OFFICE OF THE STATE INSPECTOR GENERAL

Department of Behavioral Health and Developmental Services State Operated Facilities Abuse and Neglect Investigations

Performance Audit

September 2025

Michael C. Westfall, CPA
State Inspector General

Report No. 2026-AUD-005

COMMONWEALTH OF VIRGINIA
Office of the State Inspector General

Michael C. Westfall, CPA
State Inspector General

P.O. Box 1151
Richmond, Virginia 23218

Telephone (804) 625-3255
www.osig.virginia.gov

September 26, 2025

The Honorable Glenn Youngkin
Governor of Virginia
P.O. Box 1475
Richmond, VA 23219

Dear Governor Youngkin,

The Office of the State Inspector General (OSIG) completed an audit of the Department of Behavioral Health and Developmental Services (DBHDS) state operated facilities' investigations into abuse and neglect. The final report is attached.

OSIG would like to thank Commissioner Nelson Smith and his staff for their cooperation and assistance during this audit.

Sincerely,

Michael C. Westfall, CPA
State Inspector General

cc: The Honorable John Littel, Chief of Staff to Governor Youngkin
Justin Vélez-Hagan, Deputy Chief of Staff to Governor Youngkin
Kate Stockhausen, Assistant Deputy Chief of Staff to Governor Youngkin
The Honorable Janet Vestal Kelly, Secretary of Health and Human Resources
Leah Mills, Deputy Secretary of Health and Human Resources
Lanette Walker, Chief Financial Officer for Health and Human Resources
Julie Hammel, Executive Assistant for the Secretary of Health and Human Resources
Senator Ghazala F. Hashmi, Chair, Senate Education and Health Committee
Delegate Mark D. Sickles, Chair, House Health and Human Services Committee

Nelson R. Smith, Commissioner, DBHDS
Andrew C. Diefenthaler, Chief of Staff, DBHDS
Angela Harvell, Deputy Commissioner for Facility Services, DBHDS
Divyajot Mehta, Director of Internal Audit, DBHDS
Staci Henshaw, Auditor of Public Accounts

Abuse and Neglect Investigations

What OSIG Found

Quality of Investigations at State Facilities Needs Improvement

OSIG reviewed 190 investigations into allegations of abuse and neglect at all 12 DBHDS state-operated facilities. OSIG found that over half of the investigations were not conducted as required in order to ensure a proper investigation was completed. Additionally, the final investigation report differed from facility to facility in how they were prepared and the amount and type of documentation included to support the results.

Final Determinations from Investigations Were not Supported by the Results of the Investigation

Facility directors are ultimately responsible for the final determination of investigations. A sample of 190 Departmental Instruction (DI) 201 investigations were reviewed to ensure that the decisions made by the facility directors aligned with the results of the investigation. Of the 190, there were 30 (16%) DI201 investigations where the conclusions did not align with the results of the investigations and several items were identified:

- Seventeen of the 30 cases (57%) should have either required more work performed by the investigator or the investigation was not adequate based on the data available. In these situations, the current conclusion could have been different if such work was performed.
- Twelve of the 30 cases (40%) should have been substantiated based on the investigation and supporting documentation.
- Six of the 30 cases (20%) had administrative issues present that were not addressed.

Management concurred with all 11 findings and plans to implement corrective actions by 12/31/2027.

September 2025

HIGHLIGHTS

Why OSIG Conducted This Audit

OSIG completed this review in accordance with *Code of Virginia* § 2.2309.1.B.1, which requires OSIG 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."

What OSIG Recommends

- Develop a comprehensive certification program for investigators that is conducted by individuals with expertise in the field and that includes practical, in-depth training on investigative techniques.
- Restart the practice of facility "Look-Behind" reviews, or implement a peer review process, to ensure the accuracy and completeness of investigations and the related case in CHRIS, and as a means of evaluating and enhancing performance of individual investigators.

For more information, please contact OSIG at (804) 625-3255 or www.osig.virginia.gov

TABLE OF CONTENTS

REPORT ACRONYMS

The following is an alphabetical list of acronyms used in the report.

AR – Authorized Representative
CAT – Catawba Hospital
CCCA – Commonwealth Center for Children and Adolescents
CHRIS – Computerized Human Rights Information System
CSH – Central State Hospital
DBHDS – Department of Behavioral Health and Developmental Services
DI – Departmental Instruction
DSS – Department of Social Services
ESH – Eastern State Hospital
HWDMC – Hiram W. Davis Medical Center
NVMHI – Northern Virginia Mental Health Institute
OHR – Office of Human Rights
OSIG – Office of the State Inspector General
PGH – Piedmont Geriatric Hospital
SEVTC – Southeastern Virginia Training Center
SVMHI – Southern Virginia Mental Health Institute
SWVMHI – Southwestern Virginia Mental Health Institute
VCBR – Virginia Center for Behavioral Rehabilitation
WSH – Western State Hospital

BACKGROUND

The Department of Behavioral Health and Developmental Services (DBHDS) is an agency established under the executive branch and plays a vital role in the Commonwealth of Virginia by overseeing Virginia's public behavioral health and developmental services system. The system includes 12 DBHDS facilities that encompass nine state hospitals, a training center, a medical facility, and a treatment center for sexually violent predators. They cater to a diverse population, ranging from children to geriatric individuals and those with complex needs or serious medical conditions and are as follows:

Facility	Capacity	Location	Services Provided
CAT	110	Catawba	Acute intensive psychiatric treatment for adults and geriatric adults.
CCCA	48	Staunton	Child and adolescent services for individuals under 18 with behavioral health needs.
CSH	277	Petersburg	Acute intensive psychiatric treatment and extended rehabilitation services (community preparation/psychosocial and long-term rehabilitation, forensic maximum security) for adults.
ESH	302	Williamsburg	Acute intensive psychiatric treatment for adults, and long-term rehabilitation and medium security forensic services for adults and geriatric adults.
HWDMC	94	Petersburg	Acute medical/surgical services for adults, and skilled nursing and intermediate care facility for adults and geriatric adults.
NVMHI	134	Falls Church	Acute intensive psychiatric treatment for adults and geriatric adults and medium security forensic services for adults.
PGH	123	Burkeville	Chronic disease for geriatric adults with behavioral health needs.
SEVTC	75	Chesapeake	Intermediate care facility for adults and geriatric adults with intellectual disabilities.
SVMHI	72	Danville	Acute intensive psychiatric treatment for adults.
SWVMHI	175	Marion	Acute intensive psychiatric services for adults and geriatric adults, intermediate care facility for geriatric adults, and community preparation/psychosocial rehabilitation for adults.
VCBR	676	Burkeville	Secure treatment for adults civilly committed as sexually violent predators.
WSH	302	Staunton	Acute intensive psychiatric services, long term rehabilitation, clinical evaluation, and forensic services medium security for adults.

Code of Virginia § 37.2-400 protects the legal and human rights of all individuals receiving services from DBHDS. The Office of Human Rights (OHR) plays a pivotal role in helping DBHDS fulfill its legislative mandate under this *Code* section. The Human Rights Regulations (HRR), which are part of this framework, specify the rights guaranteed to individuals, including the right to be treated with dignity and respect, to be free from abuse and neglect, and to receive appropriate care and treatment based on their understanding and needs.

To uphold these rights, the Human Rights Complaint Process allows individuals to file complaints concerning violations of their rights, including allegations of abuse, neglect, and exploitation (ANE). This process provides individuals with due process, allowing them to appeal decisions through the Local Human Rights Committee (LHRC). After a hearing by the LHRC, individuals or providers may also appeal decisions to the State Human Rights Committee (SHRC).

Departmental Instruction 201, last revised in 2018, provides the operational framework for reporting, responding to, and investigating allegations of abuse and neglect within DBHDS-operated facilities. This departmental instruction outlines the procedures for reporting incidents, conducting investigations, and ensuring that proper action is taken to protect the individuals under DBHDS care.

SCOPE

The audit scope covered investigations into allegations of abuse and neglect at DBHDS operated facilities from July 1, 2023, through July 31, 2024.

OBJECTIVES

The objectives of this audit were to:

- Determine whether the investigators have the authority, tools, and independence to evaluate abuse and neglect within DBHDS facilities.
- Determine whether the investigations of allegations of abuse and neglect are adequate and consistently applied.
- Determine whether facility management properly follow-up on investigation results, ensuring consistency and appropriateness of decisions to address any findings.

METHODOLOGY

OSIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that OSIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on the audit objectives. OSIG believes that the evidence obtained provides a reasonable basis for the findings and conclusion based on the audit objectives.

OSIG applied various methodologies during the audit process to gather and analyze information pertinent to the audit scope and to assist with developing and testing the audit objectives. The methodologies included the following:

- Reviewed policies and procedures from DBHDS Central Office and the 12 DBHDS facilities regarding abuse and investigations.
- Conducted an unannounced inspection at each of the 12 DBHDS facilities on July 31, 2024.
- Conducted interviews with officials at each of the 12 DBHDS facilities and DBHDS Central Office, including facility investigators and the Office of Human Rights.
- Reviewed the recall of surveillance footage at each of the 12 DBHDS facilities.
- Selected a statistical sample of 190 abuse and neglect investigations from Fiscal Year (FY) 2024.
    - The methodology selected was to do a stratified proportional representative sample with the strata consisting of the substantiated and unsubstantiated abuse allegations from each of the 12 DBHDS facilities. The parameters selected for this sample were a 95% confidence level, 6% margin of error, with a population size of 524 allegations resulting in a sample size of at least 178 allegations. Once the sample size was calculated, the proportions and sample sizes for each of the 12 DBHDS facilities substantiated and unsubstantiated allegations were calculated. The final sample size was 190 rather than the required 178 because the proportion that each strata represented of the population did not result in whole numbers in all instances. In these instances, they were rounded up to provide more accurate results.
- OSIG reviewed the sample of 190 abuse and neglect investigations selected to confirm they were conducted appropriately, completely, and thoroughly; and that all reporting requirements were met.
- From the sample of 190 abuse and neglect investigations selected, the final determination was based on a preponderance of evidence, and that actions were developed and implemented.

FINDINGS

FINDING #1 - QUALITY OF INVESTIGATIONS AT STATE FACILITIES NEEDS IMPROVEMENT

During a review of 190 investigations into allegations of abuse and neglect at state-operated facilities, OSIG found that over half of the investigations were not conducted as required to ensure a proper investigation was completed. In addition, the reports differed from facility to facility in how they were prepared and the amount of supporting documentation included to support the results. The issues identified included:

- One hundred twenty-two (64%) investigations did not have interviews conducted appropriately, meaning, all relevant individuals were not interviewed, statements were not taken or taken correctly, or interviews were not conducted in the proper methodology, format, or manner. Based on the results of the sample, OSIG estimates at a 95% confidence level and a 6% margin of error that 299–370 (57-71%) of the 524 investigations from FY 2024 would also fail this test.
- Eighty-five (45%) investigations did not have an investigation summary that was well-written, comprehensive and detailed, with the required relevant items. Based on the results of the sample, OSIG estimates at a 95% confidence level and a 6% margin of error that 199–273 (38-52%) of the 524 investigations from FY 2024 would also fail this test. The required relevant items include:
    - The report introduction.
    - The timeline of the investigation including processes followed, from receipt of the allegation to conclusion.
    - The summary of collected evidence.
    - Records of all investigative activities to include date, times, and persons involved.
    - The rationale for conclusions.
- Seventy-three (38%) investigations were not performed with due diligence. Based on the results of the sample, OSIG estimates at a 95% confidence level and a 6% margin of error that 163-235 (31-45%) of the 524 investigations from FY 2024 would also fail this test. The issues identified included:
    - Investigators not evaluating discrepancies between different pieces of evidence.
    - Improperly weighing one piece of evidence over another.
    - Not pursuing other potential issues of abuse, neglect, or administrative concerns when discovered (e.g., surveillance footage showed staff members on personal phones and ignoring patients, or staff failing to report allegations to the facility director immediately).
- Fifty-seven (30%) investigations did not include all relevant physical, documentary, and/or demonstrative evidence, such as taking photos of injuries or reviewing

surveillance footage. Based on the results of the sample, OSIG estimates at a 95% confidence level and a 6% margin of error that 123–193 (24-37%) of the 524 investigations from FY 2024 would also fail this test.

The Department of Behavioral Health and Developmental Services (DBHDS) outlines requirements and best practices for investigations in its Facility Investigator Training and the Labor Relations Alternative Consultants' Serious Incidents training (investigator training program prior to October 2019). These requirements include conducting thorough interviews, collecting appropriate written statements, and reviewing all relevant types of evidence. Investigations should be conducted according to a standardized process to ensure integrity, fairness, and thoroughness.

DI201 states: "The investigator shall: Submit a signed and dated investigation summary report, with all documentary evidence included, to the facility director and the advocate." However, there are no details of the minimal evidence that should be included in the summary report.

Investigators at the facilities often lack the necessary skills and knowledge to conduct investigations appropriately even with the required training. Most investigators are selected from existing staff who do not have investigation duties as part of their primary job roles. While Facility Investigator Certification is required, it is not comprehensive enough to adequately prepare investigators. The training, provided by the Office of Human Rights (OHR), who are not subject matter experts themselves, consists of a high-level PowerPoint presentation that lacks practical depth. One investigator noted, "If it was not for my background in law enforcement, I could not adequately do this job." Additionally, DBHDS does not have a system in place to evaluate investigator performance, nor does it require retraining or continuing education for investigators.

The deficiencies in training, oversight, and investigator qualifications contribute to poor-quality investigations. As a result, critical aspects of abuse and neglect allegations may be overlooked, improperly documented, or handled inappropriately, which compromises the integrity of the investigative process. This ultimately puts patients at risk and undermines trust in the system. Consistency protects DBHDS by ensuring that the reports can be relied upon by each facility and supported by proper evidence.

Recommendations:

1. DBHDS management should develop a comprehensive certification program for investigators that is conducted by individuals with expertise in the field and that includes practical, in-depth training on investigative techniques, proper interview methods, evidence collection, and documentation standards.

   a. Once implemented, DBHDS should evaluate the effectiveness of the training program, and seek input from the investigators.
   b. DBHDS should require investigators to receive continuing education in order to maintain their certification and skills.
2. DBHDS should implement a peer review program where investigators review a sample of reports from other facilities for completeness as a system for evaluating performance.
3. DBHDS should update their DI201 policy to include a standard template for investigation reports.
4. DBHDS should update their DI201 policy to include guidelines to support the minimum documentary evidence required for an investigation report to be considered complete.

DBHDS Management Response:

Management agreed with the conditions observed by OSIG and with the recommendations.

FINDING #2 - FINAL DETERMINATIONS FROM INVESTIGATIONS WERE NOT SUPPORTED BY THE RESULTS OF THE INVESTIGATION

Facility directors are ultimately responsible for the final determination of investigations. A sample of 190 DI201 investigations were reviewed to ensure that the decisions made by the facility directors aligned with the results of the investigation. Of the 190, there were 30 (16%) DI201 investigations where the conclusions did not align with the results of the investigations. Based on the results of the sample, OSIG estimates at a 95% confidence level and a 6% margin of error that 52-115 (10-20%) of the 524 investigations from FY 2024 would also fail this test. Several items were identified:

- Seventeen of the 30 cases (57%) should have either required more work performed by the investigator or the investigation was not adequate based on the data available. In these situations, the current conclusion could have been different if such work was performed.
- Twelve of the 30 (40%) cases should have been substantiated based on the investigation and supporting documentation.
- Six of the 30 cases (20%) had administrative issues present that were not addressed.

DI201states: "At the conclusion of the investigation: The investigator shall: Brief the facility director and the advocate in order to provide additional information or comments, and obtain feedback regarding the investigation findings.…The facility director shall:… Decide, based on the investigator's report and any other available information, whether the abuse, neglect, or exploitation occurred. Unless otherwise provided by law, the standard for deciding whether abuse, neglect, or exploitation has occurred is preponderance of the evidence."

There was only one facility that had documentation to support that the investigator briefed the facility director and advocate in person. When the investigation reports are not complete or are not reviewed adequately, decisions made as a result of the investigation may not be sufficient to resolve the issues reported.

Recommendations:

1. DBHDS should ensure facility directors are adequately reviewing the investigation reports ensuring that all relevant information is included.
2. DBHDS should define "brief" as it is intended to mean in the DI201.

DBHDS Management Response:

Management agreed with the conditions observed by OSIG and with the recommendations.

FINDING #3 - INCONSISTENT COMMUNICATIONS REGARDING INVESTIGATIONS

OSIG reviewed 190 abuse and neglect investigations conducted across 12 DBHDS facilities to assess compliance with regulatory and internal requirements regarding the timeliness and completeness of notifications and communications. The following deficiencies were identified in the reporting and notification processes in accordance with DI201:

- Forty-one instances (22%) where the allegation of abuse, neglect, or exploitation was not reported to the facility director immediately. Based on the results of the sample, OSIG estimates at a 95% confidence level and a 6% margin of error that 82–144 (16-27%) of the 524 investigations from FY 2024 would also fail this test.
- Sixty-five instances (34%) where the Department of Social Services was not notified within 24 hours. Based on the results of the sample, OSIG estimates at a 95% confidence level and a 6% margin of error that 143–215 (27-41%) of the 524 investigations from FY 2024 would also fail this test.
- One hundred sixteen instances (61%) where the client/authorized representative (AR) was not notified within 24 hours. Based on the results of the sample, OSIG estimates at a 95% confidence level and a 6% margin of error that 284–356 (54-68%) of the 524 investigations from FY 2024 would also fail this test.
- Forty-five instances (24%) where the advocate was not notified within 2024 hours. Based on the results of the sample, OSIG estimates at a 95% confidence level and a 6% margin of error that 92–156 (18-30%) of the 524 investigations from FY 2024 would also fail this test.
- Seventy-two instances (38%) where the client/AR were not notified of the investigation outcome. Based on the results of the sample, OSIG estimates at a 95% confidence level and a 6% margin of error that 162–235 (31-45%) of the 524 investigations from FY 2024 would also fail this test.
- Sixty-two instances (33%) where the accused staff member was not notified of the investigation outcome. Based on the results of the sample, OSIG estimates at a 95% confidence level and a 6% margin of error that 136–206 (26-39%) of the 524 investigations from FY 2024 would also fail this test.
- Sixty-nine instances (36%) where the investigation was closed prior to review by the advocate. Based on the results of the sample, OSIG estimates at a 95% confidence level and a 6% margin of error that 155–226 (29-43%) of the 524 investigations from FY 2024 would also fail this test.

In addition, OSIG identified the following inconsistencies between facilities:

- Facilities differed in the method of notification to DSS (telephone, email, fax), with some resulting in delays and discrepancies in the level of information shared.
- Of the 116 instances of the facility not notifying the client/AR, 32 were due to the facility notifying the AR only, instead of both individuals.

- Notification methods (phone, letter, face-to-face) were not consistently documented, and facilities generally lacked evidence to confirm notification timing or receipt.
- "Closure letters," the title given to the letter used to notify the client/AR, were found to be vague, lacking clear differentiation between substantiated and unsubstantiated findings, and rarely referenced corrective actions or administrative findings.
- Of the 62 cases not communicated to the staff member appropriately, the predominant issue noted was not timeliness, but instead the fact that there is no documentation to show that staff was notified at all. Per some facilities, staff are only typically notified of the results of an investigation when substantiated and/or administrative findings exist. OSIG identified this as an area of concern as well in the 2016 Unannounced Inspections of DBHDS Facilities.

Department Instruction (DI) 201 and the Virginia Human Rights Regulations establish clear requirements for the reporting and notifications of abuse and neglect allegations. These include the immediate reporting of allegations to the facility director, timely notification to DSS, the client and/or authorized representative, the advocate, and the accused staff member. Additionally, the investigations must not be closed until a review and sign-off by the Human Rights Advocate has occurred.

The deficiencies stem from a lack of standardized procedures across facilities, unclear delegation of responsibility for required notifications, and inconsistent interpretations of regulatory requirements. Facilities differed in who performed notification tasks, ranging from investigators to administrative staff, which led to variations in timeliness and completeness. The lack of clear guidance on whether both the client and authorized representative must be notified and that there is no specific stated method of notification at the start of the investigation (only the end), further impacted compliance. Lastly, any delays that occurred early in the process, specifically regarding individuals not reporting the allegation as required, often negatively impacted the timing of notifications.

Inconsistent and untimely notifications related to abuse and neglect investigations may impact the ability of stakeholders, such as clients, authorized representatives, and staff to remain fully informed about investigative processes and outcomes. When this happens, it is more difficult to ensure that all parties are aware of the status and resolution of a case. This can also limit the agency's ability to demonstrate compliance with regulatory requirements and internal expectations. In addition, the use of generalized closure letters without clear references to outcomes or follow-up actions may reduce the clarity and effectiveness of communications. Strengthening documentation and communication practices would enhance transparency, support accountability, and contribute to improved consistency across facilities.

Recommendations:

1. DBHDS management should revise DI201 to include:
    a. That the client be notified, even when they have an AR, unless it is documented in the file why they were not notified.
    b. Requirements to designate the person at the facility responsible for notification of the investigation being initiated and the outcome to staff, client, and AR.
    c. Notification of the investigation being initiated should also be followed up via written communication, to be consistent with the notification of the outcome.
2. DBHDS management should revise the format and content of closure letters to ensure clarity, inclusion of corrective action (when applicable), and distinction between substantiated and unsubstantiated findings.
3. DBHDS should reinforce the importance of notifying the facility director immediately when there are concerns alleging abuse, neglect, or exploitation.
4. DBHDS management should conduct quality assurance reviews of investigations to ensure all notification and documentation requirements are met.

DBHDS Management Response:

Management agreed with the conditions observed by OSIG and with the recommendations.

FINDING #4 - CORRECTIVE ACTIONS IDENTIFIED WERE NOT COMPLETED ADEQUATELY

Facility Directors are ultimately responsible for the final determination of investigations. There were 76 cases identified by the Facility Director where corrective actions were needed. The corrective actions for these investigations were determined to be appropriate. However, 33 of the 76 cases (43%) did not have actions completed timely due to the following:

- Twenty-four (32%) had no documentation available to support an implementation.
- Six (8%) were completed, but not within the time the director determined it should be done.
- Three (4%) were not completed at all.

DI201 states that the facility director: "In all cases shall implement any actions required to address any findings or recommendations and proceed to close the investigation in accordance with procedures in section 201-9 of this DI." Supporting documentation to ensure corrective actions are implemented are not always included in the investigation documentation. In addition, the director does not document agreement that the corrective action was completed timely and addressed the findings of the investigation.

When corrective actions are not implemented or supporting documentation of the completed corrective actions are not requested there is no way to ensure that staff knew that there were exceptions. Further there is no way to verify that opportunities to improve policies, procedures, or processes at the facility occurred. In addition, without the supporting documentation, including personnel actions, the investigation file is not complete.

Recommendations:

1. DBHDS should ensure that Facility Directors follow DI201 and ensure corrective actions are implemented as directed and are timely.
2. DBHDS should update policies and procedures to require that the completion of corrective actions be verified and documented in the DI201 Investigation documentation.

DBHDS Management Response:

Management agreed with the conditions observed by OSIG and with the recommendations.

FINDING #5 - INVESTIGATION OVERSIGHT FROM THE OFFICE OF HUMAN RIGHTS NEEDS IMPROVEMENT

The Office of Human Rights (OHR) is tasked with overseeing abuse and neglect investigations across DBHDS facilities. This responsibility includes reviewing a statistically significant number of completed investigations each year and conducting "Look-Behind" reviews to ensure the investigation findings align with what is documented in the CHRIS system. However, this level of oversight is not currently taking place. There are no centralized monitoring efforts, no quality assurance reviews, and no consistent checks being conducted at OHR.

OHR is responsible for protecting the rights of people receiving services in DBHDS facilities - including ensuring that abuse and neglect investigations are handled promptly and thoroughly, and that individuals under the care of DBHDS have their rights protected. DI201 and the advocate policy and procedures manual list out requirements for the OHR, which includes the review of cases and provides feedback regarding human rights issues and corrective actions.

Within OHR, there are currently only four advocates covering all facility-based services, as one position has been recently reassigned to serve the community. Although human rights advocates have a role in investigations, it is only a small portion of their overall responsibilities. The following chart highlights just three aspects of OHR's role related to investigations:

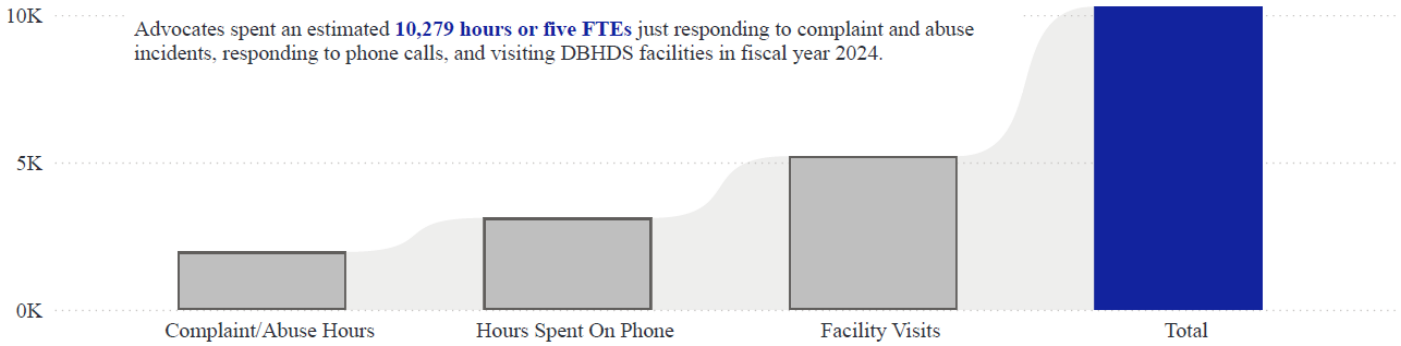
Advocates' Quantifiable Working Hours in Fiscal Year 2024

Total Hours	Complaint/Abuse Hours	Facility Hours	Phone Hours
10.28K	1.96K	5.21K	3.11K
FTE Equivalent* **4.94**	FTE Equivalent* 0.94	FTE Equivalent* 2.50	FTE Equivalent* 1.50
Productivity Equivalent** **7.23**	Productivity Equivalent** 1.38	Productivity Equivalent** 3.67	Productivity Equivalent** 2.19

*FTE Equivalent uses the hours provided for the category and divides the amount by 2,080 to represent a forty hour work week over the course of a fifty-two week year.

**Productivity Equivalent uses the hours provided for the category and divides the amount by 1,421 which is the 2,080 hour FTE equivalent less 304 hours for holiday and vacation time and less an estimated 20% of the remaining 1,776 hours (355 hours) to represent necessary administrative activity.

Estimated Advocate Hours for Fiscal Year 2024



The level of involvement and quality of support from advocates varies widely. Some facilities report strong, positive relationships with their advocates, while others have opposite experiences. Several concerning patterns emerged, as follows:

- Advocates' documentation in CHRIS isn't consistent, even for similar types of cases.
    - Advocates approve closure of cases in CHRIS when there is missing or inaccurate information in over 50% of cases reviewed.
    - Advocates did not document that the safety and the rights of the individual were protected as required during the investigation in 24% of the cases reviewed.
    - Some advocates provide more detailed information on their monitoring of the case overall, while others would just note that the case was opened, investigation finished, and that the case was okay to close in CHRIS.
- In two instances, advocate notes directly contradicted the official investigation record.
- Delays in advocates reviewing cases have resulted in late notifications to affected individuals on six occasions.

Recommendations:

1. DBHDS management should consider conducting a workload analysis to determine the appropriate workload standards for its OHR advocates. Advocate assignments should reflect the size, complexity, and location of each facility to ensure caseloads are reasonable.
2. DBHDS should ensure that OHR processes are updated to ensure that advocate responsibilities for investigations are properly documented and consistently applied across facilities.
3. DBHDS management should restart the practice of facility "Look-Behind" reviews, or implement a peer review process, to ensure the accuracy and completeness of investigations and the related case in CHRIS. This should include the OHR advocate roles.

4. DBHDS management should encourage stronger working relationships between advocates and facility staff, including gathering feedback from facilities on advocate performance.

DBHDS Management Response:

Management agreed with the conditions observed by OSIG and with the recommendations.

Finding #6 - Delayed Initiation and Interviewing Risks Evidence Reliability

Out of 190 abuse and neglect investigations reviewed, 71 cases (37%) were not initiated within 24 business hours, as determined by the investigator beginning actual work (e.g., reviewing records, scheduling interviews). Based on the results of the sample, OSIG estimates at a 95% confidence level and a 6% margin of error that 158–229 (30-44%) of the 524 investigations from FY 2024 would also fail this test. Moreover, investigators frequently delayed interviewing key parties following an incident. Across the 190 cases reviewed:

- Victims were interviewed after an average of six days,
- The first witness after eight days,
- The last witness after 12 days, and
- The accused after 11 days.

Delayed interviews may lead to less accurate determinations of abuse or neglect, impacting the quality of investigative findings.

According to 12VAC35-115-175 of Virginia's Human Rights Regulations, "within 24 hours of receipt of an allegation of abuse or neglect, the facility director shall initiate an impartial investigation conducted by an investigator." Guidance from Central Office staff clarifies that "initiation" means the investigator must begin performing actual investigative work, not merely being assigned the case.

Research literature from the National Library of Medicine and professional best practices from Occupational Safety and Health Administration (OSHA) emphasize the importance of prompt interviewing. Leading studies show that memory degradation and misinformation can begin rapidly after an event. Interviews conducted beyond one week are associated with increased memory distortion and reduced reliability, especially in vulnerable populations.

Recommendations:

1. DBHDS management should clarify and reinforce the definition of "initiation" in both policy and training materials to ensure investigators begin work within 24 business hours of the report of abuse or neglect.
2. DBHDS management should implement policy guidance that mandates the immediate initiation of investigations for certain high-risk incidents, to include injuries involving nonverbal or those with memory issue clients, suicide attempts with injuries, or any incident occurring during seclusion or restraint.
3. DBHDS management should reinforce the importance of timely interviews, especially with key witnesses and alleged victims.

DBHDS Management Response:

Management agreed with the conditions observed by OSIG and with the recommendations.

FINDING #7 – IMPROBABLE ALLEGATIONS ARE NOT BEING INVESTIGATED APPROPRIATELY

According to DI201, improbable allegations are defined as those that, upon joint consultation by the facility director, investigator, and advocate, appear to be based on inaccurate information and possibly symptomatic of an individual's illness or disability. When such a determination is made, "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 disability.
- If the clinical assessment determines that the allegation is more likely than not to be symptomatic of the individual's illness or disability, then no further investigation need take place.
- The facility director shall maintain supporting documentation in all such cases that shall include 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."

Of the 190 abuse and neglect investigations reviewed, 23 (12%) were unsubstantiated due to the allegation being improbable. Of those 23 cases, 16 (70%) did not follow required procedures, as they lacked key documentation and steps were not followed. In all 16 cases, the allegations were often presumed improbable from the outset, with minimal evidence that the investigative process and the procedure in DI201 for improbable allegations were followed, to include:

- No documented mutual determination by the facility director, investigator, and advocate to treat the allegation as potentially improbable.
- Lack of consultation with the individual's treatment team.
- No clinical assessment conducted to determine whether the allegation was symptomatic of the individual's illness or disability.
- Absence of a formal statement from the treatment team to the facility director justifying the decision.

Facility staff reported a lack of guidance and training on handling improbable allegations. Investigators often rely on existing medical records (e.g., treatment plans and team notes) rather than initiating a current, distinct clinical assessment or formal team consultation. Additionally, repetitive or previously unsubstantiated allegations for the same residents are frequently assumed improbable without proper review or evidence gathering.

Failing to follow the procedure for improbable allegations undermines the credibility, transparency, and integrity of the investigative process. It also places facilities at risk of misclassifying legitimate allegations, diminishes accountability, and may deny individuals appropriate clinical follow-up or protection.

Recommendations:

1. DBHDS management should review and revise DI201 to ensure the procedure for handling improbable allegations is clear and aligns with the needs of the investigators to determine if a case is improbable.
2. DBHDS management should issue supplemental guidance as needed to assist investigators with making the determination.
3. DBHDS management should develop and deliver training for investigators and facility leadership on the proper identification and handling of improbable allegations, as part of any revisions to the DI201 certification training, or follow-up training.
4. DBHDS management should determine who should monitor compliance with DI201 procedures for improbable allegations. The monitoring should ensure required documentation, consultations, and assessments are properly conducted and recorded.

DBHDS Management Response:

Management agreed with the conditions observed by OSIG and with the recommendations.

FINDING #8 - DATA AND STORAGE OF INVESTIGATIONS COULD BE IMPROVED

Facility investigations into abuse and neglect are managed by the Office of Human Rights (OHR). To that end, having a consistent and centralized system is necessary to ensure that goals and requirements are being met. DBHDS providers are required under the Human Rights Regulations to collect, maintain, and report information on abuse, neglect, and exploitation, prompting the creation of CHRIS, a centralized system for all DBHDS providers. Providers create a case in CHRIS following the decision to open an abuse and neglect investigation, and input relevant information such as the allegation, the location, the time, who reported it, when it was reported, the results of the investigation, and the actions taken, if any. It allows for the centralized storage of allegations into abuse and neglect, human rights complaints, and serious incidents and deaths, and are situated within the individual receiving services profile.

However, CHRIS is unable to provide relevant and reliable information due to data entry errors, data capabilities, system design, and programming. OSIG found that data contained in CHRIS was not consistent with the corresponding investigation and its related documents in 115 of the 190 cases reviewed (61%). Based on the results of the sample, OSIG estimates at a 95% confidence level and a 6% margin of error that 283-356 (54-68%) of the 524 investigations from FY 2024 would also fail this test.

Per DI201, facilities are required to submit the investigation to OHR for review via CHRIS. At a minimum, OHR is expected to review CHRIS to confirm that the investigation was thoroughly done, evidence was protected, the investigator had the necessary report writing skills, and actions were taken to protect the individual. However, this cannot be ascertained based on the current design of the system, and the fact that investigation documentation cannot be fully uploaded. As a result, facilities store and manage the investigation and its corresponding documentation independently of Central Office and share the investigation with OHR via alternative methods (e-mail) for review.

Further, there is no designated system or process for the storage or management of investigation documentation, requiring the facilities to utilize multiple systems and manual processes for investigation-related information. Due to reporting requirements, facilities may be required to report a single investigation result in three different systems, to include CHRIS, with the potential that several individuals are involved in the data entry, with the one assigned to CHRIS often times not being the investigator on the case. Facility staff have expressed frustration with this, stating it was tedious and cumbersome, especially given that they often had to develop their own ways internally to track and monitor information that was also entered into these systems.

DBHDS has indicated they are taking steps to develop a new system, which will replace CHRIS and other systems involving the reporting of incidents, with the intent of creating an improved

and unified, comprehensive case management system. By providing a comprehensive and unified system, processes can be streamlined to alleviate the burden on staff, compliance reporting can be enhanced, data can be improved, decision making can be data-driven, and service outcomes can be improved.

Recommendations:

1. DBHDS management should develop and implement a system for managing all incidents, with consideration to include an area for documentation and potential storage of abuse and neglect investigations, and for processes, where able, to be automated.
2. The Office of Human Rights should ensure that investigations and data in the system are being compared to ensure all relevant information is accurate and entered.

DBHDS Management Response:

Management agreed with the conditions observed by OSIG and with the recommendations.

FINDING #9 - ABUSE AND NEGLECT INVESTIGATION DUTIES WERE NOT DOCUMENTED IN EMPLOYEE WORK PROFILES

During OSIG's unannounced inspection in July 2024, the Employee Work Profiles (EWPs) of each facility's investigators were requested. 52 EWPs were received and reviewed in order to determine the percentage of time related to Core Responsibilities for conducting an investigation. The table below summarizes the results:

% Time per EWP (Investigator only)

Facility	0%	1%	2%	5%	10%	15%	35%	50%	55%	60%	80%	90%	95%	Total EWPs Reviewed
CAT	**10**				**1**									**11**
CCCA														**0**
CSH													**2**	**2**
ESH												**1**		**1**
HWDMC	**1**			**1**	**1**									**3**
NVMHI	**1**											**1**	**1**	**3**
PGH									**1**					**1**
SEVTC	**3**				**1**	**1**								**5**
SVMHI	**5**			**5**			**1**							**11**
SWVMHI	**4**	**1**	**1**	**3**	**2**									**11**
VCBR	**1**							**1**		**1**				**3**
WSH											**1**			**1**
Total	**25**	**1**	**1**	**9**	**5**	**1**	**1**	**1**	**1**	**1**	**1**	**2**	**3**	**52**

As shown in the table above, 25 of the 52 EWPs reviewed (48%) showed 0% Time for any core responsibilities related to conducting an investigation, yet the facilities listed these individuals as conducting A&N investigations.

DBHDS Departmental Instruction 201 issued January 18, 2018, defines an Investigator as "a person who has successfully completed investigative training and has received a certificate of completion by the department."

Department of Human Resource Management (DHRM) Policy 1.40 - Performance Planning and Evaluation, revised August 1, 2001, "provides for the establishment and communication of employees' performance plans and procedures for evaluating employees' performance." This policy states the EWP form is to be "used to complete the annual performance evaluation that includes a brief work description, performance plan, core responsibilities, performance measures, and employee development goals." However, DHRM allows agencies to develop their own forms as long as they support the provisions of this policy and contain the required information.

The policy also defines the following: "Core Responsibilities: Job responsibilities that are primary and essential to the type of work performed by an employee and normally remain relatively consistent during the performance cycle…. Performance Measures: Qualitative and/or quantitative standards or measures against which each core responsibility, special assignment and agency/departmental objective is assessed. Performance measures describe major duties, assignments and objectives in terms of complexity, accountability and results, and should be specific, measurable, attainable and relevant. These measures are referred to on the Employee Work Profile as Measures for Core Responsibilities, Measures for Special Assignments and Measures for Agency/Departmental Objectives."

Facility management provided listings of employees that perform A&N investigations that were not reflected in their respective EWPs and failed to update the EWPs of employees that perform A&N investigations. It is important for an employee to clearly understand his/her job expectations. The EWP provides a description of the work the employee will be assigned to do, the percentage of their job, and the level of performance the employee is expected to achieve to be accountable. An accurate EWP helps provide an effective means for managing the work, performance, and development of employees conducting A&N investigations to achieve DBHDS' institutional goals and objectives.

Recommendations:

1. DBHDS management should have the facilities review which personnel can perform abuse and neglect investigations.
2. DBHDS management should have the facilities update/revise EWPs to reflect the above review and update listings of who can perform abuse and neglect investigations.
3. DBHDS management should work with the facilities to ensure that job responsibilities are consistent except where warranted based on specific facility requirements.

DBHDS Management Response:

Management agreed with the conditions observed by OSIG and with the recommendations.

FINDING #10 - INSUFFICIENT RETENTION OF SURVEILLANCE VIDEO AND FAULTY CAMERAS POSE RISKS TO FACILITIES

OSIG reviewed video surveillance cameras during the unannounced inspection on July 31, 2024, to ensure the following:

- Surveillance footage has recall availability of at least 30 days.
- All cameras were functioning.
- All cameras were free of obstructions.

Issues were found for five of 12 facilities (42%) as follows:

- CSH: Buildings 94, 95, and suite 96-4 (located within building 96) only have the ability to review footage for the last 13 days.
- ESH: During the video review, facility personnel identified some obstructions blocking views in client neighborhoods and minimal existence of cameras to provide sufficient surveillance coverage other areas. In addition, facility personnel identified 'blind spots' along the walls of the outside perimeter that the existing cameras do not cover and that additional cameras are needed.
- SEVTC: Exterior cameras (non-patient areas) only go back 25 days.
- SVMHI: Camera for H2 (patient day room) was discovered to be not working when reviewing footage.
- WSH: Cameras on the first floor of the facility have recall access for only 28 days.

Library of Virginia Records Retention and Disposition Schedule GS-108, Series Number 012281 – Security and Surveillance Tapes: Not Used as Evidence states: "This series documents the surveillance and monitoring of a building or area for security purposes. This series may include but is not limited to audio or video recording. The scheduled retention period is 30 days after creation."

Best practices for addressing risks associated with malfunctioning or improperly placed video surveillance cameras show periodic inspection and maintenance can help identify and resolve issues before they cause problems. Understanding the potential risks associated with malfunctioning or improperly placed cameras can help the facility take steps to mitigate them. Management at some facilities failed to monitor the video surveillance cameras to identify issues and did not follow the Library of Virginia Records Retention and Disposition Library of Virginia Records Retention and Disposition Schedule GS-108, Series Number 012281 – Security and Surveillance Tapes: Not Used as Evidence.

A malfunctioning video surveillance camera poses several risks, including:

1. Missed Security Events:

- A non-functional camera means no video recording of potentially critical events, like abuse and neglect incidents.
- This leaves a blind spot in security coverage, making it easier for perpetrators to operate undetected.
- The lack of video evidence can also hinder investigations and potentially lead to missed opportunities for prosecution.

2. Compromised Evidence:
    - If a camera fails just as an incident is occurring, the resulting lack of footage can significantly impact an investigation.
    - The lack of video can also be detrimental to legal/administrative proceedings, potentially hindering prosecution or leading to the dismissal of charges.
    - This can make it difficult to identify perpetrators, reconstruct events, or gather crucial evidence.
3. False Sense of Security
    - Relying on a camera system that is not functioning correctly can create a false sense of security.
    - Staff may think the facility is protected when it is not, leading to complacency and increased vulnerability.
    - This can make staff less vigilant and potentially lead to more serious incidents if staff are not actively monitoring the surveillance system.

Failing to comply with the Library of Virginia Records Retention requirements for video surveillance footage can jeopardize investigations and legal proceedings, as well as the reputation of DBHDS.

Recommendations:

1. DBHDS Management should ensure these facilities address the issues with the video surveillance cameras.
2. DBHDS Management should ensure these facilities follow Library of Virginia Records Retention and Disposition Schedule GS-108, Series Number 012281 – Security and Surveillance Tapes: Not Used as Evidence.

DBHDS Management Response:

Management agreed with the conditions observed by OSIG and with the recommendations.

FINDING #11 - FACILITY ABUSE AND NEGLECT POLICIES SHOULD BE UPDATED

Policies and procedures related to abuse and neglect reporting were reviewed at the individual facilities and Central Office. Thirty attributes from the Departmental Instruction (DI201) were compared to facility policies and procedures, in addition to the adequacy of the DI201. The following exceptions were identified:

- DI201 did not include how long documentation and videos should be retained.
- Policies were not consistent throughout the facilities as they pertained to the guidance from DI201.
- Details of how to document an investigation were not in either the DI201 or facility policies.
- The DI201 did not prohibit the Facility Director from performing investigations.

Policy 5010 (FAC) 00-1 State Facility Uniform Clinical and Operational Policies and Procedures states: "It is the policy of the Board that the Department shall use Departmental Instructions as the primary mechanism to ensure uniformity of practice in the delivery of care to individuals receiving services in state facilities." Many of the individual policies and procedures at the facilities are not reviewed to ensure consistency of the DI they reference. As a result, documentation to support investigations of abuse and neglect are not consistent and may result in missing or incomplete reports.

Recommendations:

1. Management should ensure the facilities with their own policies reference DI201 and include any additional procedures specific to their facility.
2. Management should update the DI to include retention of documentation, to include retention of videos, and what elements to include in an investigation report.

DBHDS Management Response:

Management agreed with the conditions observed by OSIG and with the recommendations.

AUDIT RESULTS

This report presents the results of OSIG's audit of DBHDS State Operated Facilities Abuse and Neglect Investigations. OSIG performed the following audit testing with immaterial, if any, discrepancies noted:

- Evaluating whether investigators have sufficient authority to conduct thorough investigations.
- Assessing whether investigators are independent, especially when they serve as an investigator in addition to their normal job.
- Evaluating whether investigators have access to necessary tools and resources to complete investigations.

Based on the results and findings of the audit test work conducted of Abuse and Neglect Investigations, OSIG concluded that internal controls were operating properly, except as identified in the report findings.

APPENDIX I – CORRECTIVE ACTION PLAN

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
1- Quality of Investigations at State Facilities Needs Improvement	1. DBHDS management should develop a comprehensive certification program for investigators that is conducted by individuals with expertise in the field and that includes practical, in-depth training on investigative techniques, including proper interview methods, evidence collection, and documentation standards. a. Once implemented, DBHDS should evaluate the effectiveness of the training program, and seek input from the investigators. b. DBHDS should require investigators to receive continuing education, in order to maintain their certification and skills. 2. DBHDS should implement a peer review program where	FS & OHR: Develop and implement a structured certification program for facility investigators with Train-the-Trainer module, that defines clear competencies, processes, and standards. A. Assemble members of the Development Team, Oversight Committee, and Advisory Team. B. Design the program structure and develop training modules using nationally recognized standards. C. Develop content and materials. D. Develop the exam, establish a recertification cycle and establish framework for a mentorship program to pair newly certified investigators with experienced investigators. E. Update policies to incorporate the new investigative standards and certification requirements. F. Assess the effectiveness of the training program with a	FS & OHR: i. Facility Investigator Certification Program ii. Investigator Competency Matrix iii. Standardized Curriculum iv. Standardized Investigative Forms v. Certification Exam vi. Updated Policies and Procedures vii. Post Training Survey viii. Continuous Improvement Suggestion Form	7/1/2026	Director of Quality and Risk Management (FS) State Human Rights Director (OHR)

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
	investigators will review a sample of reports from other facilities for completeness as a system for evaluating performance. 3. DBHDS should update their DI201 policy to include a standard template for investigation reports. 4. DBHDS should update their DI201 policy to include guidelines to support the minimum documentary evidence required for an investigation report to be considered complete.	pilot group and revise as needed. G. Collect feedback, review content and make necessary adjustments through continuous improvement initiatives, including post investigation reviews.			
2- Final Determinations from Investigations Were not Supported by the Results of the Investigation	1. DBHDS should ensure facility directors are adequately reviewing the investigation reports ensuring that all relevant information is included. 2. DBHDS should define "brief" as it is intended to mean in the DI201.	A. FS & OHR: Update policies to incorporate the new investigative standards and certification requirements. B. FS: Review policies and required documentation with facility directors (CEO's). C. FS: Conduct post investigative reviews (ongoing sample).	i. FS & OHR: Updated Policies and Procedures ii. FS & OHR: Standardized Investigative Forms iii. FS: Training iv. FS: Post Investigative Reviews	i.-ii. 7/1/2026 iii. 8/1/2026 iv. 9/1/2026	Director of Quality and Risk Management (FS) State Human Rights Director (OHR)
3- Inconsistent Communications	1. DBHDS management should revise DI201 to include:	A. FS & OHR: Update policies and procedures to	i. FS & OHR: Updated Policies	i.-ii. 7/1/2026	Director of Quality and Risk

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
Regarding Investigations	a. That the client be notified, even when they have an AR, unless it is documented in the file why they were not notified. b. Requirements to designate the person at the facility responsible for notification of the investigation being initiated and the outcome to staff, client, and AR. c. Notification of the investigation being initiated should also be followed up via written communication, to be consistent with the notification of the outcome. 2. DBHDS management should revise the format and content of closure letters to ensure	incorporate the new investigative standards and certification requirements. B. FS & OHR: Develop standardized forms and implement as a part of the certification program for facility investigators. C. FS: Review policies and required documentation with facility directors (CEO's). D. FS: Conduct post investigative reviews (ongoing sample).	and Procedures ii. FS & OHR: Standardized Investigative Forms iii. FS: Training iv. FS: Post Investigative Reviews	iii. 8/1/2026 iv. 9/1/2026	Management (FS) State Human Rights Director (OHR)

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
	clarity, inclusion of corrective action (when applicable), and distinction between substantiated and unsubstantiated findings. 3. DBHDS should reinforce the importance of notifying the facility director immediately when there are concerns alleging abuse, neglect or exploitation. 4. DBHDS management should conduct quality assurance reviews of investigations to ensure all notification and documentation requirements are met.				
4- Corrective Action Identified Were Not Completed Adequately	1. DBHDS should ensure that Facility Directors follow DI201 and ensure corrective actions are implemented as directed and are timely. 2. DBHDS should update policies and procedures to require that the completion of corrective actions be verified	A. FS & OHR: Update policies and procedures to incorporate the new investigative standards and certification requirements. B. FS & OHR: Develop standardized forms and implement as a part of the certification program for facility investigators. C. FS: Review policies and required documentation with	i. FS & OHR: Updated Policies and Procedures ii. FS & OHR: Standardized Investigative Forms iii. FS: Training iv. FS: Post Investigative Reviews	i.-ii. 7/1/2026 iii. 8/1/2026 iv. 9/1/2026	Director of Quality and Risk Management (FS) State Human Rights Director (OHR)

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
	and documented in the 201 Investigation documentation.	facility directors (CEO's). D. FS: Conduct post investigative reviews (ongoing sample).			
5- Investigation Oversight from the Office of Human Rights Needs Improvement	1. DBHDS management should consider conducting a workload analysis to determine the appropriate workload standards for its OHR advocates. Advocate assignments should reflect the size, complexity, and location of each facility to ensure caseloads are reasonable. 2. DBHDS should ensure that OHR processes are updated to ensure that advocate responsibilities for investigations are properly documented and consistently applied across facilities. 3. DBHDS management should restart the practice of facility "Look-Behind reviews, or implement a peer review process, to ensure the accuracy and completeness of investigations and its case in	A. OHR: Develop enterprise policy for the Office of Human Rights. B. FS: Update facility services policy based on OHR parent policy. C. FS & OHR: Develop and implement a structured certification program for facility investigators with Train-the-Trainer module, that defines clear competencies, processes, and standards. D. FS & OHR: Facility Services Leadership and the Office of Human Rights will hold regular meetings to review barriers between facility staff and advocates as well as incident/investigation concerns. E. OHR: Conduct facility look-behinds.	i. FS & OHR: Facility Investigator Certification Program ii. FS & OHR: Updated Policies and Procedures iii. OHR: Incident Look-Behinds	i.-ii. 7/1/2026 iii. 1/31/2026	Director of Quality and Risk Management (FS) State Human Rights Director (OHR)

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
	CHRIS. This should include the OHR advocate roles. 4. DBHDS management should encourage stronger working relationships between advocates and facility staff, including gathering feedback from facilities on advocate performance.				
6- Delayed Initiation and Interviewing Risks Evidence Reliability	1. DBHDS management should clarify and reinforce the definition of "initiation" in both policy and training materials to ensure investigators begin work within 24 business hours of the report of abuse or neglect. 2. DBHDS management should implement policy guidance that mandates the immediate initiation of investigations for certain high-risk incidents, to include injuries involving nonverbal or those with memory issue clients, suicide attempts with injuries, or any	A. FS & OHR: Update policies and procedures to incorporate the new investigative standards and certification requirements. B. FS & OHR: Develop standardized forms and implement as a part of the certification program for facility investigators. C. FS: Review policies and required documentation with facility directors (CEO's). D. FS: Conduct post investigative reviews (ongoing sample).	i. FS & OHR: Updated Policies and Procedures ii. FS & OHR: Standardized Investigative Forms iii. FS: Training iv. FS: Post Investigative Reviews	i.-ii. 7/1/2026 iii. 8/1/2026 iv. 9/1/2026	Director of Quality and Risk Management (FS) State Human Rights Director (OHR)

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
	incident occurring during seclusion or restraint. 3. DBHDS management should reinforce the importance of timely interviews, especially with key witnesses and alleged victims.				
7- Improbable Allegations are not Being Investigated Appropriately	1. DBHDS management should review and revise DI201 to ensure the procedure for handling improbable allegations is clear and aligns with the needs of the investigators to determine if a case is improbable. 2. DBHDS management should issue supplemental guidance as needed to assist investigators with making the determination. 3. DBHDS management should develop and deliver training for investigators and facility leadership on the proper identification and handling of improbable allegations, as part of any revisions to the DI201	A. FS & OHR: Update policies and procedures to incorporate the new investigative standards and certification requirements. B. FS & OHR: Develop standardized forms and implement as a part of the certification program for facility investigators. C. FS: Review policies and required documentation with facility directors (CEO's). D. FS: Conduct post investigative reviews (ongoing sample).	i. FS & OHR: Updated Policies and Procedures ii. FS & OHR: Standardized Investigative Forms iii. FS: Training iv. FS: Post Investigative Reviews	i.-ii. 7/1/2026 iii. 8/1/2026 iv. 9/1/2026	Director of Quality and Risk Management (FS) State Human Rights Director (OHR)

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
	certification training, or follow-up training. 4. DBHDS management should determine who should monitor compliance with DI201 procedures for improbable allegations. The monitoring should ensure required documentation, consultations, and assessments are properly conducted and recorded.				
8- Data and Storage of Investigations Could be Improved	1. DBHDS management should develop and implement a system for managing all incidents, with consideration to include an area for documentation and potential storage of abuse and neglect investigations, and for processes, where able, to be automated. 2. The Office of Human Rights should ensure that investigations and data in the system are being compared to ensure all relevant information is accurate and entered.	A. FS & OHR: Continue efforts with Incident Management System replacement project. B. FS & OHR: Update policies and procedures to incorporate the new investigative standards and certification requirements. C. FS: Review policies and required documentation with facility directors (CEO's). D. OHR: Conduct facility look-behinds.	i. FS & OHR: New Incident Management System ii. FS & OHR: Updated Policies and Procedures iii. FS: Training iv. OHR: Incident Look-Behinds	i. 12/31/2027 ii. 7/1/2026 iii. 8/1/2026 iv. 1/31/2026	Director of Quality and Risk Management (FS) State Human Rights Director (OHR)

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
9 - Abuse and Neglect Investigation Duties Were Not Documented in Employee Work Profiles	1. DBHDS management should have the facilities review what personnel can perform abuse and neglect investigations. 2. DBHDS management should have the facilities update/revise EWPs to reflect the above review and update listings of who can perform abuse and neglect investigations. 3. DBHDS management should work with the facilities to ensure that job responsibilities are consistent except where warranted based on specific facility requirements.	A. FS & OHR: Develop and implement a structured certification program for facility investigators with Train-the-Trainer module, that defines clear competencies, processes, and standards. B. FS CEO: Following completion of the investigator training, facility CEO's will update the investigator position description.	i. FS & OHR: Facility Investigator Certification Program ii. FS CEO: Updated Position Description for Facility Investigators	i. 7/1/2026 ii. 9/1/2026 - ongoing	Director of Quality and Risk Management (FS) State Human Rights Director (OHR) Chief Executive Officer (FS CEO)
10 - Insufficient Retention of Surveillance Video and Faulty Cameras Pose Risks to Facilities	1. DBHDS Management should ensure these facilities address the issues with the video surveillance cameras. 2. DBHDS Management should ensure these facilities follow Library of Virginia Records Retention and Disposition Schedule GS-108, Series Number 012281 – Security	A. FS OEOC: Explore funding source for updated surveillance equipment. B. FS OEOC & Facility Staff: As funding is identified, procure surveillance equipment that meets requirements. C. FS CEO: Update applicable policies and procedures.	i. FS OEOC: Funding Secured ii. FS OEOC & Facility Staff: Updated Surveillance Equipment iii. FS CEO: Updated Facility Policies and Procedures	i. 9/30/2026 ii.-iii. 2/1/2027	Director, Office of Environment of Care (FS OEOC) Chief Executive Officer (FS CEO)

FINDING NO.	RECOMMENDATION	CORRECTIVE ACTION	DELIVERABLE	ESTIMATED COMPLETION DATE	RESPONSIBLE POSITION
	and Surveillance Tapes: Not Used as Evidence.				
11 - Facility Abuse and Neglect Policies Should be Updated	1. Management should ensure the facilities, with their own policies, reference DI201 and include any additional procedures specific to their facility. 2. Management should update the DI to include retention of documentation, to include retention of videos, and what elements to include in an investigation report.	A. FS & OHR: Update policies and procedures to incorporate the new investigative standards and certification requirements. B. FS CEO: Rescind or revise facility policies and, when needed, develop facility standard operating procedures (SOPs).	i. FS & OHR: Updated Central Office Policies and Procedures ii. FS CEO: Updated or Rescinded Facility Policies and Procedures	i. 7/1/2026 ii. 10/1/2026	Director of Quality and Risk Management (FS) State Human Rights Director (OHR) Chief Executive Officer (FS CEO)