

**OFFICE OF THE STATE INSPECTOR GENERAL**  
**Report to Interim Commissioner**  
**Dr. Jack Barber**

**FY 2016 Unannounced Inspections**  
**of Behavioral Health Facilities**

**OCTOBER 2016**



**June W. Jennings, CPA**  
**State Inspector General**  
**Report No. 2016-BHDS-003**



*COMMONWEALTH OF VIRGINIA*  
*Office of the State Inspector General*

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October 6, 2016

Jack Barber, MD, Interim Commissioner  
Department of Behavioral Health and Developmental Services  
1220 Bank Street  
Richmond, VA 23219

Dear Dr. Barber:

The Office of the State Inspector General (OSIG) performed unannounced inspections at nine behavioral health facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) pursuant to the *Code of Virginia* § [2.2-309.1\[B\]\(1\)](#). The overall goal of unannounced inspections is to review the quality of services provided and make policy and operational recommendations in order to prevent problems, abuses, and deficiencies and improve the effectiveness of programs and services. For FY 2016, the unannounced inspections focused specifically on the content and implementation of Departmental Instruction 201(RTS)03 Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities (DI201). Attached, please find the final report and recommendations.

By copy of this letter, OSIG is requesting that agency management provide a corrective action plan within 30 days to address this report's recommendations.

On behalf of OSIG, I would like to express our appreciation for the assistance provided by facility directors and their staff during these inspections.

If you have any questions, please call me at (804) 625-3255 or email me at [june.jennings@osig.virginia.gov](mailto:june.jennings@osig.virginia.gov). I am also available to meet with you in person to discuss this report.

Sincerely,

June W. Jennings, CPA  
State Inspector General

CC: Paul J. Reagan, Chief of Staff to Governor McAuliffe  
Suzette P. Denslow, Deputy Chief of Staff to Governor McAuliffe  
William A. Hazel Jr., MD, Secretary of Health & Human Resources  
Daniel Herr, JD, Assistant Commissioner for Behavioral Health Services, DBHDS

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## Executive Summary

The Office of the State Inspector General (OSIG) conducted a review of the content and implementation of Departmental Instruction 201(RTS)03 Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities (DI201, see Appendix I) at nine behavioral health facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) pursuant to *Code of Virginia* § [2.2-309.1](#).

While OSIG found that DI201 is being utilized in all DBHDS-operated facilities and provides a uniform structure for reporting and investigating allegations of abuse and neglect, OSIG also found a number of areas for improvement that, if addressed, will support improvement in facility cultures, enhance focus on prevention of abuse and neglect, and potentially improve recruitment and retention efforts in the facilities. OSIG identified a number of concerns with the current process, including:

- DI201 and the Guidelines for Investigators are out of date and need revision and clarification in a number of areas;
- Staff members receive inadequate training on DI201 resulting in, among other things, non-compliance with reporting requirements;
- Investigations are not consistently completed in compliance with DI201;
- Facilities do not adequately communicate required information to staff under investigation, leading to staff members feeling unsupported, isolated, and disempowered; and
- DBHDS and facilities are inconsistent in the management of human resources matters relative to investigations.

To improve the processes for reporting and investigating allegations of abuse and neglect, OSIG makes recommendations, including:

- A. Completing a comprehensive revision of DI201 and the DBHDS Guidelines for Investigators;
- B. Developing a competency-based training curriculum for investigators and facility staff, including annual refresher trainings;
- C. Revising employee work profiles for abuse and neglect investigators to ensure investigators have appropriate knowledge, skills, and abilities;
- D. Enhancing performance improvement processes by leveraging existing data and processes;
- E. Improving communication between facility administration and staff under investigation;
- F. Developing clear guidelines to guide staff reassignment, administrative leave, and the human resources mitigation process.

## Purpose and Scope of the Review

The Office of the State Inspector General (OSIG) conducted unannounced inspections of nine behavioral health facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS). These facilities included:

- Seven behavioral health facilities for adults;
- One behavioral health facility for children and adolescents; and
- One behavioral health facility for elder adults.

The inspections were performed pursuant to *Code of Virginia* § [2-309.1](#) whereby the State Inspector General shall have power and duty to:

“Provide inspections of and make policy and operational recommendations for state facilities and for providers, including licensed mental health treatment units in state correctional facilities, in order to prevent problems, abuses, and deficiencies in and improve the effectiveness of their programs and services. The State Inspector General shall provide oversight and conduct announced and unannounced inspections of state facilities and of providers, including licensed mental health treatment units in state correctional facilities, on an ongoing basis in response to specific complaints of abuse, neglect, or inadequate care and as a result of monitoring serious incident reports and reports of abuse, neglect, or inadequate care or other information received. The State Inspector General shall conduct unannounced inspections at each state facility at least once annually.”

These inspections are not designed to be comprehensive reviews of the behavioral health facilities. For FY 2016, the unannounced inspections focused specifically on the content and implementation of [Departmental Instruction 201\(RTS\)03 Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities \(DI201\)](#).

The scope and objectives of these inspections were selected after a review of DBHDS data concerning allegations of abuse and neglect, including trends in the incidence and prevalence of substantiated and unsubstantiated allegations of abuse and neglect, peer-to-peer acts of abuse (acts committed by one patient against another), and repeat patient falls. OSIG also sought input from DBHDS Central Office (CO) and facility staff. Inspections focused on FY 2015 and FY 2016 quarter one (July 1, 2014, to September 30, 2015).

Objectives of these inspections included:

1. Determine and review elements of the DBHDS-defined system for addressing abuse and neglect in its state-operated facilities and the consistency of application. These elements include:
  - DI201:
    - Abuse and neglect reporting structure;

- Standards utilized to guide the process;
  - Central Office Abuse/Neglect Review Panel (CORP);
  - Checks and balances in the process; and
  - Communication within facilities during investigations; and
  - Training and supervision of investigators and facility staff.
2. Assess the quality of abuse and neglect investigations, data and data collection processes, and the quality management process currently utilized to drive performance improvement, minimize risk, and prevent future abuse and neglect.
  3. Determine outcomes of the current system for addressing abuse and neglect and identify how these may create potential risk areas to individuals served, employees, DBHDS, and the Commonwealth.

## Background

*Code of Virginia* § [37.2-300](#) establishes DBHDS as the state authority for the Commonwealth's public behavioral health and developmental services system. This system includes nine behavioral health facilities, three training centers, one medical facility, and a rehabilitation center for sexually violent predators operated by DBHDS.

This review covered the nine behavioral health facilities in the Commonwealth:

- Catawba Hospital — 110 beds, located in Catawba, serving adults and elder adults in the Roanoke Valley with acute mental health needs;
- Central State Hospital — 277 beds, located in Petersburg, serving adults in central Virginia with acute mental health needs, accepts forensic admissions statewide, and houses the Commonwealth's only maximum security forensic program;
- Commonwealth Center for Children and Adolescents — 48 beds, located in Staunton, serving youth ages 18 and under with acute mental health needs and accepts forensic admissions;
- Eastern State Hospital — 302 beds, located in Williamsburg, serving adults and elder adults and accepts medium security forensic admissions;
- Northern Virginia Mental Health Institute — 134 beds, located in Fairfax, serving adults in northern Virginia with acute mental health needs;
- Piedmont Geriatric Hospital — 135 beds, located in Burkeville, serving elder adults with acute mental health needs;
- Southern Virginia Mental Health Institute — 72 beds, located in Danville, serving adults with mental health needs in southern Virginia and accepts medium security forensic admissions;
- Southwestern Virginia Mental Health Institute — 179 beds, located in Marion, serving adults and elder adults with acute mental health needs in Southwest Virginia; and
- Western State Hospital — 246 beds, located in Staunton, serving adults with acute mental health needs and accepts medium security forensic admissions.<sup>1</sup>

### ***Departmental Instruction 201***

The policies, procedures, and responsibilities for reporting, responding to, and investigating allegations of abuse and neglect by staff at the DBHDS-operated facilities are set forth in DI201, which was last revised in 2009. In the introduction, DI201 states:

“The Department of Behavioral Health and Developmental Services (“Department”) has a duty to provide a safe and secure environment to individuals receiving services and has a philosophy of zero tolerance for abuse and neglect. The Department will, in all instances, investigate and act upon allegations of abuse or neglect. Therefore, whenever an allegation of abuse or neglect is made, the

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<sup>1</sup> Per DBHDS Facility Census for June 6, 2016, accessed via DBHDS intranet.



Department shall take immediate steps to protect the safety and welfare of individuals who are the victims of the alleged abuse or neglect, conduct a thorough investigation pursuant to central office direction, and take any action necessary to prevent future occurrences of abuse and neglect.”

DI201 includes a discussion of the relevant statutory authority, *Code of Virginia* § [37.2-100](#), which defines abuse as:

“... any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the Department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury or death to an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse.”

The *Code* further defines neglect as:

“... failure by a person or a program or facility operated, licensed, or funded by the Department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse.”

DI201 also defines preponderance of evidence, the standard by which an allegation of abuse or neglect is found to be substantiated or unsubstantiated, as “... the facts gathered show it is more probable than not that abuse or neglect occurred; evidence that is more convincing than the opposing evidence.”

DI201 provides detailed information about the duties and responsibilities of the parties that are part of the process of reporting, responding to, and investigating allegations of abuse or neglect. In August 2009, when the DI was last revised, it indicated that in CO, these parties include the Investigations Manager and the Assistant Commissioner for Public Relations and Quality Improvement, whose responsibilities included oversight of the Office of Human Rights (OHR). According to the current DBHDS organizational chart<sup>2</sup>, the Assistant Commissioner for Quality Management and Development now oversees OHR and the Investigations Manager. The Assistant Commissioner for Quality Management and Development also has the authority to review and grant requests from facility investigators for exemptions to the deadline for investigation completion.

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<sup>2</sup> DBHDS Organization Chart, <http://www.dbhds.virginia.gov/about-dbhds/offices>, accessed April 30, 2016.

OHR is responsible for guaranteeing the human rights of individuals receiving services from programs funded, provided, or licensed by DBHDS. OHR supervises and trains abuse and neglect investigators and human rights advocates, who represent individuals receiving services throughout the Commonwealth. During an abuse and neglect investigation, advocates provide monitoring to ensure that the rights of individuals receiving services are protected throughout the process. The advocates may provide feedback and information to the abuse and neglect investigator concerning the allegation, to the individual who was the subject of the allegation, or on other human rights issues. Human rights advocates also have the authority to perform separate investigations.

The facility director is responsible for ensuring all staff have received training on DI201, including collecting statements signed by staff acknowledging their understanding of, and agreement to abide by, the policy. Additionally, facility directors are to advise an accused employee of the investigation process, ensure that the facility complies with all state laws governing the reporting of abuse or neglect, and to ensure the employee “against whom an allegation is made is presumed not to have committed abuse or neglect unless the facts of the investigation show otherwise.” Facility directors review all investigations, indicating their agreement or disagreement with the outcomes.

Each DBHDS-operated facility has an assigned abuse and neglect investigator. While abuse and neglect investigators are hired and located at facilities, they are supervised by the Investigations Manager at Central Office (CO) during the performance of investigations. Their additional roles and responsibilities vary by facility. Abuse and neglect investigators receive investigations training sometime within the first year of employment. Refresher training is not a requirement, but investigators may attend trainings in the future if desired.

Accused employees are also provided certain rights and protections under DI201, including:

- Being informed of the allegation and its nature, and that an investigation will occur;
- Being informed of their rights, including that before the investigation begins they are presumed innocent of the alleged abuse or neglect;
- Being informed of the investigation completion time frame;
- Being informed of the investigation findings; and
- Having the opportunity to present information on their own behalf to the investigator as well as the person responsible for taking disciplinary action and at any related administrative hearings.

DI201 requires any staff member who has knowledge or reason to believe that abuse or neglect has occurred to report that information directly to the facility director or their designee immediately. This may be based on direct observation, a statement from an individual receiving services, a statement from another staff member, or other information. In addition to reporting this information to the facility director,

“...workforce members may and shall when required by law, also directly notify any of the following of the possible abuse or neglect at the same time as they notify the facility director:

- Office of the (State) Inspector General;
- Central Office Investigations Manager;
- Human Rights Advocate;
- Child or adult protective services unit in the local department of social services;
- Virginia Office for Protection and Advocacy (VOPA) (now dLCV).”

DI201 prohibits staff from discussing any aspect of the investigation, tampering with any evidence, or conducting their own independent investigation.

Upon receipt of an allegation of abuse or neglect, the facility director is required to ensure the safety of individuals receiving services by — when appropriate — suspending or relocating the staff member against whom the allegation has been made, as well as ensuring the integrity of any physical evidence. Within 24 hours of receipt of an allegation, the facility abuse and neglect investigator must initiate an investigation into the allegation. This includes notifying the advocate, the local department of social services, and ensuring that the allegation is entered into the Computerized Human Rights Information System (CHRIS), a web-based database developed by DBHDS that houses and maintains human rights-related data. When the person who was the victim of the alleged abuse or neglect has an authorized representative (an individual designated to make medical and/or legal decisions for someone who has been deemed unable to do so for themselves), they must be notified as well. When the alleged abuse or neglect includes suspected criminal activity, the facility director is required to contact law enforcement. Investigators are given five working days to complete investigations at facilities that are Medicaid- or Medicare-certified (such investigations must also be reported to the Virginia Department of Health) or when an employee has been suspended. All other investigations must be completed in 10 working days. Investigators can petition the Assistant Commissioner for Quality Management and Development for an extension to these timelines.

If, during the course of an investigation, the facility director, investigator, and advocate all agree that the allegation may be improbable due to being based on inaccurate information, a number of steps must be taken. The individual’s treatment team must be consulted, and there must be a thorough clinical assessment to “ascertain if there is evidence that the event occurred or if the allegation of abuse or neglect is more likely than not to be symptomatic of the individual’s illness or cognitive disability.” If this assessment determines the latter to be the case, the investigation ends, with the facility director collecting and maintaining all supporting documentation.

Once complete, the investigator must submit a signed and dated investigation summary and provide the summary to the facility director and the human rights advocate. If the investigator,

facility director, and human rights advocate all agree with the summary report, the facility director provides their written decision (including any administrative actions required to address findings or recommendations) within seven working days. The facility director provides written notification of the results of the investigation to the individual (or their authorized representative), the human rights advocate, the Deputy Commissioner, and the staff member(s) who was (were) the subject(s) of the investigation. Administrative actions implemented to address findings or recommendations can include, but are not limited to, reassignment of staff to other units, remedial training, review of relevant policies and procedures, suspension without pay, or the issuance of a Group I, Group II, or Group III Written Notice, described in more detail below.

If the facility director or advocate have concerns about or disagree with the investigator's findings, those are to be communicated directly to the CO Investigations Manager along with the investigation file for further review. The Investigations Manager must review and make a final determination on all investigations within two working days of receipt when a staff member has been suspended, or within five days, if there was no suspension. If the Investigations Manager issues a determination different from that of the investigator, the case must be forwarded to the CORP, which has 48 hours to make their recommendations. This panel, comprised of CO staff members, consults with practicing clinicians as needed to provide specific expertise to help the panel in making their determination.

When allegations are unsubstantiated, the facility director and/or investigator are to provide the employee the opportunity to discuss the investigation and its outcomes. Once the investigation is closed, the facility director must perform the following tasks:

- Confirm the final disposition of the investigation;
- Provide written notification of the results within seven working days of closure to the individual receiving services (and, when applicable, their authorized representative), the human rights advocate, and the accused staff member(s); and
- Take appropriate corrective actions as outlined in Chapter 14, Standards of Conduct and Client Abuse, of the [DBHDS Employee Handbook](#).

### ***DBHDS Employee Handbook***

The DBHDS Employee Handbook outlines the basic human resources policies, practices, and procedures of DBHDS. Chapter 14 provides descriptions and guidelines for the DBHDS staff disciplinary processes. It specifically addresses abuse and neglect, indicating that DBHDS “has **zero** tolerance for acts of abuse or neglect.” Offenses are categorized into three groups, with Group I offenses being the least severe. Abuse or neglect of individuals receiving services is considered a Group III offense. Generally, Group III offenses are punishable upon first occurrence by suspension of up to 30 days or termination. However, the facility director may, at their discretion and after consultation with the staff member's supervisor, mitigate the disciplinary action to an appropriate sanction other than termination.

## Review Methodology

During the FY 2016 Unannounced Inspections, OSIG reviewed the implementation of DI201 in DBHDS-operated facilities. To develop the inspection design, OSIG performed a literature review concerning laws and policies governing investigation of alleged abuse and neglect in Virginia and other states. OSIG also reviewed the following data and documentation:

- DBHDS documentation, including:
  - Training manual and other materials for abuse and neglect investigators,
  - DI201 and [401\(RM\)03, Risk and Liability Management](#),
  - Relevant human resources and human rights regulations, policies, and procedures,
  - Roster of the DBHDS Abuse and Neglect Review Panel;
- Communication between DBHDS and facilities, including memoranda, emails, and letters;
- Facility documentation, including:
  - Facility-specific policies and procedures,
  - Performance improvement plans,
  - EWPs;
- Data on allegations of abuse and/or neglect and falls from DBHDS as well as individual facilities;
- Interviews with staff at each facility and at CO; and
- Reports prepared by the dLCV and communication between dLCV and DBHDS.

Inspection activities included:

- Interviews with the following:
  - Interim Commissioner, DBHDS,
  - Chief Deputy Commissioner, DBHDS,
  - Assistant Commissioner of Behavioral Health Services, DBHDS,
  - Director, Office of Human Rights, DBHDS,
  - Executive teams at each facility (executive teams typically include senior administration staff such as the facility director, risk/quality management director, fiscal director, medical director, psychosocial rehabilitation director, and others),
  - Facility directors,
  - Facility abuse and neglect investigators,
  - Facility human rights advocates, and
  - Facility staff who have been the subject of an abuse and/or neglect investigation;
- Reviewing facility documentation, including:
  - Facility-specific policies and procedures that supplement DI201,
  - Employee handbooks,
  - Facility investigator EWPs,
  - Facility census data,
  - Falls data,

- Abuse and neglect investigation data, including the number of substantiated and unsubstantiated cases,
- Abuse and neglect investigation files,
- Employee training/human resource files,
- Medical records, and
- Performance improvement plans.

Finally, OSIG sought input from current members of the facility workforce via anonymous questionnaires. A five-item questionnaire was prepared and distributed in paper form (Appendix II) to patient units at all facilities. These paper forms were accompanied by envelopes in which staff could seal their responses so that they would remain confidential. Additionally, OSIG provided a link at which staff members could submit information electronically. Paper forms were left on all units for a minimum of 24 hours, and the electronic link remained open for approximately two weeks after the last inspection was completed. Overall, OSIG received 141 anonymous responses.

## Review Results

OSIG found that DI201 is being utilized in all DBHDS-operated facilities and provides a uniform structure for reporting and investigating allegations of abuse and neglect. OSIG also found a number of areas for improvement in both content and implementation that, if addressed, will support improvement in facility cultures, enhance focus on prevention of abuse and neglect, and potentially improve recruitment and retention efforts in the facilities. Concerning content, certain key elements of DI201 are vague and in need of revision, while other important elements are not included. Adding them would serve to improve the quality of the process and outcomes. Concerning implementation, there is significant inconsistency across facilities, including lack of compliance with required timeframes, lack of required communication with investigated staff, privacy issues, and inconsistent performance of investigations. These factors combine to create a culture that is characterized by fear, guilt, stress, and retaliation according to staff members' responses to interviews and anonymous surveys.

### *Objective 1*

Determine and review elements of the DBHDS-defined system for addressing abuse and neglect in its state-operated facilities and the consistency of application and comparing this system to systems in other states in the Mid-Atlantic region. These elements include:

- DI201:
  - Abuse and neglect reporting structure;
  - Standards utilized to guide the process;
  - CORP;
  - Checks and balances in the process; and
  - Communication within facilities during investigations; and
- Training and supervision of investigators and facility staff.

### **OBSERVATION No. 1 — DI201 NEEDS TO BE REVISED.**

As a part of these inspections, OSIG performed an extensive review of DI201 and concluded a number of areas of the policy and process for addressing abuse and neglect warrant revisions as detailed below.

#### *EXTERNAL REQUEST FOR INVESTIGATION*

Currently, DI201 does not articulate the manner by which individuals external to DBHDS, including friends, family members, authorized representatives or other interested parties may initiate an independent abuse or neglect investigation within a state-operated facility. The system could be strengthened by defining a process by which these individuals or entities may make an allegation of abuse or neglect, especially on behalf of individuals whose disorders inhibit their ability to communicate effectively on their own behalf.

*CENTRAL OFFICE REVIEW PANEL*

CORP is responsible for reviewing investigations outside the scope or expertise of the Investigations Manager, and also reviews any investigation where the Investigations Manager intends to issue a final determination different from that of the investigator. DI201 stipulates that CORP will be composed of the directors of OHR, Risk and Liability Affairs and Quality Management and Development along with ad hoc members, when necessary. Currently, CORP is composed of:

- Director, OHR;
- Director, Clinical Quality and Risk Management;
- Staff from the Office of Quality Management and Development;
- Staff from the Office of Forensic Services;
- DBHDS Medical Director; and
- DBHDS Investigations Manager

When requested, DBHDS was unable to provide documentation concerning meetings of CORP, how CORP decides when to consult with clinical professionals, how CORP decides which clinical professionals with whom to consult, or the criteria by which CORP makes final decisions about investigations. Additionally, CORP meetings do not record minutes or, outside of a transmittal letter, maintain documentation concerning the final determination of investigations.

*INCONSISTENCY IN STANDARDS*

DI201 applies the definition for neglect as found in *Code of Virginia* § [37.2-100](#) to determine what individuals are reported to the Department of Health Professionals (DHP), which is:

“... failure by a person or a program or facility operated, licensed, or funded by the Department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse.”

In the section detailing the procedures for the closure of a case, DI201 indicates that, as necessary, the facility director shall notify DHP or other licensing authority as required in *Code* § [54.1-2400.6](#). This *Code* section, and specifically subsection A-3, details instances when certain healthcare providers are required to report disciplinary actions to the relevant licensing authority. “Any disciplinary proceeding begun by the institution, organization, or facility as a result of conduct involving (i) intentional or negligent conduct that causes or is likely to cause injury to a patient or patients” (emphasis added).

With DBHDS using neglect as the standard for reporting and DHP using negligent conduct or negligence, it raises a concern whether DBHDS may be over-reporting individuals to DHP. Of particular concern is that individuals who may be found guilty of minor offenses are captured by the same process as those guilty of egregious acts and reported to the licensing authority.



*PREPONDERANCE OF EVIDENCE STANDARD*

DI201 sets the evidentiary standard for substantiation of abuse or neglect as a preponderance of evidence, defined as “more probable than not that abuse or neglect occurred; evidence that is more convincing than the opposing evidence.” At its core, the preponderance of evidence standard is one that is based on simple probability, that being whether, based on the evidence presented, it is more probable than not, that what is being alleged did in fact occur. This standard is relatively low and leaves considerable room for interpretation by the investigator. The standard does not require any certainty that the alleged event occurred, but only that it be more likely than not that the alleged event occurred.

Two Mid-Atlantic states use the same standard as Virginia:

- Kentucky – “The presence of evidentiary or supportive facts ... that reveals a preponderance of the evidence;”<sup>3</sup> and
- Pennsylvania – “There only needs to be a preponderance of the evidence (50.01%) to substantiate the need for protective services.”<sup>4</sup>

While others use broader language based on legal definitions of the terms, such as:

- Delaware – “... information gathered ... does lead to a reasonable conclusion that the abuse, neglect, mistreatment, or financial exploitation occurred;”<sup>5</sup>
- Maryland – “... evidence is sufficient to prove an allegation;”<sup>6</sup>
- Tennessee – “... whether [the] situation rises to the definition of the offense;”<sup>7</sup> and
- West Virginia – “According to the legal definition of abuse and neglect.”<sup>8</sup>

Other states in the Mid-Atlantic region either have policies that do not provide an evidentiary standard or did not respond to requests for information and clarification from OSIG.

The preponderance of evidence standard — that bases its conclusion not on whether something actually happened but on whether it is more likely than not that it did happen — creates a culture where staff feel disempowered and guilty until proven innocent. This was a concern voiced both by anonymous responders to OSIG’s questionnaire as well as by staff interviewed by OSIG who had in the past been the subject of an abuse or neglect investigation. This impacts facility operations in a variety of ways.

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<sup>3</sup> Kentucky Cabinet for Health and Family Services, <http://manuals.sp.chfs.ky.gov/chapter20/Pages/209DeterminingtheFindingsofanAdultAbuseNeglectExploitationInvestigation.aspx>, accessed on February 9, 2016.

<sup>4</sup> Pennsylvania Bureau of Human Services Licensing staff via email on February 12, 2016.

<sup>5</sup> Delaware Division of Long Term Care Residents Protection, *Division of Long-Term Care Residents Protection: Policies and Procedures*, provided by Division staff via email on September 24, 2015.

<sup>6</sup> Verified by Maryland Department of Health & Mental Hygiene staff via email on February 5, 2016.

<sup>7</sup> Tennessee Office of Licensure, Department of Mental Health and Substance Abuse staff via email on February 4, 2016.

<sup>8</sup> West Virginia Department of Health and Human Resources, <http://www.dhhr.wv.gov/bcf/Services/Documents/APSpolicy2013.pdf>, accessed, February 9, 2016.

*INVESTIGATOR EMPLOYEE WORK PROFILES (EWP) AND TRAINING FOR INVESTIGATORS*

The knowledge, skills, and abilities (KSAs) an investigator is required to possess are detailed in the individual's EWP, under "Section 19. KSAs and/or Competencies required to successfully perform the work." OSIG reviewed 19 abuse and neglect investigator EWPs, including all full-time investigators and 14 of 35 part-time investigators and found that some did not include any requirement for knowledge of or experience working with individuals with behavioral health disorders. Others made no mention of knowledge of or experience in performing abuse and neglect investigations in any context or capacity. Some EWPs were more aligned with a law enforcement position rather than a behavioral health and developmental services abuse and neglect investigator. For instance, one EWP made no mention of behavioral health disorders or working with disabled or vulnerable populations (although it does include being "physically able to manage, restrain, and transport aggressive/combatative persons"). Another EWP only included the following KSAs:

- Knowledge of administrative/office management principles and practices;
- Working knowledge of principles and practices of human resource management and policies of state government impacting employment issues;
- Demonstrated ability to multitask;
- Demonstrated ability to perform clerical functions in support of human resources; and
- Must possess effectively communication skills and ability to exercise judgment in carrying out tasks within policy guidelines.

As with other investigators' roles, the EWP described immediately above includes responsibilities outside of abuse and neglect investigations. Staff with multiple roles present an area of potential risk for DBHDS, as they may create the appearance of possible conflicts of interest. For example, in one facility a facility investigator also had responsibilities in patient relations. This role could provide the investigator with knowledge of or prior experience with a patient that could, consciously or otherwise, bias their judgment during an investigation.

Several observations were made regarding training of investigators and facility staff:

- The DBHDS Guidelines for Investigators extensively covers the processes for investigations, including prioritizing caseloads, incident scene management, effective interview techniques, and evidence management. However, OSIG found no content related to important and unique elements of an investigation performed in a behavioral health facility or training center, special techniques or considerations for interviewing individuals with behavioral health disorders.
- Depending on the date an investigator is hired, they may be asked to fulfill the job requirements of an investigator but may not be trained for several months, as DBHDS only holds investigator trainings annually. Current investigators reported that additional trainings are occasionally held on an ad hoc basis, but typically occur sporadically so that as many investigators as possible can be trained at the same time. This can create a

situation where investigators are performing investigations for a considerable amount of time before receiving appropriate training. This could present risk if the investigator's prior work experience is not in a relevant setting or if the individual has no prior experience conducting investigations of any kind.

- Nearly half of investigators (47%) reported to OSIG that they found the training to be insufficient or unhelpful, and as a result, some investigators do not attend subsequent annual trainings as refreshers, noting that the process-oriented nature of the training limits its effectiveness. One facility has gone so far as to send their investigators to an independent, third-party trainer in order to help them be better trained to perform higher quality investigations.

#### *TRAINING FOR DIRECT CARE STAFF*

OSIG also interviewed 17 staff members who were the subject of an abuse or neglect investigation to learn more about their perspective on the process and its practical implementation. The questions covered topics such as training, disciplinary actions, and the impact of the investigation on how they perform their job responsibilities. Of these 17 staff, nine indicated that the only training they had received on abuse and neglect investigations was at new employee orientation. Two staff indicated that the training was simply reading DI201.

As a result of training received, staff are not always compliant with DI201 reporting requirements for allegations of abuse or neglect. When asked who they reported an allegation to, six staff indicated that they did not report suspected abuse or neglect directly to the facility director as soon as possible as mandated by DI201, but to charge nurses, the clinical director, or a supervisor. One staff member at one facility indicated that they were instructed by nurses on their unit to report any issues to them, and that according to them they "did not need to report it to the facility director." When discussing this topic, staff said they were told that these were issues to be handled at the unit level and that they usually did not need to be pursued beyond that level. Although the number reporting this issue is not high given the number who responded to OSIG inquiries, any variation has the potential to create risk.

#### *CHECKS AND BALANCES IN THE INVESTIGATION PROCESS*

DI201 has checks and balances in place to attempt to ensure a process that is transparent and free from persuasion or bias:

- Investigators are hired by facility directors.
- A minimum of one human rights advocate serves each facility. Their primary responsibility is to ensure the rights of patients at that facility (except one facility, whose human rights advocate position has been vacant since November 2015. The position was filled for two weeks in March 2016 before being vacated again. DBHDS has filled the position and the new human rights advocate is scheduled to start June 27, 2016).
- DBHDS has a panel in place to review investigations where the findings are disputed by the facility director.

The process lacks outside review by entities not employed by DBHDS. While investigators are hired by and employed by the facility they are required to investigate, during investigations they are supervised by the CO Investigations Manager. If investigations warrant further review, they are reviewed by a panel that, while able (but not required) to consult with outside professionals on an undefined, ad hoc basis, is composed entirely of DBHDS staff. Individuals with lived experience in facilities are not involved in any part of the process. There is no internal or external review or audit of the CO Investigations Manager or OHRs activities related to abuse and neglect investigations or their outcomes. Finally, DBHDS was unable to provide OSIG with any documentation that guides certain key steps of the process, such as minimum competencies for investigators, training standards, determinations made by CORP, or criteria by which requests for mitigation are evaluated (described in more detail below).

In comparison to other Mid-Atlantic states, Virginia is in the minority in placing responsibility for investigating allegations of abuse or neglect within the same agency that is responsible for operating the facilities where such alleged events occur. The specific agency varies from state to state, but out of the seven states reviewed, only Maryland and Tennessee have an organizational structure similar to Virginia.

The offices and/or agencies responsible for conducting abuse or neglect investigations in the Mid-Atlantic are:

- Delaware – Division of Long Term Care Residents Protection, Department of Health and Social Services;
- Kentucky – Adult Protective Services Branch, Cabinet for Health and Family Services;
- Maryland – Residence Grievance System, Department of Health and Mental Hygiene;
- Pennsylvania – Adult Protective Services Division, Department of Human Services [Note: Services are performed by Liberty Healthcare Corporation, the statewide protective services agency under contract with the Pennsylvania Department of Human Services.];
- South Carolina – Vulnerable Adult Investigations Unit, South Carolina Law Enforcement Division;<sup>9</sup>
- Tennessee – Office of Legal Counsel, Tennessee Department of Mental Health and Mental Retardation; and
- West Virginia – Adult Protective Services, Bureau for Children and Families, Department of Health and Human Resources.

Not only does DBHDS operate facilities, operate the OHR, and oversee the investigation of abuse or neglect within those facilities, but the staff tasked with performing these investigations are employed by the facilities they are investigating. This may result in instances where investigators' judgment is biased or influenced, whether by the perceived reputation of a certain staff member or patient, the culture of that facility, fear related to their own job security, or other factors.

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<sup>9</sup> South Carolina Code of Laws Unannotated, <http://www.scstatehouse.gov/code/t43c035.php>.

During the course of these inspections, DBHDS released proposed changes to [12VAC 35 – 115](#), “Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services.” According to DBHDS, these changes are being proposed to “improve the ability of the Human Rights Office to perform its mandated responsibilities and maximize resources, in a manner that promotes the vision of recovery, self-determination, empowerment, and community integration for individuals receiving services.” The proposed changes relate to a number of different sections of Chapter 115 of the Virginia Administrative Code, including the abuse and neglect investigations process. Currently, this process is included under Section 60, Provider’s Duties, which places responsibility for these investigations with the facility director. The proposed changes would relocate the abuse and neglect investigations process within the overall human rights complaint process (which is still within the DBHDS infrastructure).

Furthermore, the proposed regulations make a number of changes to the process that stand in conflict with DI201:

- The investigator will no longer make the final determination in an investigation. Under DI201-4, “Responsible Authorities,” the investigator shall, amongst other things, “Render a decision pursuant to applicable time frames.” However, [12VAC 35-115\[175\]\(F-6\)](#) (Proposed) indicates that “The program director shall decide, based on the investigator’s report and any other available information, whether the abuse, neglect, or exploitation occurred.”
- [12 VAC 35-115-175-F-7](#) (Proposed) extends the overall investigation process by allowing the program director an additional ten days from receipt of the investigation summary to submit a final determination and, when applicable, create an action plan.

The proposed changes ([12 VAC 35-115\[180\]\(A\)](#)) also allow the individual who was the subject of the alleged abuse or neglect to appeal the decision of the facility director or the resultant action plan to the local human rights committee (LHRC) within 10 days from receipt of the determination or action plan, a right that they currently do not have under DI201 (only the facility director or human rights advocate can forward cases to CORP for review). Adding the right to appeal is clearly a positive change, as is placing the responsibility of hearing appeals with the LHRC instead of the CORP.

#### **OBSERVATION NO. 1-A RECOMMENDATION**

DBHDS, in partnership with relevant constituents should complete a comprehensive review and revision of DI201, including:

- External requests for investigations;
- CORP;
- Inconsistency in standards;
- Investigator qualifications and training for investigators and staff; and
- Preponderance of evidence standard.

***MANAGEMENT RESPONSE***

*DBHDS concurs with this recommendation.*

**OBSERVATION NO. 1-B RECOMMENDATION**

Following the revision of DI201, DBHDS should develop a competency-based training curriculum for investigators and facility staff to include mandatory annual refresher trainings, ensuring a comprehensive review of all relevant DBHDS and facility-specific policies and procedures.

***MANAGEMENT RESPONSE***

*DBHDS concurs with this recommendation.*

**OBSERVATION NO. 1-C RECOMMENDATION**

DBHDS should standardize investigator EWP to include more relevant KSAs, including experience performing investigations and working with individuals with behavioral health and developmental disorders. DBHDS should also review all current investigator EWPs to identify gaps in employees' knowledge bases and experience, and based on that review modify the Guidelines to ensure that those gaps are addressed in training.

***MANAGEMENT RESPONSE***

*DBHDS concurs with this recommendation.*

**OBSERVATION NO. 1-D RECOMMENDATION**

To increase transparency in the investigations process, DBHDS should develop written protocols defining:

- When to consult with clinical professionals or subject matter experts external to DBHDS;
- The method by which CORP determines which clinical professionals with whom to consult;
- The criteria by which CORP makes final decisions about investigations;
- Processes for recording and maintaining meeting minutes; and
- Process for documenting the rationale for final determination of investigations.

***MANAGEMENT RESPONSE***

*DBHDS concurs with this recommendation.*

## **Objective 2**

Assess the quality of abuse and neglect investigations, data and data collection processes, and the quality management process currently utilized to drive performance improvement, minimize risk, and prevent future abuse and neglect.

### **OBSERVATION NO. 2 — ABUSE AND NEGLECT INVESTIGATIONS ARE CONDUCTED INCONSISTENTLY, PRODUCING VARIATION IN THEIR QUALITY AND OUTCOMES.**

The DBHDS Guidelines for Investigators is a 56-page document that provides investigators with instructions for performing investigations, including the coding of forms, performance of interviews, case numbering, and preparing the case file. The Guidelines indicate what documents should be included in a case file and the order that they should be stored. The Guidelines do not provide a method for tracking the progress of an investigation in order to adhere to the timeframes required in DI201.

OSIG reviewed both the contents and quality of abuse and neglect investigation files. OSIG found incomplete files at every facility, some of which were lacking key documents such as transmittal letters, notifications to investigated staff, and written witness statements. In the absence of a prescribed method, facilities have developed their own methods for tracking investigation progress, and while some methods provide a robust system for ensuring all components of investigations are performed in a timely manner, others do not. OSIG also observed that facilities with multiple investigators had case files that were inconsistently maintained, making comparisons of the files and outcomes difficult.

Facility investigators are inconsistent in taking precautions to ensure privacy of staff being investigated. Staff members from five facilities indicated they believed their privacy, guaranteed by DI201 and the Guidelines, was compromised at some point during the investigation process. Privacy was also mentioned by nine anonymous respondents as an issue in abuse and neglect investigations. OSIG learned of at least one instance when an investigator interviewed a staff member under investigation on a unit in front of peers instead of requesting the staff member meet them at an off-unit location, which would have provided more privacy.

During one of the facility inspections, OSIG was advised of an investigator using methods noncompliant with the Guidelines to take and prepare written statements. The Guidelines indicate investigators “will assist the witness to formulate and record a statement,” and that when the statement is being written that “the investigator asks a question, the witness will answer out loud in complete sentences and then write the answer in complete sentences (and must be so instructed by the investigator).” The investigator and witness are to reread the statement, make any corrections, and sign and date the statement. However, at one facility staff indicated that the investigator made audio recordings of their statements, transcribed them, and added them to the case file without giving the witness an opportunity to review the statement or acknowledge its accuracy. A review of those case files confirmed the reports.

While the Guidelines indicate that witness statements must be voluntary and “In no case will the investigator elicit statements or confessions by coercion,” one facility’s form for obtaining statements from staff requires the staff to acknowledge via signing their initials that they are, “... required to answer fully and truthfully questions specifically, directly, and narrowly related to the performance of my official duties. I further understand that if I refuse to answer fully and truthfully ... I could be subject to disciplinary action including dismissal from employment, based on such refusal.” At the bottom of the same form, the staff member is also required to acknowledge via signing their initials that, “This statement was provided freely and voluntarily,” a statement that contradicts the earlier acknowledgment.

After completing all inspections, OSIG reviewed investigation case files to determine length of time it was taking facilities to close investigations. After the investigation is completed, there remain administrative issues to address and complete, including administrative actions, disciplinary measures, grievances, and other acts of due process. At the close of the first quarter of FY 2016, more than 25 percent of all abuse and neglect investigation cases were still pending. This rate was even higher for FY15, when 30.6 percent of cases were pending as of the end of fiscal year. Some of the cases included in these figures include recently opened cases, but that does not account for all of the cases that remained open. At one facility, the average number of days that cases remained open between July 2014 and September 2015 was 23.4 days. Additionally, one facility had five pending cases that had been open between 159 and 180 days (an average of 170.4 days). While DI201 does provide a timeframe for completing investigations, it does not provide one for full, administrative closure of cases.

Investigators at one facility made multiple requests for extensions on a single investigation and requested extensions for groups of cases in batches of three or more cases at a time. DBHDS was not able to provide any written guidelines detailing the criteria by which the Assistant Commissioner for Quality Management and Development decides if an extension will be granted. The lengthy nature of these investigations also impacts unit staffing. If a staff member is reassigned or placed on administrative leave, other staff must be brought in to cover those hours, including staff from other shifts or units. This can create a disruption in the continuity of care for patients on that unit.

## **OBSERVATION NO. 2 RECOMMENDATION**

DBHDS should review and revise the Guidelines to improve the consistency of abuse and neglect investigation case files, with a specific focus on developing document templates and providing clear descriptions of all documents that should be included in the file. This revision should include a focus on the following areas:

- Maintaining staff privacy;
- Ensuring written statements are accurate representations of witnesses;
- Ensuring witness statements are not subject to coercion; and
- Ensuring investigations are performed and closed in a timely manner.



***MANAGEMENT RESPONSE***

*DBHDS concurs with this recommendation.*

**OBSERVATION No. 3 — COMMUNICATION BETWEEN FACILITIES AND THEIR STAFF DURING AND AFTER AN ABUSE OR NEGLECT INVESTIGATION IS NOT IN COMPLIANCE WITH DI201 REQUIREMENTS.**

DI201 requires certain information be provided to an individual being investigated as a result of an abuse or neglect allegation including:

- The fact that an allegation has been made, its nature, and that an investigation will take place;
- The rights the person has under DI201;
- To be informed of the timeframes for completing the investigation;
- The findings of the investigation, in written form within seven working days of investigation completion; and
- That they have the right to present information on their own behalf.

OSIG found that these requirements sometimes go unmet. OSIG spoke with 17 staff members who had been investigated in the past, and 10 of them were dissatisfied with the level of communication received from facility administrators. This can have a greater impact on staff whose investigations lasted longer than 10 days but never received any updates, as they are left with no information for an extended period of time about an investigation that could cost them their job and/or license. One investigation lasted more than 30 days, while another investigation lasted more than six months. Six of these staff members said that they had to initiate all contact with facility administrators, often making multiple calls, to receive the determination of the investigation and find out if they were allowed to return to work.

In the cases that follow, two staff indicated that 30 or more days had passed between the alleged incidents and learning about the investigation, making it difficult to remember details or give a full account of the incident. One staff member who was investigated five months prior to OSIG's investigation remained unaware they were named in an allegation of abuse or neglect that was investigated. The individual was returned to work with patient contact despite the investigation remaining open.

Individual staff member "A" was investigated following an allegation of abuse or neglect in 2015. OSIG found that the investigation was performed within the prescribed timeframes. However, the investigator's determination led to staff member "A" being placed on administrative leave while facility administrators reviewed the determination and pursued mitigation. During this time staff member "A" received no information from the facility concerning how long the investigation would last or if/when they would be allowed to return to work. Staff member "A" was allowed to return to work in a different capacity 37 days after the alleged incident.

Individual staff member “B” was also investigated following an allegation of abuse or neglect in 2015. Staff member “B” is licensed by DHP. According to the case file, the investigation was initiated within the required timeframe, but neither the investigation nor the administrative review were completed within the required timeframes. The timeline for the investigation is as follows (days elapsed are used instead of dates to protect identities):

- Investigation initiated – zero days elapsed
- Investigator’s summary and transmittal letter prepared, indicating that the allegation against Staff member “B” was unfounded but a case of systemic neglect against their unit was substantiated – 14 days elapsed
- Addendum to investigator’s summary prepared – 12 days elapsed
- Staff member “B” obtained notice to return to work – 37 days elapsed
- Memo with findings of CORP prepared – 85 days elapsed
- Memo with action plan prepared by facility director – 1 day elapsed

The action plan memo, which was the last dated item in the case file, was prepared 149 days after the investigation was initiated. During those 37 days before finding out that they could return to work (during which they were on administrative leave), staff member “B” received no communication from facility administrators. Staff member “B” described the stress felt during those 37 days as being amplified because they received no information about the investigation, the outcome of which could place their license and career in jeopardy. Staff member “B” eventually contacted facility administration concerning the status of the investigation but reported no response from four inquiries made. Staff member “B” then contacted the Employee Relations Manager at CO requesting assistance and the facility responded the same day. Subsequent to OSIG’s inspection, this investigation has been closed, 191 days after it was opened.

### **OBSERVATION NO. 3 RECOMMENDATION**

DBHDS should enforce communication requirements to ensure facility directors and their designees are compliant with the DI201 requirements to keep staff apprised of investigations, including:

- Confirming the investigation with the staff being investigated;
- Keeping the staff member apprised of the progress and resolution of the investigation, especially for staff placed on administrative leave; and
- Notifying staff when extensions to investigation timeframes have been granted by CO.

### ***MANAGEMENT RESPONSE***

*DBHDS concurs with this recommendation.*

### ***Objective 3***

Determine outcomes of the current system for addressing abuse and neglect and identify how these may create potential risk areas to individuals served, employees, DBHDS, and the Commonwealth.

**OBSERVATION NO. 4 — DBHDS-OPERATED FACILITIES ARE NOT CURRENTLY UTILIZING DI201 REPORTS AND DATA TO SUPPORT PERFORMANCE IMPROVEMENT AND PREVENT ABUSE AND NEGLECT IN THE FUTURE.**

Facilities collect data on abuse and neglect, peer-to-peer aggression, falls, and other significant events as part of compliance requirements or risk management processes. Facility structures, such as quarterly executive board and quality council meetings and required performance improvement projects, allow facilities to improve operations and quality of care as well as mitigate risks and prevent future events.

OSIG reviewed minutes from these meetings and performance improvement plans from facilities to see if efforts were being made to utilize abuse and neglect data to drive performance improvement and prevention activities. In spite of data being collected in CHRIS and other databases, OSIG found that facilities are not utilizing DI201 reports or available data to support performance improvement or develop plans to support the mitigation or prevention of abuse and neglect. By doing so, DBHDS and the facilities are missing opportunities to use available data to analyze trends and patterns and drive performance improvement. In doing so, DBHDS and the facilities may have the opportunity to prevent future abuse and neglect in a very efficient manner.

**OBSERVATION NO. 4 RECOMMENDATION**

DBHDS facilities should utilize DI201 reports and data to support performance improvement and development of plans to support prevention of abuse and neglect.

***MANAGEMENT RESPONSE***

*DBHDS concurs with this recommendation.*

**OBSERVATION NO. 5 — FACILITIES ARE INCONSISTENT IN THE MANAGEMENT OF HUMAN RESOURCES DURING AND AFTER AN ABUSE OR NEGLECT INVESTIGATION.**

OSIG found that human resource issues were handled inconsistently across facilities, including:

- Determinations regarding the reassignment of staff or placement on administrative leave during investigations;
- The application of administrative discipline after an investigation; and
- The mitigation process.

The DBHDS Employee Handbook indicates that “When an employee is accused of abuse or neglect of a client, the employee should be immediately suspended in accordance with the *Standards of Conduct*.” However, OSIG found investigations where staff members were not suspended, but reassigned to other units. In other cases, staff remained on the same unit where the alleged abuse or neglect occurred. At least one facility gives the staff member who is being investigated the option to either be reassigned to a different unit or to be placed on paid, pre-disciplinary action administrative leave. Direct care staff voiced concern that administrative

decisions about which staff are left on units, reassigned, or placed on administrative leave during the investigation are made inconsistently. Neither DI201 nor the DBHDS Employee Handbook provides any criteria or guidelines by which this determination is made.

Mitigation is a crucial component of human resource management utilized by facilities as part of the abuse and neglect investigation process. Mitigation allows for facility directors to present DBHDS with compelling reasons such as prior job performance and extenuating circumstances why employees should not be terminated, including allowing the staff member to make a statement in their own defense.

DBHDS was unable to provide any written guidelines or criteria governing the elements of the mitigation process, including:

- Who may initiate the mitigation process (depending on the facility, this process may be initiated by the facility director, the staff supervisor or the staff member themselves);
- Who reviews mitigation requests;
- What criteria are used to determine whether to approve the mitigation request; or
- How long someone has to file a request or how long DBHDS has to make a determination.

When asked about this, one facility director indicated that such guidance would be “very helpful,” adding that before they were the director they could not be sure that previous mitigation requests were being made consistently. The absence of such guidelines concerned them, noting that “if people were to ask about how these [mitigation] decisions are made I would not have anything to offer them.”

#### **OBSERVATION NO. 5 RECOMMENDATION**

DBHDS should (in collaboration with the Department of Human Resource Management as necessary) establish clear guidelines for the reassignment of investigated staff as well as mitigation process. These guidelines should include:

- Criteria for determining unit reassignment versus administrative leave;
- Who is allowed to initiate mitigation;
- What criteria are used for approving or denying mitigation requests; and
- Timelines for the process to be completed.

#### ***MANAGEMENT RESPONSE***

*DBHDS concurs with this recommendation*

## Appendix I: Departmental Instruction 201(RTS)03

Issued 10/31/03  
Revised 8/31/2009

### **Departmental Instruction 201(RTS)03 Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities**

#### **201 - 1      Background**

The Department of Behavioral Health and Developmental Services ("Department") has a duty to provide a safe and secure environment to individuals receiving services and has a philosophy of zero tolerance for abuse and neglect. The Department will, in all instances, investigate and act upon allegations of abuse or neglect. Therefore, whenever an allegation of abuse or neglect is made, the Department shall take immediate steps to protect the safety and welfare of individuals who are the victims of the alleged abuse or neglect, conduct a thorough investigation pursuant to central office direction, and take any action necessary to prevent future occurrences of abuse and neglect.

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#### **201 - 2      Purpose**

The purpose of this Departmental Instruction (DI) is to establish policies, procedures, and responsibilities for reporting, responding to, and investigating allegations of abuse and neglect of individuals receiving services in Department facilities.

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#### **201 - 3      Definitions**

**Abuse**  
Code of  
Virginia  
§37.2-100

This means any act or failure to act by an employee or other person responsible for the care of an individual in a Department facility that was performed or was failed to be performed knowingly, recklessly or intentionally, and that caused or might have caused physical or psychological harm, injury or death to a person receiving care or treatment for mental illness, mental retardation or substance abuse. Examples of abuse include, but are not limited to, acts such as:

- Rape, sexual assault, or other criminal sexual behavior,
- Assault or battery;
- Use of language that demeans, threatens, intimidates or humiliates the person;
- Misuse or misappropriation of the person's assets, goods or property;
- Use of excessive force when placing a person in physical or mechanical restraint;
- Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professionally accepted standards of practice or the person's individualized services plan; and
- Use of restrictive or intensive services or denial of services to punish the person or that is not consistent with his individualized services plan.

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<b>Facility Investigator ("Investigator")</b>	This means a person who has successfully completed investigative training and has received a certificate of completion by the Department.
<b>Neglect Code of Virginia §37.2-100</b>	This means the failure by a person, program, or facility operated, licensed, or funded by the department, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of a person receiving care or treatment for mental illness, mental retardation, or substance abuse.
<b>Open investigation</b>	This means an investigation that is begun when the facility director assigns an Investigator to it, and remains open until the facility director either determines the investigation is complete or, for investigations referred to the Investigations Manager, receives a letter from the Investigations Manager indicating that the investigation is complete.
<b>Preponderance of evidence</b>	This means the facts gathered show it is more probable than not that abuse or neglect occurred; evidence that is more convincing than the opposing evidence.
<b>Workforce</b>	This means Department classified employees, wage employees, contract employees (including locum tenens), temporary employees; volunteers, student interns; and consultants.

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#### **201 - 4 Responsible Authorities**

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<b>Central Office</b>	The <b>Investigations Manager</b> , or designee, is responsible for: <ul style="list-style-type: none"><li>• Interpreting this DI in consultation with the Assistant Commissioner for Public Relations and Quality Improvement and the Office of Human Rights, as appropriate;</li><li>• Supervising Investigators in the context of investigations pursuant to this DI;</li><li>• Assisting in the process for hiring and/or selecting Investigators and providing input into Investigators' annual performance reviews;</li><li>• Providing training, consultation and supervision to Investigators during the investigation process as needed; and</li><li>• Reviewing and making determinations for investigations referred from the facility director.</li></ul>
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**Central Office** The **Assistant Commissioner for Public Relations and Quality Improvement**  
*(Continued)* is responsible for:

- Supervising the Investigations Manager;
- Consulting with facility staff, the Investigations Manager, the Office of Human Rights, and others in implementing this DI;
- Assisting in the identification of situations or incidents which would require an investigation; and;
- Granting or denying requests for extensions to the investigation time frames in this DI.

The Investigations Manager and Assistant Commissioner for Public Relations and Quality Improvement are both responsible for identifying opportunities for system-wide learning from facility-based reviews and developing plans for dissemination of best practices as well as educational updates related to high risk areas.

The **Director of the Office of Human Rights** is responsible for oversight of the Human Rights Advocate in the course of an investigation and serves as a member of the Central Office Abuse/Neglect Review Panel.

**Human Rights Advocates ("Advocates")**, under the supervision of the Director of the Office of Human Rights, are responsible for:

- Ensuring that the rights of individuals receiving services are protected and represented from the time of the original notification of potential abuse or neglect throughout the course of the subsequent investigation; and
- Submitting the results of any independent investigation conducted in accordance with the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Behavioral Health and Developmental Services, 12 VAC 35-115- 10 et seq. ("Human Rights Regulations") to the Director of the Office of Human Rights, the facility director, and the Investigations Manager.

The **Central Office Abuse/Neglect Review Panel ("Review Panel")** is responsible for reviewing all investigations that are outside the scope or expertise of the Investigations Manager related to standards of care, are considered controversial and subject to media coverage, may create significant risk for the Department and for general consultation. The Review Panel is responsible for reviewing and making recommendations regarding any investigation sent to the Central Office when the Investigation Manager intends to issue a final

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**Central Office** determination that is different from the determination of the Investigator. The  
*(continued)* Review Panel shall be comprised of the Directors of the Offices of Human Rights,  
Risk and Liability Affairs, and Quality Management and ad hoc members, when  
necessary.

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**Facilities** **Facility directors**, or their designee(s), are responsible for the implementation of  
this instruction within the facility including the following:

- Ensuring that each workforce member:
  1. Is given a copy of this DI;
  2. Reviews this DI at the time of orientation and annually thereafter; and
  3. Signs a statement acknowledging understanding of and agreement to abide by this DI.

Signed statements shall be maintained in either official personnel files or training records for employees or official training records for volunteers, contractors, contract employees, student interns, and consultants.

- Ensuring that the safety and welfare of individuals receiving services who may be associated with or involved in the review of potential abuse or neglect;
- Ensuring that the facility complies with all state laws that govern reporting abuse and neglect;
- Ensuring that the employee against whom an allegation is made is presumed not to have committed abuse or neglect unless the facts of the investigation show otherwise; and
- Ensuring the employee is advised of the investigation process and knows he may contact the Office of Human Resources or the facility director if he has questions.

**Investigators** Investigators shall:

- Be appointed by the facility director;
- Conduct an impartial investigation;
- Render a decision pursuant to applicable time frames; and
- Be supervised by the Investigations Manager during the course of an active investigation.

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**201 - 5      Specific Guidance**

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**Scope of this DI**      This DI applies to all Department workforce members.

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**Rights of individuals**      Each individual receiving services in a state facility has the right to:

- Be protected from harm including abuse, neglect, and exploitation (See §37.2-400 12VAC35-115-50 (B) (2) and (D) (3));
- Report any potential abuse or neglect that happened to him or another individual receiving services without reprisal; and;
- Have all allegations of abuse or neglect investigated in accordance with the time frames in the Human Rights Regulations and this DI.

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**Policy regarding allegations**      All occurrences or events that may involve abuse or neglect of individuals in facilities and any information regarding such shall be reported directly to the facility director, or his designee, as appropriate, so that immediate action may be taken to safeguard individuals receiving services.

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**Workforce protections**      When an allegation of abuse/neglect has been reported, the identified workforce member shall:

- Be informed that an allegation of abuse or neglect has been made, the nature of the allegation, and that an impartial investigation will be conducted in a timely and thorough manner;
- Be explained his rights under this policy;
- Be informed of the time frames for completion of the investigation;
- Be notified of the findings of the investigation;
- Have the opportunity to present information on his own behalf to the Investigator; and
- Have the opportunity to present information on his own behalf to the person responsible for taking disciplinary action and at any related administrative hearings.

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<b>Workforce protections</b> <i>(Continued)</i>	At the time of the allegation stage, the identified workforce member is presumed to not have committed abuse/neglect.
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<b>Substantiating abuse and neglect</b>	A finding of abuse or neglect shall be substantiated by a preponderance of the evidence. The standard for substantiating abuse and neglect will be based on preponderance of the evidence gathered during the investigation process. See " <i>preponderance of the evidence</i> " in the definitions section.
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<b>Independent investigations</b>	<p>In accordance with the Human Rights Regulations, an advocate may conduct an independent investigation of an allegation of abuse and/or neglect. Results of such independent investigations shall be submitted to the Director of the Office of Human Rights, the facility director, and the Investigations Manager.</p> <p>In accordance with DI 401(RM) 03, <i>Risk and Liability Management</i>, facility risk managers are responsible for conducting investigations of injuries or other events that may also involve abuse or neglect.</p> <p>Neither of these types of investigations negates the need to also do an investigation pursuant to this DI.</p>
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<b>Release of information</b>	All requests for information received by any member of the workforce regarding abuse or neglect investigations shall be routed through the facility director.
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<b>Privacy</b>	The Department's workforce in the central office and state facilities shall take collective responsibility for appropriately securing, retaining, and sharing protected health information about all individuals entrusted to the Department's system of care, consistent with the Department's privacy policies and procedures (see DI 1001(PHI)03, <i>Privacy Policies and Procedures for the Use and Disclosure of Protected Health Information</i> ).
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<b>Personnel actions</b>	All personnel actions, including grievance resolutions that result from abuse or neglect investigations, shall be reported to the Department's assigned Human Resource Consultant.

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**201 – 6      Procedures – Reporting**

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**Reporting  
abuse and  
neglect**

Any workforce member who has any knowledge or reason to believe that an individual residing in a state facility may have been abused or neglected, or both, shall immediately report this information directly to the facility director, or designee, as appropriate.

Knowledge or reason to believe abuse or neglect has occurred may be based on, but not limited to, the following:

- Direct observation, including clinical determinations;
- A statement made by an individual receiving services;
- A statement from another workforce member.

When reporting to the facility director, the workforce member shall describe the incident as fully as possible, giving the names of any persons involved, the time, date, and location of the incident, and the names of any witnesses.

The facility director shall be notified in all cases. However, workforce members may and shall when required by law, also directly notify any of the following of the possible abuse or neglect at the same time as they notify the facility director:

- Office of the Inspector General;
- Central Office Investigations Manager;
- Human Rights Advocate;
- Child or adult protective services unit in the local department of social services;
- Virginia Office for Protection and Advocacy (VOPA)

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**Workforce  
members'  
duties**

After reporting an incident or allegation of possible abuse or neglect to the facility director, workforce members are expected to cooperate fully in the investigation process. This may include submitting written statements, if requested, to the Investigator assigned to conduct the investigation.

Workforce members shall:

- Report all incidents of suspected abuse or neglect of individuals receiving service in accordance with this DI;

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*Continued on next page*

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**Workforce members' duties**  
*(Continued)*

- Provide accurate and complete information regarding the alleged abuse or neglect;
- Provide accurate and complete information during interviews with the Investigator or in an administrative proceeding; and
- Protect the confidentiality of the investigation.

In addition, workforce members shall not:

- Discuss any aspect of the investigation, or share documents, statements, or evidence related to the investigation;
- Alter, remove, or destroy documents or evidence of any kind that is related to the investigation; or
- Conduct their own investigation by taking photographs, copying records, soliciting statements, or in any way attempting to supplant or supplement the activities of the assigned Investigator (this does not apply to the facility Risk Manager or Human Rights Advocate).

Any action by a workforce member that compromises the integrity or outcome of an investigation may be cause for disciplinary action.

Failure to report suspected abuse or neglect of children or aged or incapacitated adults may be subject to monetary penalties under §63.2-1509 and §63.2-1606 of the *Code of Virginia*.

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## 201 - 7      **Procedures—Initial Investigation**

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**Upon receipt of an allegation**      Upon receipt of an allegation of abuse or neglect, the facility director or designee shall immediately:

- Ensure that appropriate and necessary steps are taken to protect the safety and welfare of the individual receiving services. Actions may include, but are not limited to, suspending or relocating any workforce member who is the subject of an investigation; and
- Ensure that any physical evidence is protected (e.g., have the individual examined, isolate and collect clothing, take pictures, secure the scene, etc.);

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**Upon receipt of an allegation** Following the receipt of an allegation of abuse or neglect the facility director shall do the following within 24 hours:  
*(Continued)*

- Initiate an impartial investigation conducted by an Investigator;
- Notify the individual and his AR, if applicable, that an investigation has been initiated and provide the opportunity to be kept informed of the investigation process;
- Notify the Human Rights Advocate that an investigation has been initiated;
- Notify the local department of social services, as required by §§ 63.2-1509 or 63.2-1606; and;
- Ensure that the allegation is entered into the Computerized Human Rights Information System (CHRIS).

As the investigation begins, the facility director shall ensure that workforce members are reminded to cooperate fully with the investigation and not discuss the facts of the alleged abuse or neglect with anyone other than the investigation staff.

The facility director shall also immediately contact local law enforcement or the State Police Bureau of Criminal Investigations, or both, in all cases of suspected criminal activity, e.g., Virginia Code § 18.2-369. If a law enforcement agency determines that a criminal investigation is warranted, any Department investigation of the allegation of abuse or neglect may be suspended if requested by the law enforcement agency investigator.

Specific to this DI, the facility director and the Investigator shall take immediate action, based on critical care issues of the individual receiving services, to determine whether there is a need to secure evidence or sequester clinical records while ensuring that appropriate treatment continues.

**Conflict of Interest**

If any workforce member is aware of a possible personal or professional relationship of the Investigator that could compromise the integrity of an investigation of abuse or neglect, the workforce member shall immediately notify the facility director and the Investigations Manager. If a conflict of interest does in fact exist, the Investigations Manager shall take appropriate action to resolve the conflict.

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**Role of the Advocate**

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During the investigation process the Advocate may represent the individual who is the victim of the alleged abuse or neglect. The Advocate may be present during the Investigator's interview of the individual when requested by:

- (i) the individual who is the victim of the alleged abuse or neglect or his AR; or
- (ii) the Investigator, with permission of the individual.

In addition, the Advocate may be present at his own discretion.

The Advocate shall monitor the investigation process including ensuring that the facility protects the individual's human rights throughout the investigation process and providing feedback to the Investigator regarding human rights issues. The Advocate shall provide the Investigator with all information that he possesses in regard to the allegation.

The Advocate's monitoring of the Department's investigation in no way signifies the Advocate's agreement with the findings of that investigation.

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**201 - 8**

**Procedures—Investigation Process**

**Improbable allegations**

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When the facility director, Investigator, and Advocate, in consultation and agreement, determine at any time during the course of an investigation that an individual's allegation of abuse or neglect may be based on inaccurate information and as such may be an improbable allegation, the following actions shall take place as part of the investigation process:

- The individual's treatment team shall be consulted.
- A thorough clinical assessment shall be conducted to ascertain if there is evidence that the event occurred or if the allegation of abuse or neglect is more likely than not to be symptomatic of the individual's illness or cognitive disability.
- If the clinical assessment determines that the event is more likely than not to be symptomatic of the individual's illness or cognitive disability then no further investigation need take place.
- The facility director shall maintain supporting documentation in all such cases. Such documentation shall include but not be limited to:

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*Continued on next page*

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**Improbable  
allegations**  
*(continued)*

- A statement from the individual's treatment team, to the facility director indicating why the allegation did not warrant further investigation; and what, if any, treatment interventions are being implemented to address this aspect of the individual's behavior; and
- Entry of the findings into CHRIS.
- If the facility director, Investigator, or Advocate believe at any time that the case warrants further investigation, the case shall proceed through the regular investigative process.

When it is determined that there is no reason to suspect that the abuse or neglect has occurred, the Investigator shall notify the Investigations Manager, facility director and Advocate by formal letter, outlining the factors that led to this conclusion. The facility director shall then close the investigation as unsubstantiated and will follow the closure procedures in section 201-9.

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**Timeframe for  
completion**

The Investigator assigned to a case shall ensure completion of the investigation report within the following prescribed timeframes.

- **5 working days** of assignment of a case for all allegations that must be reported to the Department of Health (for Medicaid or Medicare certified facilities) or when an employee has been suspended.
- **10 working days** of assignment of a case for all other allegations unless the Commissioner or any regulation requires a shorter timeframe.

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**Extensions**

The Assistant Commissioner for Public Relations and Quality Improvement may grant an extension for the completion of any investigation; except those that must be reported to the Department of Health.

Any request to extend the 10 working day investigation timeframe shall be submitted to the Assistant Commissioner for Public Relations and Quality Improvement within six working days of assignment of the case to an Investigator and may be approved when documented circumstances justify the extension.

Copies of any approved extension request shall be forwarded to the facility director and the Advocate.

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- Investigation conclusion** At the conclusion of the investigation the Investigator shall:
- Submit a signed and dated investigations summary report and, if there is no disagreement, a transmittal letter with all documentary evidence and a determination of whether abuse and/or neglect occurred to the facility director and the Advocate.
  - Brief the facility director and the Advocate in order to provide additional information or comments and obtain feedback regarding his preliminary determination.

If either the facility director or the Advocate has concerns regarding or disagrees with the Investigator's findings or the investigation process, those concerns shall be communicated directly to the Investigations Manager. The Investigator shall immediately forward the investigation file to the Investigations Manager for review.

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- Investigation determination** For investigations that do not require additional review or consultation by the Investigations Manager, the facility director shall implement any actions required to address any findings or recommendations and proceed to close the investigations in accordance with procedures in section 201-9.

Upon receipt of the transmittal letter, in all cases, the facility director shall provide his written decision, including actions taken as a result of the investigation, within seven working days to the individual or his AR, the Advocate, any investigation authority, the Deputy Commissioner, and the involved workforce member or members.

This decision shall be in writing and in the manner, format, and language that is most easily understood by the individual.

For investigations submitted for additional review, the Investigations Manager shall review the Investigator's determination and all relevant evidence collected and shall make a final determination based on the preponderance of the evidence.

The Investigations Manager shall make this determination within the following timeframes:

- **5 working days of receipt of the investigation** when an employee has **not** been suspended; or
- **2 working days of receipt of the investigation** involving suspension of an employee.

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**Investigation determination**  
*(continued)* Upon completion of this review, the Investigations Manager shall forward a transmittal letter to the facility director with the final determination of the investigation, describing any administrative issues that need to be addressed. The investigation then shall be closed in accordance with section 201-9.

When the Investigations Manager, following a complete review, intends to issue a final determination that is different from the determination of the Investigator, the Investigations Manager shall forward the investigation file to the Central Office Abuse/Neglect Review Panel for recommendations within 48 hours.

The Review Panel shall consult with practicing clinicians who are topic area experts, as needed, but shall do so for all investigations where there is a question of clinical judgment or clinical practice directly related to a potential finding of abuse or neglect. The Review Panel shall make recommendations to the Investigations Manager regarding the final determination of the investigation within 48 hours.

The Investigations Manager shall render a final decision via transmittal letter to the facility director.

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**Medical/clinical review** All investigations referred to the Investigations Manager that involve medical practice or clinical standard of care issues shall include consultation with a Department clinical services practitioner designated by the Commissioner.

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## 201 - 9      **Procedures—Closure**

**Final actions** When the investigation is closed, the **facility director** or his/her designee shall:

- Confirm the final disposition of the investigation by signing the written in-house transmittal letter submitted by the Investigator or the transmittal letter from the Investigation Manager.
- Provide written notification of the results of the investigation, the determination, and action taken within seven working days of completion of the investigation to the following:
  - the individual receiving services;
  - his AR, if applicable;
  - the Advocate; and
  - workforce members named in the investigation.

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- Final actions**  
*(Continued)*
- **Take appropriate corrective actions as outlined in the Department's Employee Handbook, Chapter 14, in accordance with the findings of the investigation. This may include requesting mitigation through the assigned Human Resource Consultant.**
  - When an allegation is determined to be unfounded, the facility director and/or Investigator shall provide the employee the opportunity to discuss the investigations process and outcomes of the investigation;
  - Implement and track any appropriate administrative or clinical care and treatment-related actions in order to prevent future occurrences of abuse or neglect. Such actions shall be developed in consultation with the Advocate and other appropriate personnel;
  - Notify the local Department of Social Services, regulatory agencies, and others, as required;
  - Ensure that all required information about the investigation is entered into the CHRIS; and
  - Notify the Department of Health Professions or professional licensing authority as required by Virginia Code §54.1-2400.6.

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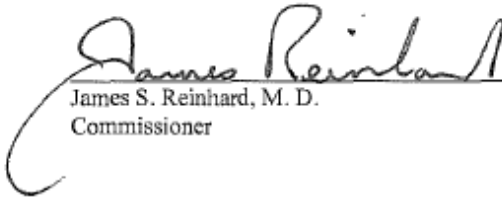
**201 - 10      References**

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- §§ 63.2-1509 and 63.2-1606 of the *Code of Virginia*
- §37.2-100 of the *Code of Virginia*
- §37.2-400 of the *Code of Virginia*
- §54.1-2400.6 of the *Code of Virginia*
- DHRM policy 1.60 Employee Standards of Conduct and Performance
- DBHDS Employee Handbook: Chapter 14
- *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services, 12 VAC 35-115*
- *Abuse/Neglect Investigations Policy and Procedures Manual*

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- Departmental Instruction 1001(PHI) 03, *Privacy Policies and Procedures for State Facility and Central Office Use, Disclosure, and Protection of Individually Identifiable Health Information.*
- Departmental Instruction 401(RM) 03, *Risk and Liability Management.*



James S. Reinhard, M. D.  
Commissioner

Effective Date: August 31, 2009  
Attachment

**Attachment I**

**Investigation Procedures**

Event/ Process	Roles and Responsibilities			
	Facility Director	Investigator	Human Rights Advocate	Investigations Manager
<p><b>Initial Allegation of Abuse or Neglect— Initial 24 hour Investigation</b></p>	<p>Take steps to protect safety and welfare of the individual.</p> <p>Protect physical evidences.</p> <p>Assign a facility investigator.</p> <p>Notify the human rights advocate and if applicable, the individual's legally authorized representative.</p> <p>Ensure allegation is entered into CHRIS system.</p> <p>Report suspected criminal activity to local law-enforcement and State Bureau of Criminal Investigations and notify department of social services, where appropriate.</p> <p>Consult with Investigator and Investigation Manager to determine whether it is necessary to sequester records.</p> <p>In conjunction with Investigator and facility advocate, determine whether the case requires further investigation.</p>	<p>Open an investigation.</p> <p>Consult with facility director and human rights advocate for help in determining whether there is a basis to suspect abuse or neglect</p> <p>Attempt to resolve improbable complaints of abuse or neglect by consulting with the facility director, facility advocate and the individual's treatment team.</p> <p>Determine whether there is a basis to proceed with the abuse or neglect investigation or whether the complaint appears improbable.</p> <p>Maintain locked confidential files.</p>	<p>Assist with the investigation, when requested, by consulting with the facility director, the investigator, Investigation Manager, and the individual who is the victim of the alleged abuse or neglect.</p> <p>Consult with the facility director and investigator to determine whether the case warrants further investigation.</p> <p>Be present during any interview of the individual receiving services.</p> <p>Monitor investigative process and procedures.</p>	<p>Provide direction and consultation to the investigator in the investigation process.</p> <p>Maintain locked confidential files.</p>
<p><b>Initial Investigation Finds No Basis for Abuse or Neglect. Complaint Improbable</b></p>	<p>Maintain documentation to support determination and terminate the investigation (see Final Actions).</p> <p>Request that the facility advocate meet with the individual who is the subject of the complaint.</p>	<p>Notify the facility director and advocate by formal letter outlining factors that led to conclusion.</p> <p>Close investigation case file as unsubstantiated.</p>	<p>Meet with the alleged victim of abuse or neglect</p>	<p>Provide guidance, supervision and assistance to facility investigators</p>

Event/ Process	Roles and Responsibilities			
	Facility Director	Investigator	Human Rights Advocate	Investigations Manager
<b>Reason to Suspect Abuse/Neglect</b>	<p>Notify the Department of Health Professions, or other professional licensing authority, as appropriate</p> <p>Notify the patient or resident's legally authorized representative and appropriate family members (with permission) of the status of the investigation.</p> <p>Notify the workforce member and his supervisor when the workforce member is suspected of the alleged abuse or neglect, and take appropriate action pursuant to the Employee Standards of Conduct and Department policy</p>	<p>Complete the investigation within the required timeframes</p> <ul style="list-style-type: none"> <li>• Within 5 working days for cases that are reported to the Department of Health or when an employee has been suspended</li> <li>• Within 10 working days for all other cases unless shorter timeframes are required by any regulation or the Commissioner</li> </ul> <p>An extension may be requested and authorized by the Assistant Commissioner for Public Relations and Quality Improvement if requested within 6 working days of assignment of investigator</p>	<p>Represent the individual receiving services.</p> <p>Be present during the investigator's interview of the person receiving service.</p> <p>Provide any relevant information to the investigator.</p>	<p>Provide guidance and supervision, to facility investigator.</p> <p>Ensure that investigations are conducted according to this DI.</p>
<b>Conclusion of Investigation</b>	<p>May consult with Investigations Manager to provide further clarification or express concerns regarding the investigator's findings, if necessary, via email or in writing</p>	<p>Submit a summary report of findings, documentary evidence and preliminary determination with signature and date.</p> <p>Forward a copy of the summary report to the facility director and human rights advocate.</p> <p>Brief the facility director and facility advocate regarding case findings.</p> <p>If there is no consensus regarding the investigative finding, the case is forwarded by the investigator to the Investigation Manager for resolution.</p>	<p>May consult with the Investigations Manager to express concerns or provide further clarification of investigator's findings, if necessary.</p>	<p>Provide guidance and assistance to facility investigator.</p> <p>Review cases where investigator, advocate and facility director can not reach a consensus.</p> <p>When the Investigation Manager intends to issue a determination that is contrary to that of the facility investigator, the case will be forwarded to the CO Abuse/Neglect Review Panel.</p> <p>The Review Panel will make recommendations regarding the final determination within 48 hours</p>

Event/ Process	Roles and Responsibilities			
	Facility Director	Investigator	Human Rights Advocate	Investigations Manager
Final Actions	<p>When <u>investigation concludes regardless of outcome</u>, provide results within seven days, to the individual receiving services, his LAR, human rights advocate and any employee or other workforce member who was subject to investigation.</p> <p>Notify local department of social services, regulatory agencies and others when required.</p> <p>Take any appropriate disciplinary actions as outlined in the Employee Standards of Conduct and Performance.</p> <p>Ensure data is entered into CHRIS.</p> <p>Provide a written decision, including actions taken as a result of the investigation within 7 working days, following completion of the investigation to the individual or the individual's authorized representative, the human right's advocate, Deputy Commissioner and the involved workforce member or members.</p>	<p>Respond to any follow-up inquiries from the Investigation Manager.</p>	<p>Discuss the investigation findings and final action of facility director with the individual receiving services and advise of his right to pursue the matter through the human rights process.</p>	<p>Upon completion of review, forward transmittal letter, including any requests for corrective action to facility director.</p>

## Appendix II: OSIG FY 2016 Unannounced State Hospital Inspections – Anonymous Reporting Form

Virginia Office of the State Inspector General  
FY2016 Unannounced State Hospital Inspections

### Anonymous Reporting Form

The Behavioral Health and Developmental Services Division of the Virginia Office of the State Inspector General (OSIG) performs annual unannounced inspections of all state-operated mental health facilities. OSIG is currently conducting an unannounced inspection at this facility. For FY16, these inspections are focusing on the reporting and investigating of alleged incidents of abuse and/or neglect. As part of these inspections, OSIG is providing all staff the opportunity to anonymously report any issues, concerns, challenges, or other feedback concerning the reporting and investigating of abuse and neglect at this facility.

Any information submitted to OSIG is confidential and will not be disclosed to facility administrators or any other state agency except as required by law. Any comments used in the final report for the FY16 Unannounced Inspections will have any identifying information removed, including the facility from which the anonymous information was received. Please use additional sheets of paper if you need more room for your responses.

In addition to this form, manila envelopes have been placed on your unit. To keep your responses anonymous, please place your form in one of these envelopes, seal the envelope, and leave it with the charge nurse. OSIG staff will collect all envelopes at the end of their inspection. If you prefer, you can go online and complete this form anonymously. Just take one of these forms, and when it is convenient visit the link below, which will be active until December 31:

<https://www.surveymonkey.com/r/JFC5GHX>

If you have any questions about these inspections or this form, please contact Jason Lowe, Senior Auditor for Behavioral Health and Developmental Services, OSIG, at 804-625-3273 or [jason.lowe@osig.virginia.gov](mailto:jason.lowe@osig.virginia.gov).

1. Do you have any concerns about an abuse and/or neglect investigation of which you or one of your colleagues have been the subject? If so, please explain.

2. Do you have any concerns or feedback about the abuse and neglect investigation process in general? If so, please explain.

3. Are you aware of any instances of alleged abuse and/or neglect (which includes witnessing the event yourself or hearing about it from a patient or other staff member) that were not reported to the facility director as required by DI 201? Please provide details if known.

4. Has the abuse and neglect investigation process had any impact on how you manage your patients and/or units?

5. Please use the space below to provide OSIG with any other feedback or information that you think would be beneficial to the unannounced inspection being performed at this facility.

Thank you for taking the time to complete this form.