure 9 shows that at each step in the process represented in the chart, there are significant drop-offs in fines. Some 78% of NOIs were approved to move forward by DC Health's General Counsel office, however only 43% of NOIs were sent to respondents. This means that nearly half of the NOIs that were approved by legal were not moved forward by the Division of Food. Of those that were marked as mailed to respondents under one-

10 25-A DCMR § 4720.1.
11 *See* 16 DCMR § 3200 for a discussion of classes of infractions and 16 DCMR § 3201 for fine amounts.
12 Out of the 16 payments ODCA found records for, only eight were in OAH records. Of those eight payments in OAH records, six were also in DC Health's records, and two were only in OAH's records. The other eight payments were only in DC Health's records and were not in OAH's records.

third, or 10% of total NOIs, were found in OAH records, indicating another significant drop-off in fines being sent to OAH.

Figure 9: FY 2025 Notice of Infraction Outcomes – Division of Food



Source: ODCA analysis of data from DC Health's internal spreadsheet-based Notice of Infraction trackers, DC Health' Salesforce payment system, and OAH's eCourt system.

In interviews, DC Health staff articulated a process for managing NOIs but had no written policies or procedures for managing the process once the NOI had been created by a Sanitarian. The failure to follow a written process resulted in high drop-off rates for fines at every stage, particularly those internal to DC Health.

Additionally, the Division of Food did not utilize available information from other internal sources to track the progress of the NOIs it issued. In particular, the Salesforce payment application had easily available records of payments made to DC Health that were not documented in the Division's internal tracker or used to inform publicly available documents provided to the D.C. Council as a part of its performance oversight hearings. In reviewing FY 2025 documentation, ODCA found that 13 of the 14 payment records in DC Health's Salesforce application were listed as "Pending OAH" in performance oversight documents.

Many of these issues also point to a lack of ownership of the NOI process. Multiple payment avenues and ways for cases to be initiated with OAH after NOI issuance, as well as ineffective communication between agencies, has led to a lack of ownership and visibility on fine outcomes. The Division of Food and DC Health have failed to effectively coordinate with OAH on tracking NOIs through available tools such as eCourt. Similarly, OAH does not have a set process to inform issuing agencies when a case is closed, or payment is received for one of its NOIs.

DC Health has indicated that it prioritizes compliance over enforcement and does not want the fine process to serve as a revenue generator. However, in the instances where it determined fines were necessary, very few resulted in payment, with greater than $200,000 of lost revenue for DC Health and the District. Additionally, with 94% of routine inspections citing at least one violation and the Division of Food's limited staffing affecting its ability to complete all required inspections, ineffective enforcement of repeat or critical violations is likely one reason compliance with the Food Code is not higher.

Recommendations

4. DC Health should update the Division of Food's Operations and Procedures Manual with policies and procedures for the Notice of Infraction process, including the role of the DC Health Office of the General Counsel, use of DC Health's payment applications, and referrals to the Office of Administrative Hearings.
5. DC Health should ensure Division of Food staff receive appropriate training and have access to the necessary reports and tools to track the payments and statuses of Notice of Infractions issued by DC Health.
6. DC Health should establish a process with the Office of Administrative Hearings (OAH) to track the status of Notice of Infractions going through OAH's process and document it in the Division of Food's Operations and Procedures Manual.

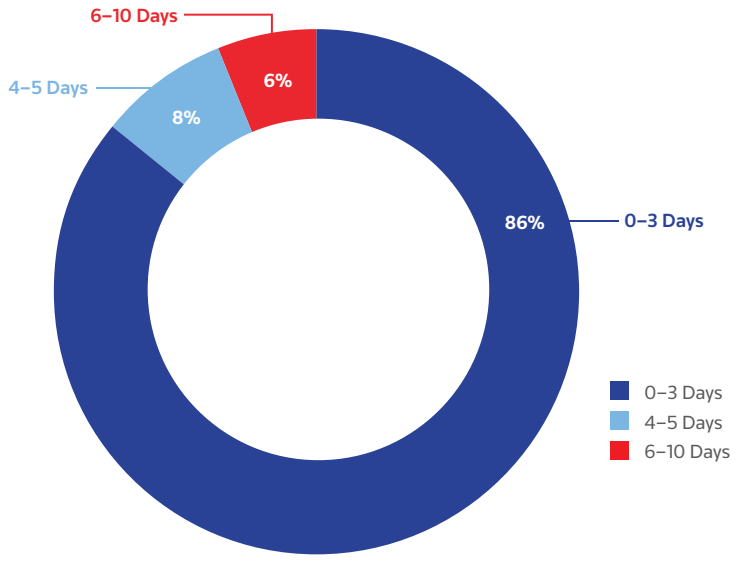
DC Health was able to quickly respond to most restaurant-related complaints due to its effective workload prioritization, coordination with the Foodborne Epidemiologist, system-based tracking, and a comparatively small complaint workload.

DC Health's Division of Food Operations and Procedures Manual requires confirmed foodborne illness (FBIs) complaints to be investigated within three calendar days of receipt. All other complaints must be investigated within five calendar days of receipt.

DC Health timely investigated 89% of restaurant-related complaints in FY 2025. Of the 504 complaints received, 79 were foodborne illness-related complaints and 425 were other types of complaints.

Some 86% of complaints received related to foodborne illness were investigated in three calendar days or fewer, with an average of 1.7 days from complaint to closure, as seen in Figure 10.

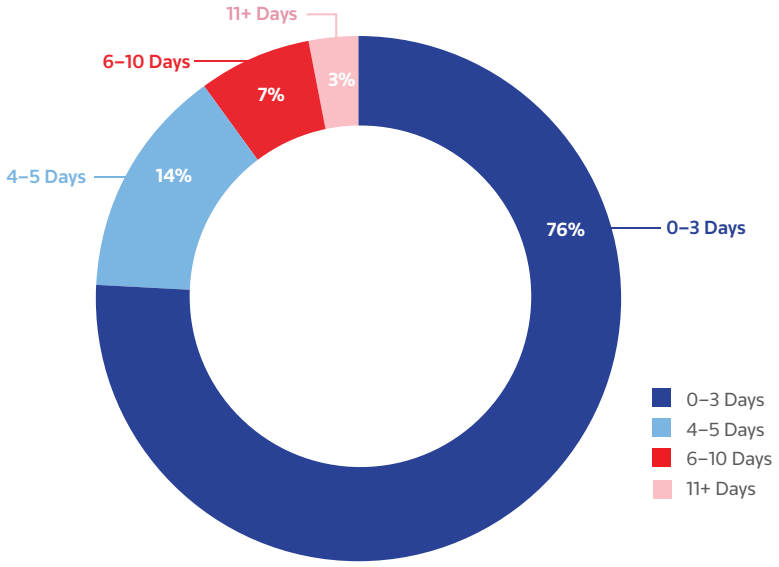
Figure 10: Days to Closure – Foodborne Illness Complaints



Source: ODCA analysis of data from DC Health's Digital Health Department (DHD) system.

Some 89% of non-foodborne illness complaints were investigated within five calendar days, with 74% being closed within three days. The average days from complaint to closure for non-foodborne illness was 2.8 days, as seen in Figure 11.

Figure 11: Days to Closure – Non-Foodborne Illness Complaints



Source: ODCA analysis of data from DC Health's Digital Health Department (DHD) system.

DC Health made a clear prioritization decision to investigate complaints per the timelines in their policy. DC Health was able to promptly investigate most complaints even when it was able to complete only 22% of required routine inspections for restaurants in FY 2025.

The workload prioritization is complemented by effective process management and coordination with other programs. Complaints are considered a priority for investigation and are entered into the Digital Health Department (DHD) system and assigned a Sanitarian for investigation. Internal reports are then used to track the number of days since the complaint was issued and its status. The system-based assignments establish clear responsibility and accountability for timely investigation, reducing the risk of unresolved or overlooked complaints.

For all foodborne illness related complaints, the Division of Food works closely with the Foodborne Epidemiologist. The Foodborne Epidemiologist takes the lead on initial investigations (contacting the complainant and asking detailed follow-up questions immediately after receiving the complaint) and then works with the Division of Food to conduct an inspection if necessary.

The effective workload prioritization and use of DHD resulted in a timely response to most complaints from DC Health and the Division of Food, helping to reduce potential vectors of foodborne illness. The timely complaint response rate also shows responsiveness to community input which helps foster a more collaborative approach with the community.

DC Health conducted restoration inspections promptly, but weaknesses in documentation retention and a breakdown in the restoration inspection process indicate gaps in oversight.

DC Health's Division of Food Operations and Procedures Manual and DCMR require restoration inspections to be completed within three days of receiving a restoration request form and the inspection fee for restaurants who received summary suspensions.[13] Summary suspensions are a matter of enforcement in instances including but not limited to imminent health hazards, no license, no DC-Issued Certified Food Protection Manager on duty, and rodent infestation. The Sanitarian issuing the summary suspension will inform the person in charge that in order for the license to be restored, all violations that caused the summary suspension must be corrected, a written request for re-inspection (restoration request form) must be submitted to DC Health, and a fee for the re-inspection must be paid prior to the restoration inspection. There are two possible fees for restoration inspections: $100 for inspections during business hours or $400 for after hours or weekends. Once the above steps have been completed, DC Health will schedule and conduct the restoration inspection.

Based on a review of the restoration request forms, payment records, and inspection logs for all 30 restaurant restoration inspections in FY 2025, DC Health did not comply with its own policy for 40% of

13 25-A DCMR § 4413.2 requires DC Health to perform the reinspection within three calendar days of receipt of request for reinspection. DC Health refers to this as a "restoration inspection".

the restaurants that received summary suspensions. In some cases, restaurants may have responded but documentation was not provided.

The following is a detailed breakdown of the reason for non-compliance:

- Nine were missing a restoration request form.
- One was missing a restoration request form and fee payment.
- One was missing a fee payment.
- One was missing a restoration inspection but had submitted a restoration request form and fee payment.

The one restaurant that did not receive a restoration inspection does have a payment record and a restoration request form on file but has not been inspected since its summary suspension. The website and Google reviews for the location appear to show it has remained open since the summary suspension.

When asked why the restaurant was not inspected after its summary suspension and the submission of all required documents and payments, DC Health provided the following response, "A restoration inspection was not conducted. The restoration inspection fee was processed, and the Restoration Request Application was received. The establishment did not follow up with their availability for inspection. Additionally, the program failed to follow up with the establishment after not receiving a response to confirm they were not open and operating in violation of the issued summary suspension." This gap in oversight exposes the public to known issues that could lead to foodborne illness.

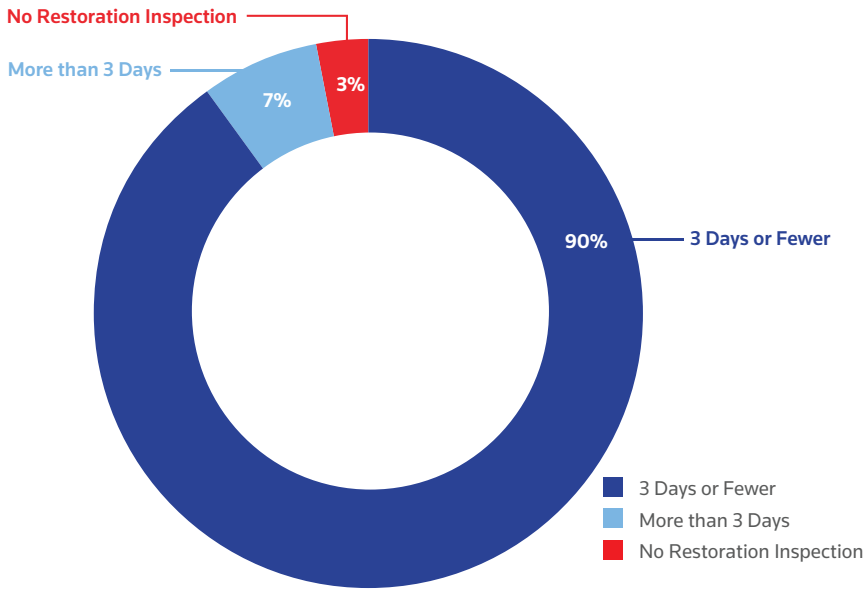
In reviewing the timeliness of restoration inspections ODCA found that they were completed on average 1.5 days after receipt of all necessary paperwork and that 27 of 30 restoration inspections were completed in three days or fewer, as shown in Figure 12.[14] [15] [16]

14 If an establishment paid a $100 fee and there was a weekend between the payment and inspection, ODCA used business days to assess the Division of Food's timeliness because the establishment did not pay for a weekend inspection.

15 Of the three inspections that were not completed within 3 days, one (Aleph & Amen) was calculated using the days between the summary suspension and restoration inspection because DC Health did not provide records or dates for the restoration form or payment.

16 For the 10 establishments that DC Health did not provide a restoration request form, ODCA used the payment date to calculate the days between paperwork completion and restoration inspection.

Figure 12: Days Between Paperwork/Payment Completion and Restoration Inspection



Source: ODCA analysis of data from DC Health's Digital Health Department (DHD) system.

The high rate of on-time restoration inspections when DC Health is only able to complete 22% of its required routine inspections shows a prioritization of restoration inspections. The established workflow and use of the Salesforce payment application resulted in quick turnaround times from payment receipt to restoration inspection. These factors generally helped mitigate the impact of insufficient staffing, encouraging compliance with the summary suspensions. Restaurants that are summarily suspended can reopen quickly if they comply with DC Health's requirements, which further reinforces timely adherence to the restoration process.

Poor document retention practices for restoration request forms by DC Health was the primary reason over half of the restoration inspections were conducted out of compliance with DC Health's policies. Additionally, in two instances, DC Health failed to collect fees for restoration inspections, resulting in at least $200 of lost revenue for the District.

Recommendations

7. DC Health should develop and implement document storage and retention procedures to ensure that Application for Establishment Restoration due to Summary Suspension forms are completed and readily accessible upon request.
8. DC Health should establish procedures in the Division of Food Operations and Procedures Manual to verify that suspended establishments are not operating while under suspension.

DC Health did not update inspection frequency based on performance, expending limited resources at locations with a history of compliance with the District's Food Code instead of focusing resources on establishments that pose a greater risk of foodborne illness.

DCMR details how the role of past performance related to nonconformance should affect inspection frequency at establishments.[17]

> Within the parameters specified in 25-A DCMR § 4401, the Department shall prioritize, and conduct more frequent inspections based upon its assessment of a food establishment's history of compliance with this Code and the establishment's potential as a vector of foodborne illness by evaluating:
>
> a. Past performance, for nonconformance with this Code or HACCP Plan requirements that are priority items or priority foundation items;[18]
> b. Past performance, for numerous or repeat violations of this Code or HACCP Plan requirements that are core items;
> c. Past performance, for complaints investigated and found to be valid;
> d. The hazards associated with the particular foods that are prepared, stored, or served;
> e. The type of operation including the methods and extent of food storage, preparation, and service;
> f. The number of people served; and
> g. Whether the population served is a highly susceptible population.

DC Health did not update inspection frequencies for restaurants in FY 2025 based on non-compliance and has no written operational policies or procedures to implement DCMR §4401. Without documentation on what threshold would need to be met to adjust the frequency of inspections for non-compliance, DC Health has no set standard for inspection frequency adjustment. Current reporting in DHD is also not set up to track violation counts and types by establishment making it difficult to monitor trends in an establishment's compliance across inspections.

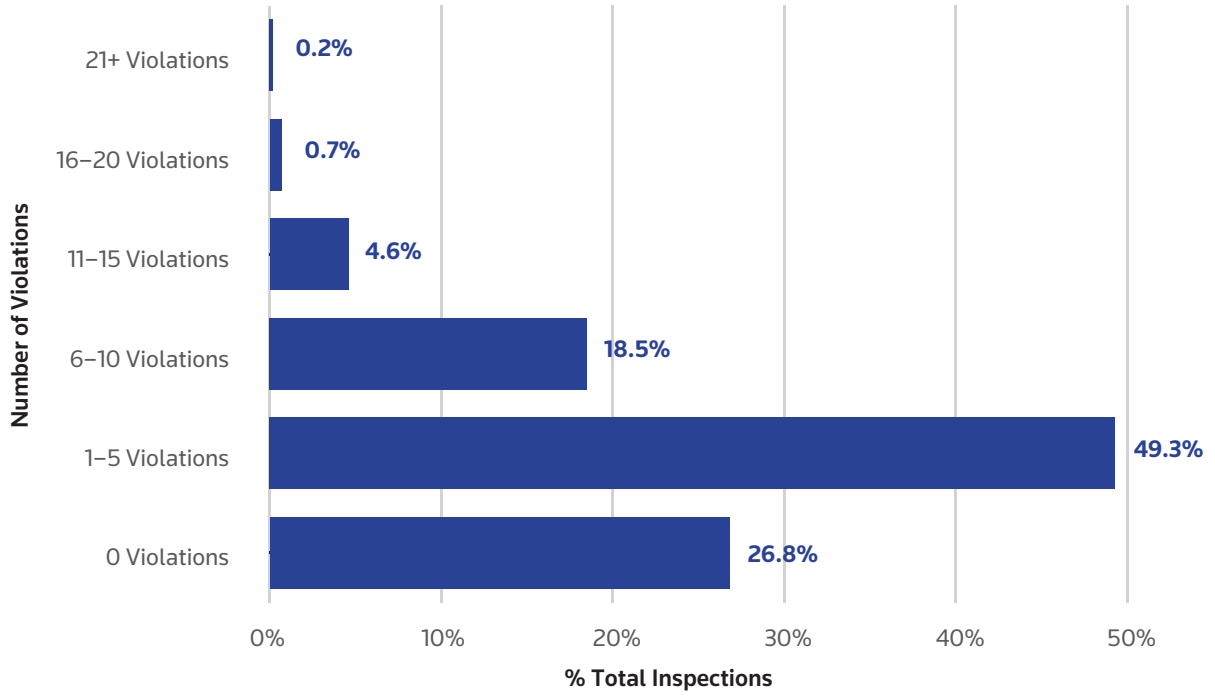
ODCA analysis found at least 17 establishments had multiple inspections with more than 10 violations apiece in FY 2025, including at least one establishment with multiple inspections that found 20 or more violations.[19] Figure 13 details violation counts across all inspection types in FY 2025. Around 95% of inspections had 10 or fewer violations, with an average of 3.4 violations for all inspection types.

17 25-A DCMR § 4401.1.

18 Hazard Analysis Critical Control Points (HACCP)

19 In checking violation count totals from the Violation Code Analysis Report in DHD against inspection reports, ODCA found that in instances where the same violation was cited multiple times in the same inspection, the report only counted it as one violation instead of multiple violations. This means that the total violation counts associated with each inspection, and the associated averages, are likely slightly higher than listed in this report. In multiple inspections reviewed by ODCA, each report had one violation that occurred twice so the total number of violations for each inspection was one higher than is recorded in this report. ODCA could not make adjustments for all inspections so it chose to continue to use the counts established in this report and reference them as a minimum that could be higher.

Figure 13: Percent of Total Inspections by Violation Count



Not adjusting inspection frequency according to establishment performance results in an inefficient allocation of limited resources. By inspecting consistently high-performing establishments at the same rate as those with repeated poor performance, DC Health missed the opportunity to focus its efforts on establishments that pose a greater risk of foodborne illness.

Recommendations:

9. DC Health should develop policies and metrics to define past performance of non-compliance with the Food Code, as well as update the Division of Food Operations and Procedures manual with how updates to inspection frequency should be made based on an establishment's history of compliance consistent with DCMR.
10. DC Health should develop reporting to track establishment compliance across inspections, including violation types and counts per inspection.

Inadequate reporting limited the Division of Food's decision making and left DC Health, the Mayor, the Council, and the public without the information needed to determine the resources required for the food inspection program to protect public health.

The U.S. Government Accountability Office (GAO) publishes Standards for Internal Control in the Federal Government that may also be adopted by state, local, and quasi-governmental entities. Internal control is

the process that management uses to help an entity achieve its objectives. It is designed to make an entity run efficiently and effectively, report reliable information, and comply with laws and regulations.

Principle 13 states, "Management should obtain or generate relevant, quality information and use it to support the functioning of the internal control system."

Principle 15 states, "Management should communicate relevant and quality information with appropriate external parties regarding matters impacting the functioning of the internal control system."[20]

DC Health relies on the Digital Health Department (DHD) system to manage the inspection workload. The available reports in DHD do not provide accurate or adequately detailed information on required routine inspection completion rates. For example, the stock report showing aggregate inspection counts by risk level cannot distinguish between inspection types (e.g. routine, follow-up, and complaint) and has incorrect totals for the number of establishments at each risk level.

DC Health reported to the D.C. Council in its FY 2025 Performance Oversight responses that it completed 58% of required inspections by conducting 3,617 total inspections at 2,689 restaurants. This does not accurately reflect the required routine inspection completion percentage based on the risk schedule, which ODCA found to be 22% in FY 2025.

See Figure 14 for a comparison of the summary data initially provided to ODCA for this audit, the data provided to the D.C. Council, and then the data from ODCA's analysis of inspection logs and license records. The difference in establishment and inspection numbers provided by DC Health for FY 2025 illustrates some of the challenges with the current reporting capabilities in addition to the incorrect percentage of required inspections completed.

Figure 14: Summary FY 2025 Food Establishment Inspection Data

Fiscal Year 2025	Number of Facilities (Restaurants)	Number of Inspections	Percentage of Required Inspections Done
(DC Health) – Summary Information Provided for ODCA Audit	2,671	3,614	N/A
(DC Health) – Performance Oversight Documentation	2,689	3,617	58%
(ODCA) - Analysis of Data from DHD	2,605	3,602	22%

Source: ODCA analysis of data from DC Health's Digital Health Department (DHD) system, summary data provided by DC Health to ODCA, and Performance Oversight documentation prepared by DC Health.

20 See Green Book pages 96 (Principle 13) and 99 (Principle 15).

In conducting data clean-up activities to determine the number of active restaurants in FY 2025, it was clear that limited and out-of-date license information was impacting reporting and operational activities. The DC Department of Licensing and Consumer Protection (DLCP) issues licenses for food services. An active license is required for an establishment to be open and indicates that DC Health needs to conduct inspections at the location. DLCP and DC Health do not conduct reconciliations on licenses with any set frequency.

DC Health does not use license data including expiration dates from DLCP to inform its work. The main impact, as reflected in the data, is that DC Health does not update a license to "Expired" until staff verify the expiration when they go out for an inspection. This results in records where licenses remain marked as "Active" in DHD even though their expiration dates have already passed. This often occurs because an establishment likely already has a new license, but DC Health does not confirm and enter it into the system until they view it on site. In interviews with Sanitarians, this can also result in inspectors showing up to inspect closed establishments.

In addition to the challenges with determining the establishment count, the stock reports in DHD do not accurately show establishment counts by risk level, requiring manual calculations outside of the system to properly calculate the risk-level breakdown of establishments needed to determine required inspection completion percentage.

These limited reporting capabilities hamper the program management's ability to make agile decisions. Stock reports in DHD are not accurate and as useful as they should be and the work required to manually clean and resolve issues in the data outside the system is time consuming, making it less practical to complete given the resource constraints in the Division of Food at DC Health.

Additionally, the lack of adequate reporting on the program's performance has left DC Health, the Mayor, the D.C. Council, and the public without the information needed to make decisions on what is required to bring the food inspection program closer to compliance with its own policies.

Recommendations

11. DC Health should ensure its information and reporting system produces accurate reports to track inspection rates for establishments as defined in the risk schedule.
12. DC Health should develop and implement a process with the Department of Licensing and Consumer Protection (DLCP) to maintain accurate license information.

DC Health generally completes inspection reports accurately and in accordance with requirements due to its structured digital inspection form and established review workflows.

DC Health uses the same inspection form to complete all food inspections; see Appendix A for a sample inspection report. DCMR requires:[21]

> The Department shall designate the form for each food establishment inspection.
>
> The Department shall document on an inspection form: (a) Administrative information about the food establishment's legal identity, street and mailing addresses, type of establishment and the nature of its operations as specified in § 4304, inspection date, and other information such as type of water supply and sewage disposal, status of the license, and personnel certificates that may be required; and (b) Specific factual observations of volatile conditions or other deviations from this Code that require correction by the licensee including: …

At the conclusion of an inspection, DC Health's operations and procedures manual states that Sanitarians shall "enter inspection reports into the inspection database upon the completion of inspection walkthroughs. Inspection reports must be signed by the Person in Charge…"

DCMR similarly articulates, "At the conclusion of the inspection and according to this Code, the Department shall provide a copy of the completed inspection report and the notice to correct violations to the licensee or to the person in charge, and request a signed acknowledgement of receipt."[22]

If the person in charge refuses to sign an acknowledgement of receipt, DCMR states:

> The Department shall inform a person who declines to sign an acknowledgment of receipt of inspectional findings as specified in § 4405 that: (a) An acknowledgment of receipt is not an agreement with finding; (b) Refusal to sign an acknowledgment of receipt will not affect the licensee's obligation to correct the violations noted in the inspection report within the time frames specified; and (c) A refusal to sign an acknowledgment of receipt is noted in the inspection report and conveyed to the Department's historical record for the food establishment.[23]

DC Health fully complied with inspection report requirements in 90% of sampled inspections, with the remaining 10% partially compliant.

ODCA used a random sample of 40 inspections to assess if the inspection forms had all required items evaluated for compliance, were signed by the establishment, and were sent to the establishment. For the four inspections that were not fully compliant:[24]

- Three were missing signatures or a note of refusal.
- One was not provided to the establishment.

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21 25-A DCMR § 4403.1-4403.2.
22 25-A DCMR § 4405.1.
23 25-A DCMR § 4406.1.
24 None of the three inspections missing signatures had a note indicating that a person at the establishment had refused to sign the report and the inspection from the sample that did not have an email receipt did not note anywhere else in system that the report was delivered via other methods.

DC Health's use of a digital inspection form with required fields, established in-system workflows for supervisory review and approval, and publicly posted inspection reports led to high compliance rates with inspection form completion and delivery requirements.[25] Each digital form is routed through a supervisory approval queue before being published, ensuring a second level of review for accuracy and completeness. Public posting of reports added an additional layer of accountability. Together, digital inspection forms and the associated system-based workflow result in consistently complete inspection reports that provide management and the public with reliable, detailed information from every inspection.

Recommendation

13. DC Health should ensure inspection reports that do not have a signature due to a refusal to sign have the refusal noted in the inspection report per DCMR.

DC Health did not conduct all necessary Quality Assurance Evaluations of Sanitarians in accordance with its policies, increasing the risk of inconsistent and lower quality inspections.

DC Health's Division of Food Operations and Procedures Manual states, "Supervisory Sanitarians shall utilize the Sanitarian Quality Assurance Report (QAR) at least twice per fiscal year for each Sanitarian to ensure that high-quality inspections are conducted and properly documented." The purpose of these evaluations is to assess both the quality and consistency of the inspections completed by Sanitarians.

The scoring system used in the sheets sums up to a maximum possible score of 100 points. Depending on the Sanitarian's score, follow-up actions may be required to ensure they maintain a high quality of work.

- Under 85
  - If the score is below 85, an additional meeting with the Sanitarian must be scheduled in order to point out issues and solutions.
  - Add meeting notes/points to the file, including an addendum that indicates the Sanitarian's name and date.
- Under 75
  - If the score is below 75, additional training is necessary. This training may include, but is not limited to, online courses, joint inspections with other Sanitarians, training by supervisors, and other relevant activities.
  - Add training requirements and complete training to the file. (Ex: If training required was online, document what course was required & get a copy of certificate of completion)

In the Division of Food Operations and Procedures Manual it indicates that the Supervisory Sanitarian should document everything and keep a file on each Sanitarian.

25 Public inspection reports can be found at https://dc.healthinspections.us/?a=Inspections.

DC Health conducted only 11 out of 26 Quality Assurance Reports in FY 2025.[26] Of the 11 QARs completed as part of the evaluation process, six had sufficient evidence that the QAR occurred and that the required follow-up actions were completed, while five did not.

The five QARs that were determined to not have sufficient evidence that they occurred were all handwritten forms that had no evidence of being sent to the assessed Sanitarians. In addition, several were unsigned, and in some cases ODCA could not verify that the signature belonged to the Sanitarian.

Of the 11 QARs, only one had a score below 85, suggesting that acceptable performance is generally being achieved. For the Sanitarian who received a score below 75, DC Health provided documentation showing that additional training and follow-up meetings occurred. While this demonstrates that required training is provided when low scores occur, the overall unreliability of information in the QARs prevents ODCA from determining that Sanitarians are being accurately assessed.

Insufficient staffing had a significant impact on the quality assurance evaluation process. When asked why two QARs per Sanitarian were not completed, the DC Health supervisor explained that they were the only supervisor on staff in FY 2025, whereas the Division of Food normally has two supervisors. As a result, their supervisory workload doubled, and they were only able to complete one QAR per Sanitarian.

Staff not receiving proper evaluations on inspection quality limits their access to necessary feedback and training. Quality Assurance Evaluations are a key mechanism for ensuring staff maintain the level of skill needed to perform their work consistently and with the required quality. If staff are not receiving proper evaluations it may result in inconsistent inspection quality and outcomes.

Recommendation

14. DC Health should develop contingency plans to ensure key supervisory responsibilities, including the completion of Quality Assurance Reports (QARs), are performed during periods of staff vacancies or reduced supervisory capacity.

26 The Division of Food at DC Health reported employing 13 Sanitarians. ODCA expected to receive at a minimum 26 Quality Assurance Reports (QAR), or two per Sanitarian.

Conclusion

The Division of Food at DC Health plays an integral role in protecting public health by overseeing the safety of the District's food supply and inspecting its roughly 6,500 food establishments. In FY 2025, DC Health completed only 22% of the required routine inspections for restaurants. Additionally, 94% of routine inspections at restaurants found at least one violation, leading to a high follow-up rate that greatly increased the number of inspections that DC Health needed to conduct.

Several factors contributed to DC Health's inability to successfully fulfill its purpose to safeguard public health in its management of the District's food supply, but the primary cause was insufficient staffing. In FY 2025, DC Health staff conducted inspections at nearly twice the rate recommended by the FDA and still fell far short of completing required routine inspections.

While DC Health has made some notable prioritization decisions with its limited staffing, resource constraints have also led to a degradation of key operations and procedures. Staff evaluations were not consistently or adequately conducted, repeated non-compliance at establishments did not result in adjusted inspection frequencies, and the fine process was not effectively administered.

Together, these factors reduced DC Health's effectiveness in promoting food safety, as infrequent or inconsistent inspections, along with limited enforcement of repeat violations, do not provide restaurants with clear expectations or adequate opportunities to strengthen their understanding of legal obligations.

DC Health also lacked the necessary reporting functionality to properly monitor and report on its work, limiting both internal and external decision-making. Without adequate reporting tools, DC Health cannot make informed workload decisions and District officials responsible for resource allocation do not receive accurate or adequate information about program operations.

ODCA believes that additional staffing, better technology, consistent enforcement, and sustainable inspection frequencies would improve the quality of inspections and food establishments' compliance with the code, helping the Division of Food to fulfill its role in protecting public health.

Summary of Report Recommendations

Our audit identified 14 recommendations that could improve operations at DC Health.

Findings	Recommendations
DC Health completed only 22% of the routine inspections required by its risk-based schedule at restaurants in FY 2025.	**1.** DC Health should periodically review best practices for inspection frequency and if necessary, modify the risk-based schedule to establish more sustainable routine inspection requirements. Any adjustments should remain consistent with the FDA Model Food Code, ensuring public health protections are maintained while enabling broader and more consistent inspection coverage across the District's food establishments. **2.** DC Health should create and implement a staffing plan that identifies the personnel levels needed to complete timely routine inspection requirements in accordance with the risk-based inspection schedule.
DC Health did not consistently enforce all Food Code violations in FY 2025. In a sample of inspections with violations, only 55% resulted in either corrective action or additional enforcement action.	**3.** DC Health should develop and implement changes to the Division of Food Operations and Procedures Manual for the timeframes to conduct follow-up inspections and when to issue Notice of Infractions for restaurants that fail to comply with the food safety requirements.
202 of the 234 Notice of Infractions generated in FY 2025 by the Division of Food at DC Health remain unpaid and are not part of proceedings at the Office of Administrative Hearings. This indicates that DC Health lacks a reliable and consistent process for managing Notice of Infractions, rendering them an ineffective enforcement mechanism.	**4.** DC Health should update the Division of Food's Operations and Procedures Manual with policies and procedures for the Notice of Infraction process, including the role of the DC Health Office of the General Counsel, use of DC Health's payment applications, and referrals to the Office of Administrative Hearings. **5.** DC Health should ensure Division of Food staff receive appropriate training and have access to the necessary reports and tools to track the payments and statuses of Notice of Infractions issued by DC Health. **6.** DC Health should establish a process with the Office of Administrative Hearings (OAH) to track the status of Notice of Infractions going through OAH's process and document it in the Division of Food's Operations and Procedures Manual.

Findings	Recommendations
DC Health was able to quickly respond to most restaurant-related complaints due to its effective workload prioritization, coordination with the Foodborne Epidemiologist, system-based tracking, and a comparatively small complaint workload.	
DC Health conducted restoration inspections promptly, but weaknesses in documentation retention and a breakdown in the restoration inspection process indicate gaps in oversight.	**7.** DC Health should develop and implement document storage and retention procedures to ensure that Application for Establishment Restoration due to Summary Suspension forms are completed and readily accessible upon request. **8.** DC Health should establish procedures in the Division of Food Operations and Procedures Manual to verify that suspended establishments are not operating while under suspension.
DC Health did not update inspection frequency based on performance, expending limited resources at locations with a history of compliance with the District's Food Code instead of focusing resources on establishments that pose a greater risk of foodborne illness.	**9.** DC Health should develop policies and metrics to define past performance of non-compliance with the Food Code, as well as update the Division of Food Operations and Procedures manual with how updates to inspection frequency should be made based on an establishment's history of compliance consistent with DCMR. **10.** DC Health should develop reporting to track establishment compliance across inspections, including violation types and counts per inspection.
Inadequate reporting limited the Division of Food's decision making and left DC Health, the Mayor, the Council, and the public without the information needed to determine the resources required for the food inspection program to protect public health.	**11.** DC Health should ensure its information and reporting system produces accurate reports to track inspection rates for establishments as defined in the risk schedule. **12.** DC Health should develop and implement a process with the Department of Licensing and Consumer Protection (DLCP) to maintain accurate license information.
DC Health generally completes inspection reports accurately and in accordance with requirements due to its structured digital inspection form and established review workflows.	**13.** DC Health should ensure inspection reports that do not have a signature due to a refusal to sign have the refusal noted in the inspection report per DCMR.

Findings	Recommendations
DC Health did not conduct all necessary Quality Assurance Evaluations of Sanitarians in accordance with its policies, increasing the risk of inconsistent and lower quality inspections.	**14.** DC Health should develop contingency plans to ensure key supervisory responsibilities, including the completion of Quality Assurance Reports (QARs), are performed during periods of staff vacancies or reduced supervisory capacity.

Agency Comments

On October 19, 2026, we sent a draft copy of this report to DC Health for review and written comment. DC Health responded with comments on November 06, 2026. Agency comments and Completed Recommendation Agreement Form are included here in their entirety.

November 6, 2026

Kathleen Patterson
District of Columbia Auditor
1331 Pennsylvania Avenue, N.W., Suite 800S
Washington, DC 20004

Dear Kathleen Patterson,

We appreciate the Office of the District of Columbia Auditor's (ODCA) focus on restaurant regulation in the District. We hope that through this most recent audit, the public will better understand how DC Health prioritizes food safety and appreciate the work DC Health is doing to improve its processes to keep District residents and visitors safe from foodborne pathogens.

Food safety is a critical component of the Department's public health mission. When people consume contaminated foods, it can cause malnutrition or contribute to a range of diseases ranging from short-term gastrointestinal issues to cancers.[1] In addition to restaurants, DC Health regularly inspects and regulates approximately 3,000 other food establishments including grocery stores, bakeries, and school cafeterias. Beyond inspections, our epidemiologists carefully monitor food borne illness cases across all eight Wards through hospitals, health professionals, and self-reported illnesses. In Fiscal Year 2026, our Office of Environmental Epidemiology conducted 887 investigations related to food borne illness. This work helps us understand where contaminated food may be coming from, connects impacted people with care, and guides future interventions to reduce exposure to food-borne illnesses.

DC Health recognized the need for improvement noted within the audit report. Many of the actions recommended are well underway and will be completed before or soon after the time the report is issued. The agency procured an updated electronic environmental health data system in the summer of 2026 to ensure that inspection records are accurately maintained and that the Notice of Infraction process is transparent. In addition, the Division of Food Safety implemented a new risk-based inspection schedule earlier this spring to focus its limited resources on the highest risk entities. Finally, DC Health is actively collaborating with other District government agencies, like the Department of Licensing and Consumer Protection, to ensure greater coordination when multiple regulatory frameworks are being applied.

While the agency – like all health departments throughout the country – must make hard decisions based on what funding is available, we believe that we have effectively used our budget to prioritize food safety and transparency so that residents, visitors, and workers in the District can feel confident that they can safely enjoy food purchased at any of our licensed food establishments. The Division of Food Safety and the Department, as a whole, appreciates the time and effort expended by ODCA to ensure that residents are safe while dining at District restaurants.

[1] World Health Organization. (2026, June 4). Food safety. https://www.who.int/news-room/fact-sheets/detail/food-safety

Should you have any questions about these responses, please do not hesitate to contact DC Health's Chief of Staff, Carl Filler, at carl.filler@dc.gov.

Sincerely,

Ayanna Bennett, MD, MSPH, FAAP
Director, DC Health

Recommendation Agreement Form

Office of the District of Columbia Auditor

Recommendation Agreement and Action Form

Insufficient Staff & Lack of Enforcement

Limit DC Food Safety Oversight

Recommendation 1	
DC Health should periodically review best practices for inspection frequency and if necessary, modify the risk-based schedule to establish more sustainable routine inspection requirements. Any adjustments should remain consistent with the FDA Model Food Code, ensuring public health protections are maintained while enabling broader and more consistent inspection coverage across the District's food establishments.	
Agency Response to Recommendation:	☒ Agree ☐ Agree in Part ☐ Do not Agree
Will you take, or have you taken, corrective action?	☒ Yes ☐ No
Planned Corrective Action(s):	DC Health has established a new risk-based inspection schedule that establishes a more effective routine inspection standard. The schedule will be reviewed annually to evaluate capacity and efficacy.
Target Date or Date Implemented:	February 20, 2026

Recommendation 2	
DC Health should create and implement a staffing plan that identifies the personnel levels needed to complete timely routine inspection requirements in accordance with the risk-based inspection schedule.	
Agency Response to Recommendation:	☐ Agree ☒ Agree in Part ☐ Do not Agree
Will you take, or have you taken, corrective action?	☒ Yes ☐ No
Planned Corrective Action(s):	DC Health agrees to create a staffing plan based on the risk-based inspection schedule and federal guidance. However, implementation of the staffing plan is dependent on securing the necessary funding through the budget process should there be a gap between current staffing levels and future levels.
Target Date or Date Implemented:	January 31, 2027

Recommendation 3	
DC Health should develop and implement changes to the Division of Food Operations and Procedures Manual for the timeframes to conduct follow-up inspections and when to issue Notice of Infractions for restaurants that fail to comply with the food safety requirements.	
Agency Response to Recommendation:	☒ Agree ☐ Agree in Part ☐ Do not Agree
Will you take, or have you taken, corrective action?	☒ Yes ☐ No
Planned Corrective Action(s):	DC Health commits to updating the Division of Food Operations and Procedures Manual to include timeframes for inspectors to conduct follow-up inspections. The Manual will also include the timeframe in which Notice of Infractions will be issued to restaurants that are non-compliant.
Target Date or Date Implemented:	January 31, 2027

Recommendation 4	
DC Health should update the Division of Food's Operations and Procedures Manual with policies and procedures for the Notice of Infraction process, including the role of the DC Health Office of the General Counsel, use of DC Health's payment applications, and referrals to the Office of Administrative Hearings.	
Agency Response to Recommendation:	☒ Agree ☐ Agree in Part ☐ Do not Agree
Will you take, or have you taken, corrective action?	☒ Yes ☐ No
Planned Corrective Action(s):	DC Health agrees to update the Operations and Procedures Manual to include the detailed procedure that is involved in issuing Notice of Infractions (NOIs). The Office of the General Counsel reviews all NOIs sent by the Division of Food for legal sufficiency to ensure the inspection reports and supporting documentation establish the alleged violations and that the appropriate legal requirements are cited. The Manual will be updated to include a new NOI process once DC Health administers a new IT system (Digital Health Department - DHD). The Division of Food plans to leverage DHD to process all payments. All approved NOIs are currently submitted to the Office of Administrative Hearings (OAH). However, DC Health will formalize this referral process in the Manual.
Target Date or Date Implemented:	September 30, 2027

Recommendation 5	
DC Health should ensure Division of Food staff receive appropriate training and have access to the necessary reports and tools to track the payments and statuses of Notice of Infractions issued by DC Health.	
Agency Response to Recommendation:	☒ Agree ☐ Agree in Part ☐ Do not Agree
Will you take, or have you taken, corrective action?	☒ Yes ☐ No
Planned Corrective Action(s):	DC Health agrees with this recommendation as the Environmental Health Administration is working to implement a new system (DHD) to track NOIs. The system is estimated to be operational early spring. Once the system is live, the appropriate Division of Food staff will be trained on the system and have access to reports and tools, as well as have the ability to track payments and the status of any NOIs.
Target Date or Date Implemented:	September 30, 2027

Recommendation 6	
DC Health should establish a process with the Office of Administrative Hearings (OAH) to track the status of Notice of Infractions going through OAH's process and document it in the Division of Food's Operations and Procedures Manual.	
Agency Response to Recommendation:	☒ Agree ☐ Agree in Part ☐ Do not Agree
Will you take, or have you taken, corrective action?	☒ Yes ☐ No
Planned Corrective Action(s):	DC Health commits to update the Operations and Procedures Manual to include the detailed procedure that is involved in issuing Notice of Infractions (NOIs). The Division of Food is exploring the possibility of a Memorandum of Agreement (MOA) to provide DC Health staff with greater data from the OAH NOI database. Currently, DC Health staff have access to the OAH portal, however, DC Health is working to expand access to more staff.
Target Date or Date Implemented:	September 30, 2027

Recommendation 7	
DC Health should develop and implement document storage and retention procedures to ensure that Application for Establishment Restoration due to Summary Suspension forms are completed and readily accessible upon request.	
Agency Response to Recommendation:	☒ Agree ☐ Agree in Part ☐ Do not Agree
Will you take, or have you taken, corrective action?	☒ Yes ☐ No
Planned Corrective Action(s):	Through the new DHD system, DC Health will ensure documents are stored and retained in an efficient manner. Implementation will include training on the new procedure and how to complete each form accurately.
Target Date or Date Implemented:	September 30, 2027

Recommendation 8	
DC Health should establish procedures in the Division of Food Operations and Procedures Manual to verify that suspended establishments are not operating while under suspension.	
Agency Response to Recommendation:	☒ Agree ☐ Agree in Part ☐ Do not Agree
Will you take, or have you taken, corrective action?	☒ Yes ☐ No
Planned Corrective Action(s):	DC Health will include a procedure to verify suspended establishments are not operating in the Division of Food Operations and Procedures Manual and each staff member will be trained on the procedure.
Target Date or Date Implemented:	January 31, 2027

Recommendation 9	
DC Health should develop policies and metrics to define past performance of non-compliance with the Food Code, as well as update the Division of Food Operations and Procedures Manual with how updates to inspection frequency should be made based on an establishment's history of compliance consistent with DCMR.	
Agency Response to Recommendation:	☒ Agree ☐ Agree in Part ☐ Do not Agree
Will you take, or have you taken, corrective action?	☒ Yes ☐ No
Planned Corrective Action(s):	DC Health is committed to developing policies and metrics that outline how to define non-compliance. Once the policies are developed, the Manual will be updated accordingly. The Division of Food's new DHD system will allow for updates to the risk-level and capture historical data in a complete manner.
Target Date or Date Implemented:	September 30, 2027

Recommendation 10	
DC Health should develop reporting to track establishment compliance across inspections, including violation types and counts per inspection.	
Agency Response to Recommendation:	☒ Agree ☐ Agree in Part ☐ Do not Agree
Will you take, or have you taken, corrective action?	☒ Yes ☐ No
Planned Corrective Action(s):	DC Health commits to developing a reporting system through the new DHD platform. With this new platform, Food Safety inspectors will be able to ensure establishments are in compliance, while also having the ability to track violation types and counts per inspection.
Target Date or Date Implemented:	September 30, 2027

Recommendation 11	
DC Health should ensure its information and reporting system produces accurate reports to track inspection rates for establishments as defined in the risk schedule.	
Agency Response to Recommendation:	☒ Agree ☐ Agree in Part ☐ Do not Agree
Will you take, or have you taken, corrective action?	☒ Yes ☐ No
Planned Corrective Action(s):	DC Health agrees to ensure the new DHD system will accurately produce reports that will then allow the Division of Food to inspect establishments according to the revised risk schedule. Implementing this system will improve inspections rates for food establishments.
Target Date or Date Implemented:	September 30, 2027

Recommendation 12	
DC Health should develop and implement a process with the Department of Licensing and Consumer Protection (DLCP) to maintain accurate license information.	
Agency Response to Recommendation:	☒ Agree ☐ Agree in Part ☐ Do not Agree
Will you take, or have you taken, corrective action?	☒ Yes ☐ No
Planned Corrective Action(s):	DC Health and the Department of Licensing and Consumer Protection (DLCP) are actively working together to develop a process that would allow for better visibility into business license status. This will ensure that Division of Food staff have access to current information when conducting their enforcement responsibilities.
Target Date or Date Implemented:	March 31, 2027

Recommendation 13	
DC Health should ensure inspection reports that do not have a signature due to a refusal to sign have the refusal noted in the inspection report per DCMR.	
Agency Response to Recommendation:	☒ Agree ☐ Agree in Part ☐ Do not Agree
Will you take, or have you taken, corrective action?	☒ Yes ☐ No
Planned Corrective Action(s):	DC Health's standard process includes the ability to record a refusal within the signature box for the establishment. DC Health commits to training staff on this process to make the refusal more prominent in the inspection reports to ensure it is well-documented.
Target Date or Date Implemented:	December 1, 2026

Recommendation 14	
DC Health should develop contingency plans to ensure key supervisory responsibilities, including the completion of Quality Assurance Reports (QARs), are performed during periods of staff vacancies or reduced supervisory capacity.	
Agency Response to Recommendation:	☒ Agree ☐ Agree in Part ☐ Do not Agree
Will you take, or have you taken, corrective action?	☒ Yes ☐ No
Planned Corrective Action(s):	DC Health commits to drafting an internal memorandum that outlines the necessary steps to ensure contingency if there are staff vacancies or supervisory capacity is decreased. The memorandum will list all supervisory responsibilities and the staff member delegated to complete each task.
Target Date or Date Implemented:	January 31, 2027

ODCA Response to Agency Comments

We appreciate DC Health's comments on the draft report, its concurrence with our recommendations, and its collaboration throughout the audit process. In agreeing with all 14 of the report's recommendations, the department also indicates it will complete implementation by the end of FY 2027. We are encouraged by DC Health's ongoing efforts to implement the recommendations and look forward to improved program outcomes.

Appendices

Appendix A

Food Establishment Inspection Report

DC HEALTH

Food Establishment Inspection Report

Pursuant to Title 25-A of the District of Columbia Municipal Regulations

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Health Regulation & Licensing Administration • Office of Food, Drug, Radiation, and Community Hygiene • 2201 Shannon Place, SE - 2nd Floor • Washington, DC 20020
http://doh.dc.gov/service/food-safety email: food.safety@dc.gov

Establishment Name_____

Address_____

City/State/Zip Code_____

Telephone_____E-mail address_____

Date of Inspection ____ ____/_____ Time In_____ Time Out ____:____ _____

License Holder_____

License/Customer No._____

License Period____/____/_____ ____/____/_____ Type of Inspection_____

Establishment Type:_____ Risk Category 1☐ 2☐ 3■ 4☐ 5☐

Basic Establishment Information

Priority Violations	0	**COS**	0	**R**	0
Priority Foundation Violations	2	**COS**	0	**R**	0
Core Violations	3	**COS**	2	**R**	0

Certified Food Protection Manager

CFPM #:

CFPM Expiratio

D.C. licensed tr

D.C. licensed sewage & liquid waste transport contractor:

D.C. licensed pesticide operator/contractor:

D.C. licensed ventilation hood system cleaning contractor:

Summary Violation Information

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS			
Compliance Status		**COS**	**R**
	Supervision		
IN OUT	1.Person in charge present, demonstrates knowledge, and performs duties	☐	☐
IN OUT	2.Certified Food Protection Manager	☐	☐
	Employee Health		
IN OUT	3.Management, food employee, and conditional employee; knowledge, responsibilities, and reporting	☐	☐
IN OUT	4.Proper use of restriction and exclusion	☐	☐
IN OUT	5.Procedures for responding to vomiting and diarrheal events	☐	☐
	Good Hygienic Practices		
IN OUT N/O	6.Proper eating, tasting, drinking, or tobacco use	☐	☐
IN OUT N/O	7.No discharge from eyes, nose, and mouth	☐	☐
	Control of Hands as a Vehicle of Contamination		
IN OUT N/O	8.Hands clean and properly washed	☐	☐
IN OUT N/A N/O	9.No bare hand contact with RTE foods or a pre-approved alternate procedure properly allowed	☐	☐
IN OUT	10.Adequate handwashing sinks properly supplied and accessible	☐	☐
	Approved Source		
IN OUT	11.Food obtained from approved source	☐	☐
IN OUT N/A N/O	12.Food received at proper temperature	☐	☐
IN OUT	13.Food in good condition, safe, and unadulterated	☐	☐
IN OUT N/A N/O	14.Required records available: shellstock tags, parasite destruction	☐	☐
	Protection from Contamination		
IN OUT N/A	15.Food separated and protected	☐	☐
IN OUT N/A	16.Food-contact surfaces: cleaned and sanitized	☐	☐
IN OUT	17.Proper disposition of returned, previously served, reconditioned, and unsafe food	☐	☐
	Potentially Hazardous Food (Time/Temperature Control for Safety Food)		
IN OUT N/A N/O	18.Proper cooking time and temperatures	☐	☐
IN OUT N/A N/O	19.Proper reheating procedures for hot holding	☐	☐
IN OUT N/A N/O	20.Proper cooling time and temperature	☐	☐
IN OUT N/A N/O	21.Proper hot holding temperatures	☐	☐
IN OUT N/A	22.Proper cold holding temperatures	☐	☐
IN OUT N/A N/O	23.Proper date marking and disposition	☐	☐
IN OUT N/A N/O	24.Time as a public health control: procedures and records	☐	☐
	Consumer Advisory		
IN OUT N/A	25.Consumer advisory provided for raw or undercooked foods	☐	☐
	Highly Susceptible Populations		
IN OUT N/A	26.Pasteurized foods used; prohibited foods not offered	☐	☐
	Chemical		
IN OUT N/A	27.Food additives: approved and properly used	☐	☐
IN OUT N/A	28.Toxic substances properly identified, stored, and used	☐	☐
	Conformance with Approved Procedures		
IN OUT N/A	29.Compliance with variance, specialized process, and HACCP plan	☐	☐

Results of Each Item Checked During Inspection

GOOD RETAIL PRACTICES			
Compliance Status		**COS**	**R**
	Safe Food and Water		
IN OUT N/A	30.Pasteurized eggs used where required	☐	☐
IN OUT	31.Water and ice from approved source	☐	☐
IN OUT N/A	32.Variance obtained for specialized processing methods	☐	☐
	Food Temperature Control		
IN OUT	33.Proper cooling methods used; adequate equipment for temperature control	☐	☐
IN OUT N/A N/O	34.Plant food properly cooked for hot holding	☐	☐
IN OUT N/A N/O	35.Approved thawing methods used	☐	☐
	eters provided and accurate	☐	☐
	Food Identification		
	perly labeled; original container	☐	☐
	Prevention of Food Contamination		
	odents, and animals not present	☐	☐
IN OUT	39.Contamination prevented during food preparation, storage, and display	■	☐
IN OUT N/A	40.Personal cleanliness	☐	☐
IN OUT	41.Wiping cloths: properly used and stored	☐	☐
IN OUT N/A N/O	42.Washing fruits and vegetables	☐	☐
	Proper Use of Utensils		
IN OUT	43.In-use utensils: properly stored	☐	☐
IN OUT	44.Utensils, equipment and linens: properly stored, dried, and handled	☐	☐
IN OUT	45.Single-use/single-service articles: properly stored and used	☐	☐
IN OUT N/A	46.Gloves used properly	☐	☐
	Utensils, Equipment, and Vending		
IN OUT	47.Food and nonfood-contact surfaces cleanable, properly designed, constructed, and used	☐	☐
IN OUT	48.Warewashing facilities: installed, maintained, and used; test strips	☐	☐
IN OUT	49.Nonfood-contact surfaces clean	■	
	Physical Facilities		
IN OUT	50.Hot and cold water available; adequate pressure	☐	☐
IN OUT	51.Plumbing installed; proper backflow devices		
IN OUT	52.Sewage and waste water properly disposed	☐	☐
IN OUT	53.Toilet facilities: properly constructed, supplied, and cleaned	☐	☐
IN OUT	54.Garbage and refuse properly disposed; facilities maintained	☐	☐
IN OUT	55.Physical facilities installed, maintained, and clean	☐	☐
IN OUT	56.Adequate ventilation and lighting; designated areas used	☐	☐

IN = in compliance OUT = not in compliance N/O = not observed
N/A = not applicable COS = corrected on-site R = repeat violation

Status Legend

Establishment Name _____ Establishment Address _____

OBSERVATIONS	25 DCMR	CORRECTIVE ACTIONS
38. - Observed evidence of fruit flies at bar area at downstairs location. (Correct cited violations within 5- Calendar days.)	3210.1	The premises shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to minimize their presence on the ...a) Routinely inspecting incoming shipments of food and supplies; Pf (b) ...ing the premises for evidence of pests; Pf (c) Using methods, if pests ...s trapping devices or other means of pest control as specified in ...10 and 3411; Pf and (d) Eliminating harborage conditions. Pf
39. - Food is not stored in a manner to protect from cross... contamination(PIC elevated beverages off floor inside wa... (Corrected On Site)		...d in Sections 816.2 and 816.3, food shall be protected from ... storing the food: (a) In a clean, dry location; (b) Where it is not ..., dust, or other contamination; and (c) At least fifteen centimeters (15 ...s (6 in.) above the floor.
49. - Observed debris inside reach-in freezer and refrigerator. (PIC interior of reach-in refrigerator and freezer.) (Corrected On Site)	1900.3	Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.
50. - There is no hot or cold water available at handsink downstairs ...ear dishmachine area.(Correct cited violations withinn 5- Calendar days.)	2306.1	Hot or cold water under pressure shall be provided to all fixtures, equipment, and nonfood equipment that are required to use hot or cold water, except that water supplied as specified in Section 2308.1(a) and (b) to a temporary food establishment or in response to a temporary interruption of a water supply need not be under pressure. Pf
51. - Warewashing equipment not in good repair.(Correct cited violations within 14- calendar days.)	2418.1	A plumbing system shall be: (a) Repaired according to the D.C. Plumbing Code (2008) incorporating the International Plumbing Code 2006, as amended by the D.C. Plumbing Code Supplement (subtitle F of 12 DCMR); and (b) Maintained in good repair.

Summary of Violations, Required Corrective Actions, and Timeframe for Correction

TEMPERATURES

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
(Cold Holding)	40.0F	(Refrigerator - reach-in) (Cold Holding)	36.0F	(Handwashing Sink)	100.0F	(Refrigerator - walk-in) (Cold Holding)	30.0F
(Handwashing Sink)	110.8F	(Handwashing Sink)	106.7F	(3-compartment sink)	129.0F	Eggs (Hot Holding)	154.0F
(Refrigerator - walk-in) (Cold Holding)	39.0F	(Handwashing Sink)	107.0F	(Cold Holding)	30.0F	Marinara Sauce (Hot Holding)	163.0F
(Handwashing Sink)	101.0F	(Reach-in Refrigerator) (Cold Holding)	34.0F	Carrots (Cold Holding)	36.0F	Cheese sauce (Hot Holding)	140.0F

Inspector Comments:
Correct cited violations within 5- Calendar days. If you have any questions, please email food.safety@dc.gov.

Additional Comments

DC Health does not assign a grade, percentage, or rating for establishment inspection reports. We perform a pass-fail inspection. The amount of ... violations are tallied at the top of each inspection report. DC Health also performs follow up inspections to ensure the violations which were cit... ...d.
To view an establishment's inspection report, follow this link: https://dc.healthinspections.us.

Person-in-Charge (Signature) (Print) Date

Inspector (Signature) (Print) Badge # Date

Food Establishment Inspection Reports can be found here:
https://dc.healthinspections.us/?a=Inspections

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The mission of the Office of the District of Columbia Auditor (ODCA) is to support the Council of the District of Columbia by making sound recommendations that improve the effectiveness, efficiency, and accountability of the District government.

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