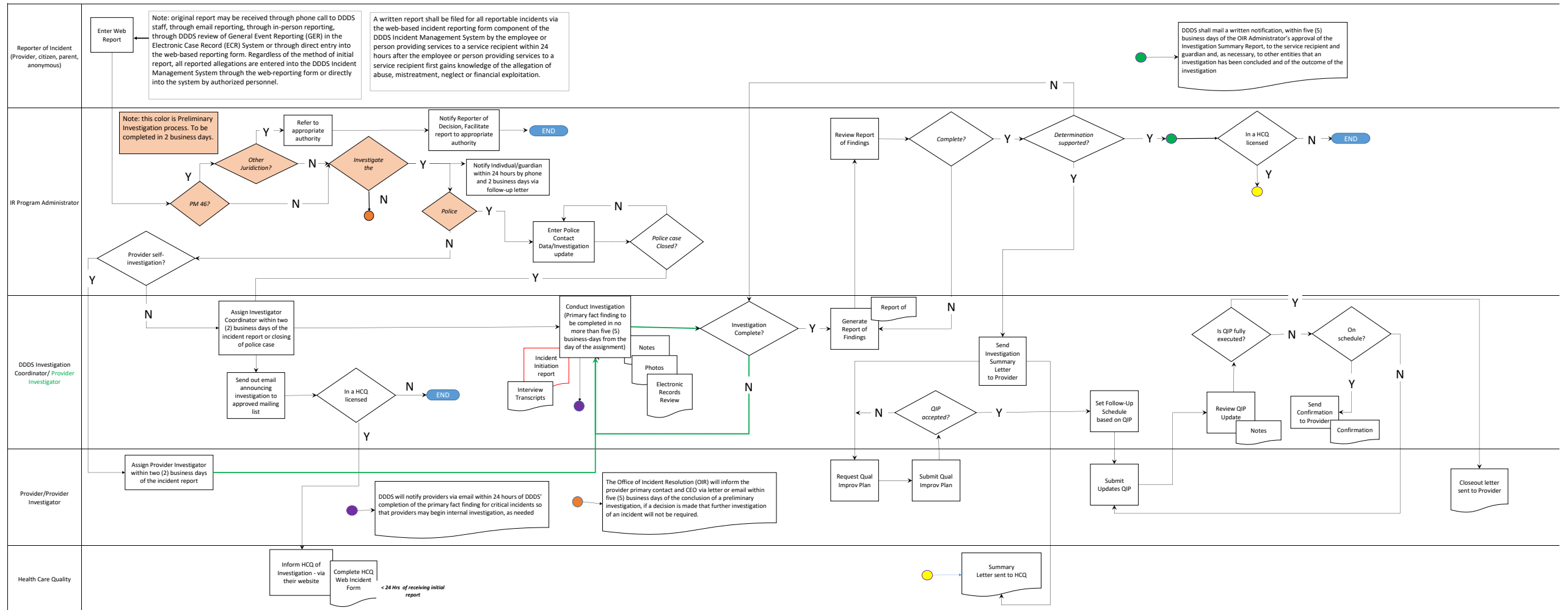


DDDS Reportable Incident Investigation Process Flowchart

September 6, 2019





**Department of Health and Social Services
Policy Memorandum # 46
Responding to Reportable Incidents/Allegations**

**March 2, 2016
Revised: August 22, 2016**

I. Purpose

- a. To identify and define reportable incidents and allegations that warrant notifications and investigations.
- b. To identify standardized reporting and investigative procedures of reportable incidents and allegations.

II. Policy

- a. It shall be the policy of the Delaware Health and Social Services (DHSS) that individuals receiving residential services (community or institutional based) and/or attend a DHSS funded day program shall be free of abuse, neglect, mistreatment, significant injury and financial exploitation.
- b. It shall be the policy of the DHSS that Divisions initiate a policy/procedures that minimally include the requirements set forth in this policy memorandum.

III. Scope

This policy applies to employees and contractors of the Division of Developmental Disabilities Services (DDDS), Division of Long Term Care Residents Protection (DLTCRP), Division of Substance Abuse and Mental Health (DSAMH), and Division of Services for Aging and Adults with Physical Disabilities (DSAPD). It is intended to protect the well-being of the following individuals:

- a. Individuals who live in a community residential placement or Long-Term Care facility, unlicensed or licensed by the Division of Long Term Care Residents Protection, operated by or for any of the aforementioned DHSS Divisions;
- b. Individuals who receive treatment at the Delaware Psychiatric Center (DPC);
- c. Individuals who attend a DHSS funded day program if the reportable incident is alleged to have occurred while receiving day program services.

IV. Definitions

- A. **Bullying** shall mean any written, digital, electronic, verbal or physical acts or actions that may elicit fear or cause harm to an individual's emotional, psychological or physical well-being. Inciting, soliciting or coercing a single entity or group to demean, dehumanize, embarrass or cause emotional, psychological or physical harm to an individual is also considered bullying.
- B. **Division** shall refer to the Division of Developmental Disabilities Services, Division of Long term Care Residents Protection, Division of Substance Abuse and Mental Health and Division of Services for Aging and Adults with Physical Disabilities.

- C. **Health Care Surrogate** shall mean the individual who has the highest priority to act for the patient under Delaware law. Delaware law presumes a person has decision-making capacity until a physician determines that a patient does not have decision-making capacity. The hierarchy under Delaware Law to act as the authorized-representative for a person without decision-making capacity is as follows:
1. The court-appointed Guardian, only with the appropriate authority;
 2. The patient's most recently appointed Agent in an Advance Health Care Directive or Health Care Power of Attorney, only with the appropriate authority;
 3. If there is no Guardian or Agent or if the designated Guardian or Agent is unavailable, or if the patient revoked an Advance Health Care Directive pursuant to 16 Del.C. § 2504, the Surrogate Statute applies and will allow either the individual named by the patient prior to losing decision-making capacity or if none, the individual recognized by the Surrogate Statute, 16 Del.C. § 2507, to act.
- D. **Immediately** shall mean as soon as the situation is stabilized (e.g., actions have been taken to provide treatment, comfort and safety in individuals involved) and minimally within eight (8) hours of discovery of the incident.
- E. **Individual (Served)** shall mean the people who receive services from the DHSS Divisions and are covered within the scope of this policy (see section III).
- F. **Long Term Care Facility** shall mean any facility operated by or for DHSS which provides long term care residential services. It also includes the Delaware Psychiatric Center.
- G. **Reportable Incidents** shall mean suspicion of any of the following occurrences:
1. **Abuse** shall mean:
 - a. Physical abuse by unnecessarily inflicting pain or injury to a patient or resident. This includes but is not limited to, hitting, kicking, punching, slapping or pulling hair. When any act constituting physical abuse has been proven, the infliction of pain is assumed;
 - b. Sexual abuse which includes, but is not limited to, any sexual contact, sexual penetration, or sexual intercourse by an employee or contractor, as defined in 11 DE Code, Ch. 5, §761, with an individual. It shall be no defense that the sexual contact, sexual penetration, or sexual intercourse was consensual;
 - c. Sexual act (any) between staff and an individual and any non-consensual sexual act between individuals or between an individual and any other person such as a visitor;
 - d. Emotional abuse which includes, but is not limited to, ridiculing, demeaning, humiliating, bullying or cursing at an individual, or threatening an individual with physical harm.
 2. **Financial Exploitation** shall mean the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the individual by any person or entity for any person's or entity's profit or advantage other than for the individual's profit or advantage. "Financial exploitation" includes, but is not limited to:
 - a. The use of deception, intimidation, or undue influence by a person or entity in a position of trust and confidence with an individual to obtain or use the property, income, resources, or trust funds of an individual for the benefit of a person or entity other than the individual;
 - b. The breach of a fiduciary duty, including but not limited to, the misuse of a power of

- attorney , trust, or a guardianship appointment that results in the unauthorized appropriation, sale or transfer of the property, income, resources or trust funds of the individual for the benefit of a person or entity other than the individual; and
- c. Obtaining or using an individual's property, income, resources, or trust funds without lawful authority, by a person or entity who knows or clearly should know that the individual lacks the capacity to consent to the release or use of his or her property, income, resources, or trust funds. (31 Del.C. §3902(11)).
3. **Medication Diversion** shall mean knowingly or intentionally interrupting, obstructing or altering the delivery or administration of a prescription drug to an individual receiving services, provided that such prescription was :
 - a. Prescribed or ordered by a licensed health care practitioner for the individual receiving services **and**
 - b. The interruption, obstruction or alteration occurred without the prescription or order of a licensed health care practitioner.
 4. **Mistreatment** shall mean include the inappropriate use of medications, isolation, or physical or chemical restraints on or of an individual receiving services.
 5. **Neglect** shall mean:
 - a. Lack of attention to the physical needs of an individual receiving services to include but not limited to toileting, bathing, nutrition and safety;
 - b. Failure to report problems or changes in health problems or changes in health condition to an immediate supervisor or nurse;
 - c. Failure to carry out a prescribed treatment plan or plan of care that resulted in a negative impact or potential negative impact or the neglect resulted in a repeated trend;
 - d. A knowing failure to provide adequate staffing which results in a medical emergency to any individual receiving services where there has been documented history of at least 2 prior cited instances of such inadequate staffing within the past 2 years in violation of minimum maintenance of staffing levels as required by statute or regulations promulgated by the Department, all so as to evidence a willful pattern of such neglect. (16 DE Code, §1161-1169).
 6. **Unanticipated death** shall include all deaths of individuals served that are of a suspicious and/or unusual nature. They shall also include those deaths whereby the Division of Forensic Science assumed jurisdiction.
 7. **Significant Injury** shall include:
 - a. Injury from an incident of unknown source in which the initial investigation or evaluation supports the conclusion that the injury is suspicious. Circumstances which may cause an injury to be suspicious are: the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time, or the incidence of injuries over time;
 - b. Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours;
 - c. Areas of contusions or bruises caused by staff to a dependent resident during ambulation, transport, transfer or bathing;
 - d. Significant error or omission in medication/treatment, including drug diversion, which causes the resident discomfort, jeopardizes the individual's health and safety or requires periodic monitoring for up to 48 hours;

- e. A burn greater than first degree;
- f. Any serious unusual and/or life-threatening injury.

H. **Residential Facility** shall include any facility operated by or for DHSS including long term care licensed facilities, group homes, foster homes and other supervised community living arrangements.

V. **Standards**

- A. The Division Director, or his/her designee within the scope of this policy, is hereby designated as an official DHSS designee under the State Mandatory Patient Abuse Reporting Law and/or as it applies to Policy Memorandum #46.
- B. The Division Director or designee shall review reportable incidents and initiate investigations for reports that fall within the purview of this policy. He/she shall ensure that actions have been taken to protect the health and safety of individuals who are in immediate danger from further abuse.
- C. Nothing in this policy shall replace additional federal and state statutory requirements relative to reporting and responding to allegations of abuse, neglect, mistreatment, significant injury, financial exploitation, medication diversion or unanticipated death.
- D. The requirements set forth in this policy memorandum and the respective Division policy shall be incorporated into Divisional operational procedures and all contracts of agencies/entities that provide services to people covered by this policy.
- E. Each Division shall develop written policy/procedures that include the requirements set forth in this policy. The Division policy shall be approved by the applicable Division Director prior to implementation and a copy forwarded to the Office of the Secretary.
- F. DHSS shall develop standardized protocol for Divisions to implement relative to orienting the individuals served, guardians of person (or property if the allegation involves financial exploitation), other legally authorized persons. Divisions shall customize their orientation to include their protocol and contacts.
- G. All persons covered by the scope of this policy shall be required to attend annual training on the requirements of this policy.
- H. Each Division shall develop a process that describes the monitoring, trending and follow up quality improvement protocol in response to reportable incident investigations.
- I. Laws prohibiting intimidation of witnesses and victims (11Del.C., §3531-3534) shall be understood by all employees and contractors identified in the Scope section of this policy.
- J. Employees and contractors identified in Scope section of this policy shall protect the confidentiality of records and information related to the investigation as well as persons involved in the case. The investigative process shall be confidential and not subject to disclosure pursuant to 24 De Code, §1768 and because it is privileged under the governmental privilege for investigative files.

K. The policy shall minimally include the following:

1. **The process for responding to reportable incidents:**

- a. The person who has reasonable cause to believe that an individual has been abused, neglected, mistreated, financially exploited, had their medication diverted, received a significant injury or died an unanticipated death shall immediately take actions to ensure the individual receives all necessary medical treatment and evaluation **and then;**
- b. Take actions to protect all individuals from further physical or emotional harm **and then;**
- c. Ensure that individuals reported to be victims of sexual assault are examined by a Sexual Assault Nurse Examiner (SANE) at the hospital **and then (or concurrently if possible);** contact the local law enforcement to report crimes against individuals **and then;**
- d. Report immediately to the Division's Designated recipient of reportable incidents **and then;**
- e. Make a verbal report to the DLTCRP by telephoning the 24 hour toll free number at 1-877-453-0012 if the individual lives in a facility that is licensed by the DLTCRP.

2. **Other notifications that are required:**

- a. Persons not included within the Scope of this policy may also notify the Division of their suspicion of a reportable incident. Such a report shall trigger the same reporting, notification and response procedure as delineated within this policy;
- b. The Division Director or designee shall notify the Office of the Secretary, Office of the Attorney General/Medicaid Fraud Control Unit and DLTCRP if an individual dies as a result of suspected abuse, neglect, mistreatment, significant injury;
- c. The Division's designated recipient(s) of reportable incidents shall issue notification to all required entities regarding the reportable incident, within 24 hours of receiving notification. Notifications are situational specific and may include any combination of the following non-exhaustive list of entities:
 - i. Office of the Secretary
 - ii. Division Director or designee
 - iii. Division of Long Term Care Residents Protection (verbal followed by web based reporting for licensed facilities/homes)
 - iv. Division of Medicaid and Medical Assistance (if the individual receives services funded by Medicaid)
 - v. Local law enforcement (for all reasonable suspicion of crime)
 - vi. Delaware State Police Drug Diversion Unit (for medication diversion allegations)
 - vii. DHSS Medical Director (for unanticipated deaths)
 - viii. Adult Protective Services (for non-residential)
 - ix. Child Protective Services (individual under 18)
 - x. Elder Abuse Hotline
 - xi. Community Legal Aid Society, Inc (if required by 16 DE Code, §5162)
 - xii. Division of Forensic Science (for unanticipated deaths)
- d. The designee of any hospital or residential center that admits individuals pursuant to 16 Del. CH. 50, 51 or 55 shall notify the Community Legal Aid Society, Inc. (CLASI) within 72 hours of an individual's death by any means pursuant to 16 Del. CH. 51, §5162;
- e. Individual to Individual incidents involving at least one person who lives in a Long Term Care Facility or licensed residential facility involving abuse and/or assault and results in actual harm/injury to at least one of the individuals, that is not the result of staff

- negligence shall be reported to the DLTCRP via their web based Incident Report;
- f. The Division shall notify the individual (reported victim) unless there is an identified guardian of person (or property if the allegation involves financial exploitation), health care surrogate pursuant to Title 16, §2507 or other legally authorized person of the reportable incident. Exceptions to this standard shall include if the alleged offender is the guardian or primary contact person, or release of information has the potential to harm or if the individual served (Victim) expressly communicates that he/she does not want the non-guardian family contact person to be contacted about the allegation. Notifications shall occur with the following frequency:
 - i. Initial notification on the day the reportable incident is reported by the Division's designated recipient of reportable incidents (verbal and written);
 - ii. Follow-up notification if the investigation exceeds 5 working days (for Long Term Care Facilities and the Delaware Psychiatric Center) or 10 calendar days (verbal or written);
 - iii. Notification at the conclusion of the investigation (verbal and written).
 - g. Incidents that involve conduct that a reasonable person would suspect also constitute a criminal offense under local, State or Federal law shall be reported to the appropriate law enforcement agency. Such reports to law enforcement shall be made within two (2) hours for serious bodily injury.
 - h. The Division shall notify the supporter under a supported decision making agreement if the individual who is the victim of the incident requests such notice be given or if the victim is unable to contact the supporter and the supporter has been engaged in discussions with the provider or Agency prior to the incident.

3. Requirements regarding investigators and investigations:

- a. Each Division shall develop a protocol that identifies the minimal training requirements for investigators and the Division's protocol for tracking compliance thereof.
- b. The Division or contractor investigator shall always ensure that they have approval to proceed with an investigation from law enforcement or Division of Forensic Science, when they are involved.
- c. Investigative reports shall minimally include:
 - i. Direct interview with the individual;
 - ii. Interview with the reporter of the allegation;
 - iii. Interview with all potential witnesses and individuals whom may have pertinent information;
 - iv. Written statements from employees/contractors interviewed (attempts should also be made to obtain written statements from other people interviewed);
 - v. Documents and physical evidence that relate to the investigation.
- d. Investigations shall be completed within 10 days. The following exceptions apply:
 - 1) investigations shall be completed within five (5) working days of the incident pursuant to 42 CFR §§483.13 (c)(2) and (4),
 - 2) the Division Director or designee approves an extension of this time frame due to extenuating facts related to the investigation and notifies the DLTCRP, if applicable.
- e. Division employee and contractors are mandated to fully cooperate with investigations initiated, as required by this policy, and all other subsequent investigations by other review entities such as but not limited to those conducted by DLTCRP, law enforcement, Office of the Attorney General/Medicaid Fraud Unit, Division of Forensic Science, all regulatory and licensing agencies and Adult Protective Services.

4. Requirements for responding to other complaints:

- a. Divisions are required to develop policy/procedures for the investigation of complaints involving individuals receiving DHSS services from DDDS, DSAMH, and DSAAPD, who are not covered by the scope of this policy.

5. Initial and closing notification to the individual, his/her guardian of person (or property if the allegation involves financial exploitation) identified health care surrogate pursuant to Title 16, §2507 or other legally authorized person shall only include:

- a. Notice that the allegation of (specify type) has been received, reassurance that the person is safe and protected and that an investigation has been initiated;
 - b. Notice of the content of the interim notification shall only include that the investigation process continues. The Divisions shall have a protocol for responding to requests for more information (ie., determine if more information can be shared and respond back to contact person);
 - c. Notice of the completion of the investigation shall only include the following information: a) the investigation was completed, b) brief explanation of the Division's follow up protocol, and c) if the investigation was referred to the DLTCRP. Information related to the investigation and any employee personnel action shall never be disclosed;
 - d. Investigative reports completed pursuant to the scope of this policy are confidential and fall under peer review protections. The DHSS Divisions within the scope of this policy are entities charged with helping to safeguard the health and safety of their clients/residents/patients. They shall be recognized as a "public health authority" and as a "health oversight agency" and they shall be recognized in the performance of their function as a peer review organization or auditor or evaluator with respect to such aspects of health delivery systems or providers.
- L. Requests for disclosure of the investigation shall be forwarded to the applicable Division Director or Division Director's Designee who will consult with the Deputy Attorney General.
- M. An internal report (not the investigation) may be forwarded to the Human Resources Office to determine appropriate level of discipline when a substantiated investigation involves a State employee.
- N. Divisions shall forward all investigative reports to DLTCRP for incidents involving individuals living in licensed facilities or licensed community residential placements.
- O. Divisions may refer substantiated investigative reports to the DLTCRP for Adult Abuse Registry (AAR) placement consideration, for individuals in non-licensed facilities or non-licensed community residential placement.

VI. Implementation

- A. This policy shall be effective within thirty (30) days of issuance.
- B. Any part of this policy which is in violation of State or Federal laws shall be null and void; all other parts shall remain operative.

VII. References

- A. 16 DE Code, §1131-1140
- B. 16 DE Code, §5162
- C. 16 DE Code, §2507
- D. 16 DE Code, §1161-1169
- E. 24 De Code, §1768
- F. 11 De Code, §3531-3534
- G. 11 DE Code, §761
- H. 16 DE Code, §9401A
- I. DLTCRP Report of Findings

VIII. Exhibits

- A. <http://delcode.delaware.gov/title11/c005/index.shtml>
- B. <http://delcode.delaware.gov/title16/c011/sc03/index.shtml>
- C. <http://delcode.delaware.gov/title31/c039/index.shtml>
- D. Initial Notification Letter Template
- E. Close out letter for non-licensed residential/day template
- F. Close out letter for licensed homes/facilities template
- G. PM #46 Tri-fold

 8/22/16

Rita M. Landgraf, Secretary Date



MATTHEW P. DENN
ATTORNEY GENERAL

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FAX (302) 577-2496
FRAUD DIVISION (302) 577-8600
FAX (302) 577-6499

June 10, 2015

[REDACTED]

Re: Community Interactions FOIA Request

[REDACTED]

Your May 29, 2015 email to the FOIA officer of the Department of Health and Social Services (“DHSS”) has been forwarded to me for response. Let me note at the outset that, in addition to a Freedom of Information Act (“FOIA”) request, your letter seems to raise allegations of neglect and abuse that may warrant investigation under P.M. 46. By copy of this letter to Mary Anderson of DDDS, I ask that she review these allegations and take the appropriate response.

DHSS will not comply with your FOIA request for its investigative files on Community Interactions. The investigative file is exempt from FOIA under 29 *Del. C.* §§10002(g)(1) (medical file), (g)(3)(investigative file), and (g)(6)(statutory and common law exemptions). The investigative file is protected as a peer review report pursuant to 24 *Del. C.* §1768 under both Delaware statute and case law and is subject to a qualified governmental privilege. I direct your attention to pertinent case law, including *Hagadorn v. Davidson*, 1990 WL 18274 (Del. Super.); *Atamian v. Bahar*, 2002 WL 264533 (Del. Super.); and *Williams v. Alexander*, 1980 WL 3043 (Del. Ch. 1980).

Please contact me if you have any questions.

Very truly yours,

A. Ann Woolfolk
Deputy Attorney General

cc: Ms. Kathleen Weiss (via email)
Ms. Mary Anderson (via email)

Joint Report



U.S. Department of Health and Human Services
Office of Inspector General,
Administration for Community Living, and
Office for Civil Rights

Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight

January 2018





The Department of Health and Human Services (HHS), Office of Inspector General (OIG), provides independent and objective oversight that promotes economy, efficiency, and effectiveness in HHS programs and operations. OIG's program integrity and oversight activities are shaped by legislative and budgetary requirements and adhere to professional standards established by the Government Accountability Office (GAO), the Department of Justice (DOJ), and the Inspectors General community. OIG carries out its mission to protect the integrity of HHS programs and the health and welfare of the people served by those programs through a nation-wide network of audits, investigations, and evaluations.



The Administration for Community Living (ACL) serves as the Federal agency responsible for increasing access to community supports while focusing attention and resources on the unique needs of older Americans and people with disabilities across the lifespan. ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers. By funding services and supports provided by networks of community-based organizations and with investments in research and innovation, ACL helps make this principle a reality for millions of Americans.



The HHS Office for Civil Rights (OCR) is the Department's civil rights, conscience and religious freedom, and health privacy rights law enforcement agency. OCR's disability nondiscrimination enforcement authorities include Section 504 of the Rehabilitation Act, Title II of the Americans with Disabilities Act, and Section 1557 of the Affordable Care Act.

Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight

Group Home Beneficiaries Are at Risk of Serious Harm



- OIG found that health and safety policies and procedures were not being followed. Failure to comply with these policies and procedures left group home beneficiaries at risk of serious harm.
- These are not isolated incidents but a systemic problem – 49 States had media reports of health and safety problems in group homes.

A Roadmap for States – Compliance Oversight Model Practices

A toolbox for better health and safety outcomes in group homes



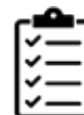
Model Practices for State Incident Management and Investigation

- Reporting and notification
- Incident review
- Investigation
- Corrective action and implementation
- Trend analysis



Model Practices for State Mortality Reviews

- Identify cause and circumstances of beneficiary death
- Where warranted, take corrective action
- Identify mortality trends
- Systemic responses and evaluation of their efficacy
- Reporting



Model Practices for State Incident Management Audits

- Assess incident reporting
- Assess response and review of incidents
- Assess investigations
- Assess corrective actions
- Assess identification and response to incident trends

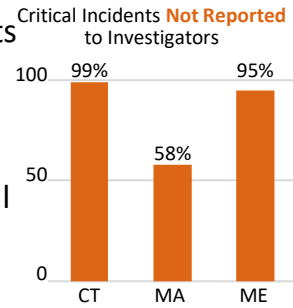


Model Practices for State Quality Assurance

- Oversight of service planning and delivery
- Periodic assessment of performance
- Review network capacity and accessibility
- Compliance monitoring of requirements and outcomes

OIG Group Home Health and Safety Work

- **Objective:** To determine if group homes complied with Federal and State requirements for reporting, recording, and detecting critical incidents in group homes
- **Where we did the work:** Connecticut, Massachusetts, and Maine
- **Finding:** OIG found serious lapses in basic health and safety practices in group homes.
- **Recommendations:** Connecticut, Massachusetts, and Maine should provide additional training, update policies and procedures, and provide access to Medicaid claims data.
- **Referrals:** OIG made multiple referrals to local law enforcement to address specific incidents of harm.



Examples

Connecticut did not report to investigators three separate critical incidents. A resident suffered from repeated head injuries that required treatment at a local hospital's emergency room. An immediate protective service order was issued for the beneficiary based on information OIG provided.

Massachusetts did not report to investigators two separate critical incidents. A resident suffered head lacerations while being restrained by the group home's aides. The resident required treatment at a local hospital's emergency room. Investigations were opened for both incidents based on information OIG provided.

OIG Reports on Group Home Health and Safety

- *Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries (May 2016 – A-01-14-00002)*
- *Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries (July 2016 – A-01-14-00008)*
- *Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities (August 2017 – A-01-16-00001)*

Government Partnership – OIG, ACL, and OCR

- **Depth of expertise and multiple perspectives**
- Developing a set of **Model Practices that provide States with a roadmap** for how to implement better health and safety practices, many of which are already required
- **Coordination with: DOJ, CMS, State stakeholders**

Joint Report Suggestions to CMS:

CMS Guidance

Encourage States to implement compliance oversight programs for group homes, such as the Model Practices, and regularly report to CMS

CMS "SWAT" Team

Form a "SWAT" team to address systemic problems in State implementation and compliance with health and safety oversight

CMS Take Action

Take immediate action in response to serious health and safety findings in group homes, using authorities under 42 CFR § 441.304(g)

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I. EXECUTIVE SUMMARY

This joint report is issued by the U.S. Department of Health and Human Services, Office of Inspector General (OIG); Administration for Community Living (ACL); and Office for Civil Rights (OCR) to help improve the health, safety, and respect for the civil rights of individuals living in group homes. The joint report provides suggested model practices to the Centers for Medicare & Medicaid Services (CMS) and States for comprehensive compliance oversight of group homes to help ensure better health and safety outcomes. In addition, the Joint Report provides suggestions for how CMS can assist States when serious health and safety issues arise that require immediate attention.

In recent decades, the United States has seen a shift from institutional care settings to more community-based services and supports. This change is attributable to multiple factors, including a growing desire of individuals, including individuals with disabilities, to live and participate in typical communities; the increased flexibility and use of Medicaid funding for community-based, long-term services and supports; and the implementation of the Supreme Court's *Olmstead* decision.¹ In addition, community-based settings, such as group homes, provide many individuals with greater independence, the choice to live in the community, and access to other opportunities.

Access to services that support community living is a key part of this transformation. Group homes and other residential settings that meet the requirements for home and community-based service provision as defined by the U.S. Department of Health and Human Services (HHS), CMS, are part of the spectrum of integrated options. However, individuals with developmental disabilities are at higher risk of abuse and neglect, particularly where they live (irrespective of residential setting type), and may have little or no access to police, support services, or external advocates.²

In response to a congressional request concerning the number of deaths and cases of abuse of individuals with developmental disabilities residing in group homes, OIG performed reviews in four States. The congressional request arose in part because of a 2012

82 of the 1,361 deaths of individuals with developmental disabilities in Connecticut involved suspected abuse or neglect.

– CT OPA Report (2012)

¹ In *Olmstead v. L.C.*, 527 U.S. 581 (1999), the U.S. Supreme Court established that unjustified isolation is a form of discrimination under the Americans with Disabilities Act.

² Christy J. Carroll, Efthalia Esser, and Tracey L. Abbott. *State of the States on Abuse and Neglect of Individuals with Developmental Disabilities*. North Dakota Center for Persons with Disabilities, Minot State University, 2010. Available at <http://www.ndcpd.org/assets/abuse--neglect-state-of-the-state-paper.pdf>. Accessed on October 18, 2017. See also OIG, *Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance With Applicable Requirements* (A-01-17-00504). Available at <https://oig.hhs.gov/newsroom/media-materials/2017/2017-snf.asp>. Accessed on November 8, 2017. OIG identified 134 Medicare beneficiaries whose injuries may have been the result of potential abuse or neglect that occurred from January 1, 2015, through December 31, 2016. OIG also found that a significant percentage of these incidents may not have been reported to law enforcement.

report issued by the Connecticut Office of Protection and Advocacy for Persons with Disabilities (OPA) that found that 82 of the 1,361 deaths state-wide of individuals with developmental disabilities from January 2004 through December 2010 involved suspected abuse or neglect. OPA investigated 81 of those deaths. The deaths involved individuals with injuries such as broken bones; safety issues such as choking incidents and burns associated with scalding; car accidents involving unlicensed drivers; and inadequate medical services at private and public group homes, State training schools, regional centers, skilled nursing facilities, and hospitals. Investigators cited abuse, neglect, and medical errors as contributing factors in these deaths.

OIG's objective in its reviews was to identify instances in which the State agencies that administer the State Medicaid program did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who reside in group homes.

In OIG's audits of Connecticut, Massachusetts, and Maine, the State agencies did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities. These audits found that these State agencies:

- failed to ensure that group homes reported all critical incidents,
- failed to ensure that all critical incidents reported by group homes were properly recorded,
- failed to ensure that group homes always reported incidents at the correct severity level,
- failed to ensure that all data on critical incidents were collected and reviewed, and
- failed to ensure that reasonable suspicions of abuse or neglect were properly reported.

As a result of these and similar findings, OIG began meeting regularly with colleagues in the Administration for Community Living and the HHS Office for Civil Rights. The goal was to combine these Federal stakeholders' knowledge and resources to develop comprehensive suggestions for CMS and States that would improve the health and safety of group home beneficiaries while helping maintain their independence.³ In addition, the Department of

An Example of a Group Home's Unreported Critical Incident

A group home did not report a critical incident involving a resident with developmental disabilities. This resident suffered a second-degree burn on his right shoulder that required treatment at a local hospital's emergency room. The group home's aide, while assisting the resident in taking a shower, noticed the injury. The resident's medical records noted the aide stated that the cause of the injury was unknown and the resident could not describe how he received the injury. Because the injury met the definition of a "critical incident," the group home should have reported it.

³ See Appendix E for related HHS reports and activities.

Justice (DOJ), Civil Rights Division, provided technical assistance based on its experience with incident management and quality assurance processes that help qualified individuals with disabilities live successfully in community-based settings. We also sought input from CMS and State stakeholders when developing these comprehensive compliance oversight suggested practices.

OIG, ACL, and OCR recognize there are limitations on the ability of a broad set of compliance oversight practices to fully encompass the varying and diverse legal, cultural, and regional differences of every State in the country. Accordingly, we seek to assist CMS in empowering State government partners to bring about the highest level of health and safety possible for group home beneficiaries. Our suggestions for CMS are focused on State compliance oversight practices, as well as, actions CMS can take to support States and beneficiaries when systemic and serious health and safety issues arise.

Our suggestions for ensuring group-home beneficiary health and safety involve four key compliance oversight components:

1. reliable incident management and investigation processes;
2. audit protocols that ensure compliance with reporting, review, and response requirements;
3. effective mortality reviews of unexpected deaths; and
4. quality assurance mechanisms that ensure the delivery and fiscal integrity of appropriate community-based services.

Accordingly, we developed four sets of Model Practices that address each of these key components and align with the requirements currently contained in the CMS Home and Community-Based Services (HCBS) Waiver (see HCBS waiver, Appendix G-1, Participant Safeguards: Response to Critical Events or Incidents⁴). The four Model Practices are:



Model Practices for State Incident Management and Investigation (Appendix A)

Model Practices for Incident Management Audits (Appendix B)

Model Practices for State Mortality Reviews (Appendix C)

Model Practices for State Quality Assurance (Appendix D)

⁴ Available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/hcbs-waivers-application.pdf>. Accessed on November 8, 2017.

Collectively implementing these four suggested compliance oversight components should help substantially to ensure the protection of beneficiaries' health, safety, and civil rights; the accountability of provider and service agencies; and the delivery of public services compatible with funding expectations and commitments. These elements are explained more fully in the appendices. We believe that these Model Practices provide a roadmap for States that will help them to ensure the health and safety of group home beneficiaries. States may adopt these Model Practices in whole or in part, depending on the needs of their particular State and population. Although these Model Practices focus specifically on the group home setting, many elements may apply to other noninstitutional care settings as well.

II. BACKGROUND

HHS OIG performed reviews in four States in response to a congressional request concerning the number of deaths and cases of abuse of individuals with developmental disabilities residing in group homes. The congressional request arose in part because of a 2012 report issued by the Connecticut OPA, which found that 82 of the 1,361 deaths state-wide of people with developmental disabilities, from January 2004 through December 2010, involved suspected abuse or neglect. OPA investigated 81 of those deaths. The deaths involved individuals with injuries such as broken bones; safety issues such as choking incidents and burns associated with scalding; car accidents involving unlicensed drivers; and inadequate medical services at private and public group homes, State training schools, regional centers, skilled nursing facilities, and hospitals. Investigators cited abuse, neglect, and medical errors as contributing factors in these deaths.

OIG's objective was to identify instances in which State agencies did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes.

OIG's objective was to identify instances in which State agencies did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes.

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has

considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Medicaid Home and Community-Based Services Waiver

The Social Security Act (the Act) authorizes the Medicaid Home and Community-Based Services Waiver (HCBS waiver) program (the Act § 1915(c)). The program permits a State to furnish home and community-based services that assist Medicaid beneficiaries and make it possible for them to live in the community and avoid institutionalization. There are a number of community-based residential options through which individuals with developmental disabilities can receive Medicaid-funded HCBS, depending on what is offered in a particular State's waiver.⁵ Waiver services complement or supplement the services that are available to participants through the Medicaid State plan and other Federal, State, and local public programs and the support that families and communities provide.

Each State has broad discretion to design its waiver program to address the needs of specific populations targeted by the State under its HCBS waiver authority.

State agencies may administer the HCBS waivers and implement portions of the waivers through interdepartmental service agreements with other units of State government. The HCBS waiver program supports individuals who require comprehensive support services. These individuals reside either in an out-of-home setting, such as a group home, with 24-hour support or in their family or own home with additional in-home support and supervision.

States must provide certain assurances to CMS to receive approval for HCBS waivers, including that necessary safeguards have been taken to protect the health and welfare of the beneficiaries receiving services (42 CFR § 441.302). A State must provide specific information regarding its plan or process related to beneficiary safeguards, which includes whether the State operates a critical event or incident reporting system (see HCBS waiver, Appendix G-1, Participant Safeguards: Response to Critical Events or Incidents). In its waiver, a State agency generally reports that it has a critical event or incident reporting system that relies on the policies and procedures of the State Department of Developmental Services (DDS) (or a similar State agency).

Medicaid permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries and make it possible for them to live in the community and avoid institutionalization.

⁵ Medicaid beneficiaries eligible for waiver services can receive HCBS in group homes, host homes or adult foster care arrangements, supported living options in apartments or homes with roommates of their choosing, family homes, or privately owned individual homes owned or rented by the beneficiary. The audit conducted by OIG was confined solely to a review of reporting and monitoring actions involving individuals with developmental disabilities living in group homes.

Critical Incident Reporting for Group Homes

The classification of critical incidents in HCBS waivers varies across States and the specific population served by the waiver. The HCBS waiver may classify critical incidents as requiring either a minor or major level of review. Critical incidents requiring a major level of review generally include deaths, physical and sexual assaults, suicide attempts, unplanned hospitalizations, near drowning, missing persons, and serious injuries. Critical incidents requiring a minor level of review generally include suspected verbal or emotional abuse, theft, and property damage. For critical incidents that involve suspected abuse or neglect, the HCBS waiver and State regulations also require mandated reporting.

Critical Incidents

- Deaths
- Physical/sexual assault
- Suicide attempts
- Unplanned hospitalizations
- Near drowning
- Missing persons
- Serious Injuries

How OIG Conducted Its Reviews

OIG reviewed Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes at selected State agencies. OIG conducted these reviews in Connecticut, Massachusetts, New York, and Maine using Medicaid claims data. OIG's audit period for this series of reviews was from 2012 to 2015. OIG's audit reports on these reviews made recommendations to the State agencies regarding improving policies and procedures.

OIG conducted these performance audits in accordance with generally accepted government auditing standards. Those standards require that audits be planned and performed to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on audit objectives. OIG believes that the evidence obtained provides a reasonable basis for its findings and conclusions based on its audit objectives. OIG's work in this area is continuing in additional States and settings such as skilled nursing facilities. OIG will be issuing a report to CMS that consolidates findings from the individual States. The report will contain specific recommendations to CMS to help improve the program.

OIG's Findings

In OIG's audits of Connecticut, Massachusetts, and Maine, the State agencies did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities. Summaries of five of OIG's findings follow.



1. State Agencies Did Not Ensure That Group Homes Reported All Critical Incidents

Group homes in Connecticut and Massachusetts and community-based providers in Maine are required to report critical incidents to the State DDS (for Connecticut and Massachusetts) or to the State agency for Maine. OIG found that group homes and community-based providers did not report all critical incidents involving Medicaid beneficiaries with developmental disabilities. In Connecticut, of the 310 emergency room visits by 245 of these Medicaid beneficiaries, 176 visits met DDS’s definition at the time of a critical incident because they included a severe injury. However, group homes did not report 24 (14 percent) of the critical incidents to DDS. In Massachusetts, group homes reported 499 (85 percent) of the 587 critical incidents treated in hospital emergency rooms. However, group homes did not report to DDS 88 (15 percent) of the critical incidents. In Maine, community-based providers reported 1,474 (66 percent) of the 2,243 critical incidents treated in hospital emergency rooms. However, community-based providers did not report to the State agency 769 (34 percent) of the critical incidents.

An Example of a Group Home’s Unreported Critical Incident

A group home did not report to DDS a critical incident involving a resident with Down syndrome and dementia. The resident was encouraged to wear a helmet for protection during seizures and a gait belt when he transferred positions. The resident required one-on-one supervision while walking during a number of specified activities within the group home. The resident had an unwitnessed fall in the group home’s kitchen, which was followed by a period of unconsciousness. Hospital emergency room staff evaluated the resident for a trauma to the right side of his head and face with computerized axial tomography. Because these injuries met the DDS definitions of a “critical incident” and a “severe injury,” the group home should have reported the incident immediately.

An Example of a Group Home’s Unreported Critical Incident

A group home did not report to DDS a critical incident involving a resident with developmental disabilities. This resident suffered a second-degree burn on his right shoulder that required treatment at a local hospital’s emergency room. The injury was noticed by one of the group home’s aides who was helping the resident take a shower. The aide stated that the cause of the injury was unknown and that the resident could not describe how he received the injury. Because the injury met the DDS definition of a “critical incident,” the group home should have reported the incident.

An Example of a Critical Incident Not Reported by the Community-Based Provider

A community-based provider did not report to the State agency a critical incident involving a beneficiary with developmental disabilities. This beneficiary suffered a laceration of unknown origin to her left ear that required treatment at a local hospital’s emergency room. The injury was a jagged laceration that required suturing to close the wound. The community-based provider’s staff stated the cause of the injury was unknown and that the beneficiary could not

provide a history of the injury. Because the injury met the State agency’s definition of a “critical incident,” the community-based provider should have reported the incident.



2. State Agencies Did Not Ensure That All Critical Incidents Reported by Group Homes Were Properly Recorded

In Connecticut, OIG found that DDS did not record all critical incidents reported by group homes. Specifically, group homes reported 152 critical incidents to DDS, but DDS did not record 34 (22 percent) of these incidents into its incident reporting system. Because DDS did not record these incidents, the DDS Division of Investigations and OPA never received notice that these incidents occurred and, therefore, could not determine whether abuse or neglect contributed to these injuries. DDS did not enter all critical incidents into its incident reporting system because it did not always follow procedures. Furthermore, these unrecorded critical incidents were not detected because DDS did not have a way to coordinate with the State agency to detect unrecorded and unreported critical incidents.

An Example of a Critical Incident Not Recorded by DDS

A group home reported to DDS a critical incident involving a resident with developmental disabilities who used a wheelchair and had cerebral palsy and pulmonary disease. The group home’s staff reported the resident was dropped while being transferred. This resident suffered a displaced fractured clavicle that required treatment at a local hospital’s emergency room. Hospital staff used x-rays in their evaluation of him. Because the group home reported this incident to DDS, DDS should have entered the incident into its incident reporting system within 5 days. DDS, however, did not record the incident.



3. State Agencies Did Not Ensure That Group Homes Always Reported Incidents at the Correct Severity Level

In Connecticut, OIG found that group homes did not always correctly report to DDS emergency room visits related to severe injuries, which DDS would have treated as critical incidents. Instead, the group homes frequently reported to DDS emergency room visits as involving either minor or moderate injuries. Even though emergency room visits involving minor and moderate injuries are reportable, DDS did not treat them as critical incidents. DDS reviewed the 176 emergency room records supplied by OIG and determined that 86 (49 percent) emergency room visits originally classified by the group homes as involving either minor or moderate injuries actually involved severe injuries and would have therefore met Connecticut’s definition of critical incidents. Accordingly, State agencies could not investigate these 86 critical incidents for potential abuse or neglect.

An Example of a Group Home Reporting the Incorrect Severity Level of an Injury

A group home reported injuries involving a resident with developmental disabilities, scoliosis, and spastic paralysis of all four limbs at an incorrect severity level. This resident suffered a lacerated upper lip, facial contusions, an acute cervical strain, and a fractured tooth; these injuries required treatment at a local hospital’s emergency room. During the resident’s

treatment, hospital staff evaluated him for additional spine and skull injuries using computerized axial tomography. The group home’s staff reported that the resident was injured when he fell from a shower chair, but they also reported that they did not witness his fall. The group home reported these injuries to DDS, but it reported the severity level of the injuries as only “moderate” instead of “severe.” As a result, this critical incident was not investigated by either DDS or OPA for potential abuse or neglect.



4. State Agencies Did Not Ensure That All Data on Critical Incidents Were Collected and Reviewed

In Connecticut and Massachusetts, OIG found that DDS did not review and analyze all data on critical incidents. In Connecticut, DDS reviewed medication errors quarterly, but it reviewed internal critical incident data only annually. DDS did not have a way to obtain all data regarding critical events and incidents from the State agency. Accordingly, DDS could not review relevant Medicaid claims data for injuries that required emergency room treatment or hospital admission—key elements in determining whether beneficiaries were involved with critical incidents and whether those incidents were reported and investigated within required timeframes. If DDS had access to relevant Medicaid claims data as contained in the Connecticut Medicaid Management Information System (MMIS), it could have performed a data match similar to the one OIG performed. Because it could not, DDS was unable to detect the 24 critical incidents that group homes did not report or the 34 critical incidents that group homes reported but DDS did not enter into its incident reporting system.

In Massachusetts, DDS reviewed and analyzed only the incidents that were reported by the group homes. DDS did not have a way to obtain and analyze all data regarding critical incidents from the State agency. Accordingly, DDS could not analyze relevant Medicaid claims data for injuries that required emergency room visits or hospital admissions—key elements in determining whether beneficiaries were involved with critical incidents and whether those incidents were reported and investigated within required timeframes. If DDS had access to the relevant Medicaid claims data as contained in the Massachusetts MMIS, it could have performed a data match similar to the one OIG performed. Because it could not, DDS was unable to detect the 88 critical incidents that group homes did not report.

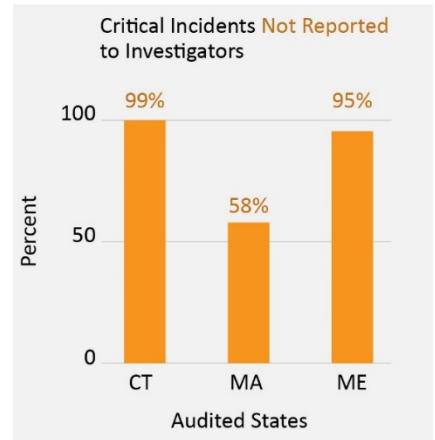


5. State Agencies Did Not Ensure That Reasonable Suspicions of Abuse or Neglect Were Properly Reported

In Connecticut, Massachusetts, and Maine, OIG found that they did not always report reasonable suspicions of abuse or neglect.

Although Connecticut group homes reported 152 critical incidents to DDS during the period of our audit, DDS did not report 151 of the 152 to OPA as potential incidents of abuse or neglect involving Medicaid beneficiaries who had developmental disabilities. OIG reported to OPA the 176 critical incidents it identified during its audit (the 152 critical incidents that DDS did not

report and 24 critical incidents that group homes failed to report). OPA stated that DDS should have reported all 176 as incidents with a reasonable suspicion of abuse or neglect. OPA then opened 24 new investigations and updated 9 ongoing investigations—33 critical incidents involving potential abuse or neglect. *OPA also issued 8 immediate protective service orders involving 14 critical incidents to protect group home residents with developmental disabilities from potential harm.*



In Massachusetts, of the 587 critical incidents involving Medicaid beneficiaries with developmental disabilities that occurred during the period of our review, 73 (12 percent) were reported to the Disabled Persons Protection Commission (DPPC) as potential incidents of abuse or neglect. However, the remaining 514 (88 percent) were not reported to DPPC. OIG reported to DPPC the 514 unreported critical incidents it identified. DPPC officials stated that they believed that 102 of the unreported incidents (20 percent) should have been reported as incidents with reasonable suspicion of abuse or neglect. DPPC officials stated that 240 incidents (47 percent) did not have to be reported and that they did not have enough information to determine whether the remaining 172 incidents (33 percent) should have been reported. Therefore, OIG determined that staff of DDS and group homes did not report as required 58 percent of the 175 incidents (73 critical incidents reported to DPPC plus 102 additional critical incidents that should have been reported) that met the State’s “reasonable cause to believe” threshold regarding whether a suspicion of abuse or neglect exists.

In Maine, the State agency must also immediately report the suspected abuse, neglect, or exploitation of an incapacitated or dependent adult to the appropriate district attorney’s office. The State agency did not report all suspected incidents of abuse, neglect, or exploitation to the appropriate district attorney’s office. During the audit period, the State agency received 15,939 critical incident reports for 15,897 individual critical incidents related to potential abuse or neglect involving 1,886 beneficiaries from community-based providers. There were no records demonstrating that the State agency reported 15,130 (95 percent) of the 15,897 critical incidents.⁶

An Example of DDS Not Reporting a Critical Incident That Had Reasonable Suspicion of Abuse or Neglect

Connecticut DDS did not report to OPA any of the three separate critical incidents that occurred in 2012 and 2013 involving a nonverbal group home resident with cerebral palsy and a history of self-injury. This resident suffered from repeated head injuries that required treatment at a local

⁶ Maine State agency staff review critical incident reports submitted to the State agency and determine if the reports should be sent to an Adult Protective Services Unit supervisor for further assessment. A State agency supervisor reviews the reports and decides whether or not the State agency will accept the reports for investigation. The “Not Accepted for Investigation” category includes critical incidents for which the State agency (1) completed an assessment but did not accept for investigation and (2) did not complete an assessment for investigation. We did not determine how many critical incidents were not assessed for investigation.

hospital's emergency room. These injuries included contusions with bruising and swelling of the head and face. This resident was evaluated with x-rays and computerized axial tomography. Because these injuries met the DDS definition of a "critical incident" and there was reasonable evidence to suspect abuse or neglect, DDS should have reported the incidents immediately to OPA. *On the basis of the information OIG provided, OPA issued an immediate protective service order for this beneficiary.*

An Example of DDS Not Reporting a Critical Incident That Had Reasonable Suspicion of Abuse or Neglect

Staff of the Massachusetts DDS and the group home did not report to DPPC either of two separate critical incidents that occurred in December 2013 and April 2014 involving a resident with oppositional defiance disorder and seizures. This resident suffered head lacerations that required treatment at a local hospital's emergency room. The medical records noted that the resident was injured while being restrained by the group home's aides. The resident cut her head on a bed headboard during the first incident and on a chair during the second incident. In each case, the group home submitted an incident report to DDS, but neither DDS staff nor group home staff filed a report with DPPC. Because these injuries met the DDS definition of a "critical incident" and DPPC officials stated that there was reasonable evidence to suspect abuse or neglect, DDS should have reported the incidents immediately to DPPC. *On the basis of the information OIG provided, DPPC opened investigations of both incidents.*

The Formation of an Interagency Group To Examine Group Home Health and Safety

As a result of these and similar findings, OIG contacted stakeholders across Government that shared our interest and concerns in the area of group-home health and safety. OIG's Federal partners shared a concern about the systemic failures identified in critical incident reporting and monitoring of incident management within group homes. The group also realized that strong incident reporting and management systems constitute a critical element of enhanced quality assurance for community-based settings. OIG began meeting regularly with its colleagues in the Administration for Community Living and the HHS Office for Civil Rights. We hoped to combine our knowledge and resources to develop comprehensive suggestions for CMS and States that would improve the health and safety of group home beneficiaries across the country. In addition, we received technical assistance from DOJ, Civil Rights Division, and sought input from CMS and State stakeholders. While this approach is unusual, we believe the magnitude of the danger for beneficiaries has warranted this effort and the joint report that has come from it.

While this approach is unusual, we believe the magnitude of the danger for beneficiaries has warranted this effort and the joint report that has come from it.

This interagency group began meeting in August 2016 to discuss and examine how to ensure the systemic health and safety of group home beneficiaries. The group developed three suggestions for CMS. First, we developed a model for comprehensive compliance oversight through four Model Practices that address the key components of ensuring beneficiary health and safety and that align with the requirements currently contained in the 1915(c) HCBS waiver (Appendix G-1, Participant Safeguards: Response to Critical Events or Incidents). The four Model Practices are:

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- Model Practices for State Incident Management and Investigation (Appendix A)
 - Model Practices for Incident Management Audits (Appendix B)
 - Model Practices for State Mortality Reviews (Appendix C)
 - Model Practices for State Quality Assurance (Appendix D)

We believe that these Model Practices provide a roadmap for States that will empower them to ensure the health and safety of group home beneficiaries. States may adopt these Model Practices in whole or in part depending on the needs of their particular State and population. Although these Model Practices are specifically focused on the group home setting, many elements may apply to other noninstitutional care settings as well.

Second and third, we developed suggestions for actions CMS can take to support States and beneficiaries when systemic and serious health and safety problems arise in group homes. Where there is evidence of a systemic failure to implement compliance oversight for group homes, CMS should form a “SWAT” team to assist the State in addressing the problem effectively. Where there are serious health and safety findings, CMS should take immediate action, using its authorities under 42 CFR § 441.304(g) for group homes, to ensure that beneficiaries are safe.

III. KEY COMPONENTS OF HEALTH AND SAFETY COMPLIANCE OVERSIGHT

Generally, assurance of program beneficiary health and safety involves four critical components:

1. reliable incident management and investigation processes;
2. audit protocols that ensure compliance with reporting, review, and response requirements;
3. effective mortality reviews of unexpected deaths; and
4. quality assurance mechanisms that ensure the delivery and fiscal integrity of appropriate community-based services.

In turn, each of these four components of health and safety assurances must embody certain critical elements to be effective and reliable. These elements are delineated in the Model Practices presented in Appendices A through D. As noted, these practices align with existing requirements contained in the HCBS waiver (Appendix G-1, Participant Safeguards: Response to Critical Events or Incidents).

1. Reliable Incident Management and Investigation Processes

Incident management involves providing immediate and effective responses to serious incidents to protect the involved beneficiary's safety and well-being and to mitigate reoccurrence. It also involves ensuring that the facts and circumstances of serious incidents are reviewed quickly and effectively and, as warranted, investigated. It includes ensuring that trends and patterns regarding serious incidents are identified and addressed through timely implementation of effective corrective actions (e.g., additional provider and staff training focused on both quality assurance and improvement, necessary changes and reforms to specific protocols in service delivery, and enhancements to standard operating policies). It involves ensuring that appropriate governmental entities and provider and support coordination agencies receive timely notification of serious incidents, and it includes public reporting regarding the overall safety and well-being of Medicaid beneficiaries.

Collectively, these four compliance oversight components help ensure that beneficiary health, safety, and civil rights are adequately protected, that provider and service agencies operate under appropriate accountability mechanisms, and that public services are delivered consistent with funding expectations.

2. Audit Protocols That Ensure Compliance With Reporting, Review, and Response Requirements

An effective audit system of public agency and provider incident management activities involves processes to assess for timely and appropriate incident reporting, investigation, and response and for implementation of timely and appropriate corrective actions to minimize reoccurrence. It also involves assessments to determine if public agencies and providers are undertaking systemic reviews to identify and appropriately address incident trends or patterns.

3. Effective Mortality Reviews of Unexpected Deaths

An effective mortality review protocol involves timely reporting of all beneficiary deaths, including identification of the cause of death and the circumstances contributing to or associated with the death. It includes, where warranted, identification and implementation of corrective actions likely to minimize the reoccurrence of the immediate factors contributing to the death. It also includes identification of mortality trends and patterns that warrant systemic responses to reduce avoidable risks of death and other adverse outcomes. It includes the timely implementation of systemic responses and ongoing evaluation of their efficacy. And it includes periodic reporting of mortality trends and responses to ensure public reporting regarding the health, welfare, and safety of program beneficiaries.

4. Quality Assurance Mechanisms That Ensure the Delivery and Fiscal Integrity of Appropriate Community-Based Services

A comprehensive quality assurance system of community-based services includes the incident management, audit, and mortality review components discussed above and certain other elements of quality assurance. The quality assurance system includes the oversight of individualized service planning and delivery; the enhanced oversight of, and support for, high-risk beneficiaries; the assessment of the inclusion of service beneficiaries into their community; initial certification reviews of all new service providers and support coordination agencies; periodic assessments of the performance of service providers and support coordination agencies; audits of provider workforce assurances and background checks; reviews of the provider network's capacity, stability, and accessibility; assessments of the fiscal integrity of service billing and reimbursement; and compliance monitoring related to Federal fiscal and programmatic requirements.




Collectively, these four compliance oversight components help ensure that beneficiary health, safety, and civil rights are adequately protected, that provider and service agencies operate under appropriate accountability mechanisms, and that public services are delivered consistent with funding expectations and commitments. Additionally, we hope adoption and implementation of the suggested Model Practices across the four critical element areas will ultimately inform larger quality improvement efforts related to delivery of home and community-based services and the experience of beneficiaries receiving these supports to realize community-living goals.

IV. CONCLUSION

OIG's audit work in this area is continuing in additional States. Media coverage and disturbing trends identified by advocacy organizations and protection and advocacy entities throughout the country continue to uncover terrible examples of abuse and neglect of Medicaid beneficiaries in group homes, nursing facilities, and hospitals.

OIG, ACL, and OCR make the following suggestions to help maintain independence, human dignity, choice, and self-determination for Medicaid beneficiaries; improve compliance with *Olmstead*; and ensure safety and a high quality of care for beneficiaries.

Based on OIG's audit work and work with the interagency group, OIG, ACL, and OCR suggest that CMS:

-  encourage States to implement comprehensive compliance oversight systems for group homes, such as the Model Practices, and regularly report their findings to CMS;
-  form a "SWAT" team to address, in a timely manner, systemic problems in State implementation of and compliance with health and safety oversight systems for group homes; and
-  take immediate action in response to serious health and safety findings, for group homes using the authority under 42 CFR § 441.304(g).

APPENDIX A

Model Practices for State Incident Management and Investigation

This appendix sets forth the Model Practices for State Incident Management and Investigation. As detailed below, incident management and investigation involve providing immediate and effective responses to serious incidents to protect the involved beneficiary's safety and well-being and to mitigate reoccurrence.

- I. Intended Outcomes of Incident Management and Investigation
- II. Participants in State Incident Management and Investigation
- III. Essential Components of State Incident Management and Investigation
- IV. Detailed Elements of the Essential Components
 - A. Reporting and Notifications
 - B. Incident Reviews
 - C. Investigations
 - D. Corrective Action Recommendations and Implementation
 - E. Trend Analysis

Attachment A: Suggested Data Elements for Incident and Investigation Database Systems

I. Intended Outcomes of Incident Management and Investigation

- A. To ensure responses to serious incidents in community-based service systems that timely and effectively resolve the immediate event/situation (i.e., protecting the safety and well-being of the individuals involved and preventing a reoccurrence);
- B. To ensure that the facts and circumstances of serious incidents are timely and effectively reviewed and investigated as required;
- C. To ensure that trends and patterns regarding serious incidents are identified and addressed with appropriate recommendations for corrective actions (including but not limited to additional provider and staff training focused on both quality assurance and improvement, necessary changes and reforms to specific protocols in service delivery, and enhancements to standard operating policies);
- D. To ensure that recommendations for corrective actions associated with serious incidents are timely and effectively implemented;
- E. To ensure that implemented corrective actions are effective in preventing or reducing the occurrence of serious incidents;

- F. To ensure that Government officials (Federal and State), provider and support coordination agencies, and designated protection and advocacy entities receive timely and effective notification of serious incidents; and
- G. To ensure public reporting related to the overall safety and well-being of individuals supported by community-based service systems and support for the quality assurance of community-living options for individuals.

II. Participants in State Incident Management and Investigation

- A. This model for State Incident Management and Investigation focuses on two main participants: service provider agencies and State officials.
- B. Other primary reporters of incidents include service recipients, family members, and friends of service recipients, as well as support coordinators and advocates. Support coordinators and support coordination agencies also have primary roles in the immediate review of reported incidents and timely responses to health and safety issues for involved service recipients. On occasion, service providers may invite these participants to contribute to discussions of particular incidents at meetings of the provider’s Incident Management Review Committee. These participants can provide valuable information in many incident investigations.
- C. The Federal Government also has statutory roles of ensuring that States’ incident management and investigation programs actually work as designed to ensure the accountable reporting, investigation, resolution, and prevention of serious events and situations that do or could jeopardize the health and welfare of service recipients. Additionally, the Federal Government should have the capacity to undertake independent incident investigations and audits of States’ Incident Management and Investigation processes in response to State quality assurance reports, citizen complaints, and concerns that may surface in Medicaid or Medicare data. The Federal Government also has the unique capacity to identify and respond to trends in incidents and incident investigation findings across States and to use its observations to frame ongoing, needed quality improvements in the Federal regulatory framework for States’ community-based service systems.

III. Essential Components of State Incident Management and Investigation

- A. Reporting and Notification
- B. Incident Review
- C. Investigation
- D. Corrective Action Recommendations and Implementation
- E. Trend Analysis

IV. Detailed Elements of the Essential Components

A. REPORTING AND NOTIFICATIONS

1. Service Providers
 - i. Service providers should ensure that all incidents are reported as soon as possible after discovery.
2. Support Coordinators and Support Coordination Agencies
 - i. Support coordinators and support coordination agencies should be required to report to designated State officials any instances of failed incident reporting or failed external notifications of incidents.
3. Service Providers and the State
 - i. Service providers and the State should ensure that individuals (including service recipients, staff, and family members) are free from retaliation or adverse consequences because they reported incidents or allegations of abuse, neglect, exploitation, or other staff misconduct or errors.

Service providers should ensure that failed incident reporting and delays in incident reporting result in appropriate employee discipline, including employee suspension or termination.
 - ii. The State should take assertive steps to identify patterns of failed incident reporting and delays in incident reporting by service providers. The steps should include reviews of incident reporting by service providers and support coordination agencies. These reviews should rely on cross-reference assessments of a variety of data sources (e.g., hospitalization and emergency room billing records, licensure or certification findings, grievance and complaint reports, and daily note documentation).

The State should also ensure that it imposes appropriate sanctions against such providers, including fines, suspension of permission to enroll new participants, waiver contract termination, and decertification.
4. Service Providers, Support Coordination Agencies, and the State
 - i. The State, service providers, and support coordination agencies should ensure safeguards are in place to protect the confidentiality

of incident reports and any databases containing incident report information.

5. The State

- i. The State should disseminate and ensure appropriate training of service providers and support coordinators regarding what events, situations, and circumstances constitute reportable incidents. Reportable incidents should include:
 - a. deaths;
 - b. allegations of physical, psychological, or financial exploitation;
 - c. allegations of physical or psychological neglect;
 - d. allegations of physical or psychological abuse;
 - e. allegations of sexual abuse;
 - f. incidents involving the inappropriate restraint or seclusion of service recipients;
 - g. events that lead to adverse consequences or outcomes to service recipients because of staff misconduct or error;
 - h. events that result in injury or illness to a service recipient requiring medical treatment beyond first aid;
 - i. choking incidents;
 - j. hospital emergency room visits where the injury or the medical condition could indicate abuse or neglect, as well as unplanned hospitalizations of service recipients;
 - k. service recipient elopements whereby the individual is removed from staff supervision or the individual is placed at risk of serious harm;
 - l. behavioral incidents of a service recipient that result in (a) employee physical intervention with the service recipient including restraint, (b) serious risk of harm to the individual, other service recipients, employees, or community citizens, or (c) property damage valued at more than \$150;

- m. emergency situations, including fires, flooding, and serious property damage, that result in harm or risk of harm to service recipients;
 - n. financial exploitation or theft of a service recipient's property or funds of \$25 or greater;
 - o. incidents that may involve criminal conduct by service recipients or employees; and
 - p. incidents involving law enforcement personnel.
- ii. The State should identify criteria for ranking incidents by seriousness of harm or potential harm to service recipients.
 - iii. The State should implement policies requiring service providers to inform families or guardians and support coordinators about reported incidents as soon as possible after discovery and in all cases within 72 hours.
 - iv. The State should ensure that clarification is sent to service providers of any required external incident report notifications to other State officials or agencies (including law enforcement as applicable) for certain serious incidents, including deaths, allegations of abuse and neglect, and possible criminal acts.
 - v. The State should take assertive steps to identify patterns of failed or delayed external notifications of incidents by service providers and to ensure that it takes appropriate actions against such providers, including fines, suspension of permission to enroll new participants, waiver contract termination, and decertification.
6. Federal Government
- i. In the context of its overall role in protecting waiver service recipients from harm, the Federal Government should ensure reviews of accountable incident reporting by States. Such reviews include Federal oversight to ensure that States are conducting credible assessments of accountable incident reporting, as well as periodic federally directed assessments of incident reporting by service providers.

B. INCIDENT REVIEWS

1. States should set objective criteria to ensure that for those incidents that result in significant injury, service providers ensure a preliminary review by senior management and an immediate response to all incidents within 24 hours of their discovery.
2. Service providers should establish Incident Management Review Committees to ensure a comprehensive review of incidents and investigation findings. Every Incident Management Review Committee should:
 - i. identify the facts surrounding incidents, including any contributing factors;
 - ii. review investigations of reported incidents;
 - iii. identify needed corrective actions or remedies to prevent or reduce the likelihood of future similar incidents;
 - iv. review and either accept or reject the recommended corrective actions from investigations and mortality reviews of incidents;
 - v. document in its official minutes all accepted recommendations and rationales for any rejected recommendations;
 - vi. ensure that recommended corrective actions or remedies are implemented in a timely and appropriate manner; and
 - vii. evaluate the outcomes of instituted corrective actions or remedies.
3. Service providers' Incident Management Review Committees should meet on a regularly scheduled basis (e.g., biweekly), except when none of the above-listed review activities are pending.
4. The State should establish a State Incident Management Review Committee, which should:
 - i. reach out to adult protective services, protection and advocacy entities, and other partners that can provide data on the number and types of incidences reported in group homes and technical assistance and subject matter expertise to the committee's deliberations;
 - ii. review particularly serious incidents (including substantiated reports of abuse and neglect and apparently preventable deaths);

- iii. review the adequacy of State and provider investigations of serious incidents in accordance with the standards specific in Section C, Investigations, below;
 - iv. identify and review trends and patterns in reported incidents and the findings, conclusions, and recommendations in State investigations;
 - v. review annual reports of the trends and patterns in reported incidents and State investigations;
 - vi. identify and respond to State, regional, and other identified trends and patterns in incidents and State investigations; and
 - vii. discuss potential systems-wide corrective actions for improving quality assurance (including but not limited to additional training of providers and State personnel; necessary changes and reforms to specific protocols in service delivery, incidence reporting, and management; and enhancements to specific policies and provider requirements).
5. The State Incident Management Review Committee should meet regularly to ensure its review responsibilities are carried out in timely manner. Service providers and State Incident Management Review Committees should maintain appropriate minutes of their meetings, meeting attendees, their deliberations regarding incidents, and recommendations for corrective actions.
 6. The State should ensure comprehensive oversight of the operation of the State's Incident Management and Investigation Program, including but not limited to periodic State-conducted reviews of the incident management and investigation activities of provider and support coordination agencies, State investigators, and the State's Incident Management Review Committee.

C. INVESTIGATIONS

1. The State should ensure independent State investigations of:
 - i. allegations of physical or emotional abuse and neglect that result in serious or repeated harm to service recipients;
 - ii. allegations of sexual abuse;
 - iii. allegations of financial exploitation in which the goods stolen are valued at more than \$250 or thefts of lesser value occurring repeatedly;

- iv. deaths that occurred unexpectedly or that appear or are alleged to be due to provider or support coordinator misconduct, abuse, or neglect;
 - v. incidents that result in potentially life-threatening or serious injury or illness that appear or are alleged to be due to provider or support coordinator misconduct, abuse, or neglect or that occurred under suspicious circumstances (e.g., repetitive ER visits, multiple uses of physical restraints per day);
 - vi. incidents that result in potentially life-threatening or serious injury that were due to environmental hazards (e.g., fires, drownings, serious automobile accidents, weather emergencies); and
 - vii. incidents that result in criminal charges or incarceration of service recipients or employees.
2. For serious incidents not described above, the State may (at its discretion) delegate the conduct of the investigations to provider or support coordination agencies or another authorized entity.
 3. Regardless of whether incident investigations are conducted by State investigators or a delegated agency or entity, incident investigations involving allegations of physical abuse and neglect that result in death or potentially life-threatening or serious injury or illness should be completed within 14 days. When the 14-day timeframe cannot be met, the State should ensure that a designated senior State official reviews and approves timeframe extensions.

All other incident investigations should be completed within 30 days. When the 30-day timeframe cannot be met, the State should ensure that a designated senior State official reviews and approves timeframe extensions.
 4. Regardless of whether incident investigations are conducted by State investigators or a delegated agency or entity, the State should ensure that all investigators have successfully completed a competency-based training program that meets generally accepted professional standards.
 5. Regardless of whether incident investigations are conducted by State investigators or a delegated agency or entity, the State should develop and ensure compliance with performance standards for conducting incident investigations. Such standards should include:
 - i. a review of the person-centered service plan of the service recipient and other reported incidents in the past year;

- ii. a review of the circumstances leading up to and following the incident;
 - iii. interviews with all witnesses to the incident (employees, service recipients, and community citizens);
 - iv. interviews with family members or guardians of the service recipient;
 - v. interviews with other relevant parties, including provider agency supervisory, management, and health care personnel and the assigned support coordinator for the service recipient;
 - vi. reports of the State protection and advocacy entity related to investigations of incidences that have occurred in group home settings;
 - vii. reviews of relevant documents and medical records maintained by the service provider, support coordinator, or external health care entities, including hospitals and outpatient medical providers; and
 - viii. reviews of law enforcement reports, death certificates, and autopsy reports (as available).
6. Regardless of whether incident investigations are conducted by State investigators or a delegated agency or entity, the State should develop a standard template for incident investigation reports that includes sections related to:
- i. findings and observations associated with all completed investigative activities,
 - ii. the investigation's conclusions, and
 - iii. the investigation's recommended corrective actions.
7. Regardless of whether incident investigations are conducted by State investigators or a delegated agency or entity, the State should ensure appropriate reviews and approval of completed investigations by trained State personnel. Such reviews should include:
- i. the investigation's compliance with the above investigation performance and format requirements and
 - ii. the appropriateness of the investigation's findings, conclusions, and recommendations.

8. The State should make reasonable efforts to ensure that State investigators and State investigation reviewers (including members of the State Incident Management Review Committee) have access to death certificates, autopsy reports, and medical and hospital records pertinent to the investigation of unusual, suspicious, sudden, or apparently preventable deaths.
9. The State should assure that administrative or legislative efforts, or both, will be made to ensure that autopsies are requested and conducted for deaths in which abuse or neglect is suspected or alleged or the circumstances of the death are unusual, suspicious, sudden, or apparently preventable.
10. The State should ensure the dissemination of appropriate summaries⁷ of investigation findings, conclusions, and recommendations for corrective action to:
 - i. relevant service provider personnel including employees directly associated with the incident,
 - ii. the service recipient's support coordinator and support coordination agency, and
 - iii. the service recipient and his or her family or friends (with consent of the individual service recipient or their legal guardian or legal representative if the service recipient is unable to provide consent).

D. CORRECTIVE ACTION RECOMMENDATIONS AND IMPLEMENTATION

1. The State should conduct a trend analysis of incidents and identify the specific incident types that would benefit from a systemic intervention.
2. The State should inform providers, support coordinators, and other stakeholders of recommendations for corrective actions, including any systemic interventions required as the result of trend analysis, and their responsibility to address such recommendations in a timely manner by implementing them or substantiating that they are unnecessary.
3. Providers and the State should maintain accountable tracking systems for all recommendations for corrective actions emanating from incident reviews and investigations. Such tracking systems should include accepted and rejected recommended corrective actions and ongoing status

⁷ Summaries should be informative but protect the confidentiality of service recipients and individuals interviewed in the course of the investigation.

reporting of the implementation and date of accepted recommended corrective actions.

4. Providers, support coordination agencies, and the State should ensure that accepted recommended corrective actions are implemented within the required timeframes, and they should provide written documentation to the State justifying any implementation delay of more than 30 days.
5. The State should ensure ongoing monitoring of the implementation of accepted recommended corrective actions (via its tracking system) by service providers and the State.
6. Service providers identified as having recurring deficiencies in the timely implementation of accepted recommended corrected actions should be subject to State actions, including fines, suspension of permission to enroll new participants, waiver contract termination, and decertification.
7. Service providers and the State should periodically, at least annually, review their corrective action tracking systems to evaluate:
 - i. the systems' overall performance in ensuring the timely implementation of accepted recommended corrective actions and
 - ii. the effectiveness of implemented corrective actions to achieve the intended outcomes.

E. TREND ANALYSIS

1. Service providers and the State should ensure timely entry of data into the Incident and Investigation Database Systems. Those data should include:
 - i. incident reports;
 - ii. findings and recommendations of their Incident Management Review Committees;
 - iii. findings and recommendations of State incident investigations; and
 - iv. the status of corrective actions. (See Attachment A for specific recommended data elements to be included in Incident and Investigation Database Systems.)
2. Using their Incident and Investigation Database Systems, service providers are responsible for identifying trends and patterns in filed incidents and the findings and recommendations of their Incident Management Review Committees and State investigations involving their service recipients.

3. Service providers should ensure on a quarterly basis that identified trends and patterns are shared with their Incident Management Review Committees. Service providers should provide to the State an annual report of identified trends and patterns in their incidents, incident review findings and recommendations, and State incident investigations.
4. Using their ongoing and annual trend analysis activities, service providers are responsible for identifying needed additional corrective actions (including systemic actions) and for ensuring that they are implemented in a timely manner.
5. The State is responsible for ensuring that service providers comply with the above trend analysis requirements, including their obligation to identify and implement needed additional corrective actions to address adverse trends and patterns in service recipient protection and safety.
6. Using the State Incident and Investigation Database System, as well as providers' annual trend analysis reports, the State should at least biennially conduct its own trend analysis of reported incidents, the findings and recommendations of the State's Incident Management Review Committee, and the findings and recommendations of State investigations. Reports of these analyses, after the deletion of any personally identifiable information, should be available to the public to ensure the transparency of the State's Incident Management and Investigation program. Based on this analysis, the State should identify and implement any additional corrective actions that are needed. Such additional recommendations may address:
 - i. needed state-wide remedies,
 - ii. needed regional remedies, and
 - iii. needed remedies for select groups of service recipients and providers.

Attachment A

Suggested Data Elements for Incident and Investigation Database Systems

- Name (or identification number) of individual involved
- Incident report identification number
- Date the incident occurred
- Provider agency
- Region (administrative waiver region)
- Location of incident (e.g., residential home, own home with family, day program site, community location)
- Age of the individual involved
- Sex of the individual involved
- Race or ethnicity of the individual involved
- Type of disability
- Type of incident (use a standardized list with definitions)
- Level of harm or injury to the individual: (i) none, (ii) injury or harm requiring treatment up to and including first aid, (iii) injury or harm requiring medical treatment beyond first aid, injury or harm requiring hospitalization, and (iv) injury or harm resulting in death
- Narrative description of the incident (fairly detailed narrative description of up to 150 words)
- Service provider or service provider's Incident Management Review Committee investigative findings and recommendations
- Incident referred for State investigation (yes/no)
- Date of the State Incident Management Review (if applicable)
- Findings and recommendation of the State Incident Management Review Committee (narrative field of up to 150 words) (if applicable)
- Date of State investigation (if applicable)

- State investigation substantiated physical abuse (yes/no)
- State investigation substantiated neglect (yes/no)
- State investigation substantiated sexual abuse (yes/no)
- State investigation substantiated exploitation (yes/no)
- State investigation substantiated psychological or verbal abuse, or both (yes/no)
- State investigation substantiated other form of staff misconduct not associated with abuse, neglect, or exploitation (yes/no)
- Incident is identified in trending analysis (yes/no)
- Narrative description of State investigation findings, recommendations, and corrective actions (narrative field of up to 150 words) (if applicable)
- Narrative fields that track recommendation implementation and corrective action relevant to State Incident Management Review Committee and State investigation recommendations and corrective actions (optional)

APPENDIX B

Model Practices for Incident Management Audits

This appendix sets forth the Model Practices for Incident Management Audits. As detailed below, effective incident management auditing involves processes to assess timely and appropriate incident reporting, investigation, and response and for implementation of timely and appropriate corrective actions to minimize reoccurrence.

- I. Major Components
- II. Audit Expectations
- III. Audit Performance Measures
 - A. Incident Reporting and External Notifications
 - B. Individual Incident Review
 - C. Incident Investigations
 - D. Implementation and Effectiveness of Corrective Actions
 - E. Systemic Incident Review for Trends and Patterns
- IV. Incident Documentation Audits
 - A. Audit Sample
 - B. Audit Reporting, Compliance Scoring, and Corrective Actions
 - C. Audit Methods
- V. Medicaid Data Correlation Audits
 - A. Sample Requirements
 - B. Audit Reporting, Compliance Scoring, and Corrective Actions
 - C. Audit Methods

I. Major Components

The Incident Management Audit process has two components designed to assess, each from different perspectives, the basic expectations and performance measures of a State's Incident Management and Investigation activities.

- A. The Incident Documentation Audit is an audit of a sample of incident reports, incident investigations, and other documents (i.e., protection and advocacy complaint data) and documentation associated with incidents for all service recipients in currently approved and operational CMS-funded community programs. The Incident Documentation Audit can be conducted at the Federal or State levels as part of waiver applications or renewals. In response to complaints or other concerns, CMS or States can conduct selected elements of an Incident Documentation Audit. This type of audit focuses on the State's actions to incidents that were reported.
- B. The Medicaid Data Correlation Audit is an audit of Medicaid service claim data to determine if (as appropriate) incident reports were filed, incident investigations and reviews were conducted, and appropriate corrective actions were recommended and implemented in a timely manner in response to serious

incidents requiring health care services at a hospital emergency room or in other areas of the hospital. This audit evaluates whether serious incidents associated with hospital emergency room visits and unplanned hospitalizations were reported.

II. Audit Expectations

Incident Management Audits address five major expectations of a State's Incident Management and Investigation activities:

1. Accountable incident reporting and external notifications of serious incidents
2. Timely and appropriate response and review of individual incidents
3. Timely, comprehensive, and nonpartial investigations of individual incidents
4. Timely implementation of appropriate corrective actions in response to individual incidents
5. Informative systemic review of incidents to identify, address, and respond to trends and patterns in incidents

III. Audit Performance Measures

A. ACCOUNTABLE INCIDENT REPORTING AND EXTERNAL NOTIFICATIONS OF SERIOUS INCIDENTS

1. Documentation shows that service providers and support coordination agencies have an appropriate understanding of what events and situations should be reported as incidents.
2. Incident reports for incidents resulting in significant injuries are filed as soon as possible, but in all cases within 24 hours.
3. Incident reports provide a clear, complete, and legible description of the incidents.
4. Incident reports (or associated documentation) provide a description of the provider's immediate response to the incidents.
5. The documented providers' immediate responses to incidents ensure service recipients' safety and well-being.
6. Incident reports (or associated documentation) show that law enforcement was notified of incidents that may be associated with possible criminal acts as soon as possible.

7. Incident reports (or associated documentation) show that in accordance with State rules and regulations other external parties (including but not limited to family, conservators, guardians, the State's Medicaid agency, and the State's protection and advocacy entity) or other appropriate parties were notified of incidents in a timely manner.
8. Documentation shows that the State identifies and imposes appropriate sanctions against service providers, support coordination agencies, and others that are identified as having a pattern of *not* complying with the above performance measures related to incident reporting and notifications.

B. INDIVIDUAL INCIDENT REVIEW

1. Incident reports (or associated documentation) show that providers ensure a timely review of all incidents by senior management or the provider's Incident Management Committee or both.
2. The meeting minutes from a service provider's Incident Management Committee show that the committee reviews all incidents in accordance with CMS expectations as described in the State's approved HCBS waiver application and the State's regulatory and policy requirements.
3. The meeting minutes from a service provider's Incident Management Committee show that the committee meets as frequently as needed to ensure the timely review of incidents.
4. The meeting minutes from a service provider's Incident Management Committee show that the Committee is composed of appropriate members consistent with CMS expectations as described in the State's approved HCBS waiver application and the State's regulatory and policy requirements.
5. The meeting minutes from a service provider's Incident Management Committee show that the committee thoroughly reviews incidents and associated investigations such that the committee:
 - i. identifies the facts surrounding incidents as well as the contributing factors associated with incidents;
 - ii. reviews incident investigation reports and discusses their findings and recommendations;
 - iii. considers additionally needed corrective actions and remedies to prevent or reduce the likelihood of future similar incidents;
 - iv. explicitly accepts or rejects the recommended corrective actions in investigations; and

- v. tracks accepted recommended corrective actions to ensure that they are carried out in a timely manner.
6. The meeting minutes from a service provider's Incident Management Committee provide a listing of all incidents reviewed and an adequate summary of the committee's findings and recommendations and other activities of the committee.
 7. Documentation shows that the State identifies and imposes appropriate sanctions against service providers that are identified as having a pattern of *not* complying with the above performance measures related to incident reviews and Incident Management Committees.

C. INCIDENT INVESTIGATIONS

1. Documentation indicates that independent investigations are ensured for all incidents associated with unexpected deaths; allegations of physical, emotional, and sexual abuse; allegations of neglect; allegations of financial exploitation (> \$250); and other serious incidents as required by State rules and regulations.
2. Documentation indicates that investigations are completed within 30 days of the date the incident report was filed, except in instances when supplemental documentation indicates a justifiable rationale for the delay in the completion of the investigation.

Examples of a justifiable rationale include delays because of an ongoing law enforcement investigation or the unavailability of an important witness because of serious illness or injury.

3. Documentation indicates that investigations are conducted by investigators who have completed a certified investigator training program approved by CMS as described in the State's approved HCBS waiver application, the State, or both.
4. Documentation indicates that investigations include basic required investigative activities, including:
 - i. a review of the person-centered service plan of the service recipient and other reported incidents in the past year;
 - ii. a review of the circumstances leading up to and following the incident;
 - iii. interviews with all witnesses to the incident (employees, service recipients, and other individuals in the community);

- iv. interviews with family members or guardians of the service recipient (with the consent of the service recipient or his or her legal guardian or legal representative if the recipient is unable to provide consent)
 - v. interviews with other relevant parties, including provider agency supervisory, management, and health care personnel and the assigned support coordinator for the service recipient;
 - vi. reviews of relevant documents and medical records maintained by the service provider, support coordinator, protection and advocacy entities, or external health care entities, including hospitals and outpatient medical providers; and
 - vii. reviews of law enforcement reports, death certificates, and autopsy reports (as available).
5. Investigation reports are prepared using a standard format complying with any standards established by CMS that ensures discrete narratives related to (i) a listing of the investigative activities, (ii) findings and observations associated with all completed investigative activities, and (iii) the investigation's conclusions and recommendations.
 6. Investigation reports indicate that investigators have access to and review death certificates, autopsy reports, and medical and hospital records pertinent to incidents being investigated.
 7. Investigation reports indicate that autopsies are requested and conducted for deaths where abuse or neglect is suspected or alleged and other deaths caused by suspected provider or support coordinator misconduct.
 8. Appropriate summaries of investigation findings, conclusions, and recommendations for corrective action are prepared and made available to:
 - i. relevant service provider personnel, including employees directly associated with the incident;
 - ii. the service recipient's support coordinator and support coordination agency;
 - iii. the service recipient and his or her family and friends (with the consent of the service recipient or his or her legal guardian or legal representative if the service recipient is unable to provide consent); and
 - iv. the State protection and advocacy entity.

9. Documentation indicates that the service recipient or their legal guardian or legal representative have had the opportunity to review the investigation findings, conclusions, and recommendations and have had the opportunity to respond to any investigation findings through a predetermined grievance process under the State HCBS waiver authority.
10. Documentation indicates that the State identifies and imposes appropriate sanctions against service providers that are identified as having a pattern of *not* complying with the above performance measures related to incident investigations.

D. IMPLEMENTATION AND EFFECTIVENESS OF CORRECTIVE ACTIONS

1. Documentation indicates that service providers, support coordination agencies, and other pertinent individuals or entities take timely and effective actions to implement recommendations for corrective actions related to individual incidents.

Timely is defined as “as soon as possible” and within 30 days in all cases except where a written reasonable justification for the delayed implementation is available.
2. Documentation indicates that the State maintains an accountable tracking system to monitor the implementation of recommendations for corrective actions emanating from incident reviews and investigations.
3. Documentation indicates that the State ensures appropriate methods to verify (on a sample basis) that the recommendations for corrective actions from the reports of service providers, support coordination agencies, and others were in fact implemented.
4. Documentation indicates that the State identifies and imposes appropriate sanctions against service providers, support coordination agencies, and others that are identified as having a pattern of *not* responding to recommended corrective actions in a timely and effective manner.

E. SYSTEMIC INCIDENT REVIEW FOR TRENDS AND PATTERNS

1. Meeting minutes from a service provider’s Incident Management Committee or other documentation and reports indicate that the service provider periodically, at least annually, reviews incident data, including investigative findings and recommended corrective actions. The review is to identify trends and patterns in filed incidents as well as noncompliance issues related to the State’s regulatory and policy requirements for incident management.

2. Meeting minutes from a service provider’s Incident Management Committee or other documentation and reports indicate that identified trends and patterns (as referenced above) are addressed in a timely and appropriate manner.
3. Meeting minutes from a service provider’s Incident Management Committee or other service provider documentation and reports indicate that the service provider periodically evaluates actions taken in response to identified trends and patterns to ensure that they have been effective in addressing identified problems and concerns.
4. State documentation or reports indicate that the State regularly reviews trend and pattern analyses reports prepared by service providers and takes appropriate actions to respond to issues and concerns affecting the health and welfare of service recipients.
5. State documentation or reports indicate that the State periodically conducts state-wide incident studies to identify trends and patterns in reported incidents and investigation findings and that it takes appropriate actions to respond to identified issues and concerns affecting the health and welfare of service recipients.

IV. Incident Documentation Audits

A. AUDIT SAMPLE

1. The Incident Documentation Audit is based on the review of a sample of incident reports filed in the first quarter of the 12-month period before the date of the State’s submittal of a new waiver application or a renewal waiver application.⁸ These samples include:
 - i. all unexpected deaths;
 - ii. all allegations of physical or sexual abuse;
 - iii. all allegations of financial exploitation for amounts greater than \$250;
 - iv. a statistically significant random sample of allegations of neglect;
 - v. a statistically significant random sample of other “serious” incidents (not included above); and

⁸ Multiple Incident Documentation Audits are not necessary for States that submit multiple new waiver applications or waiver renewal applications within a 3-year period.

- vi. a statistically significant random sample of “nonserious” incidents.

B. AUDIT REPORTING, COMPLIANCE SCORING, AND CORRECTIVE ACTIONS

1. States should report to CMS Incident Documentation Audit findings in aggregate across all of the above samples as well as separately for each of the above samples.
2. States should also report their Incident Documentation Audit findings by Medicaid regional administration units. Additionally, as applicable, findings should identify service providers that demonstrate an increase in incidences or a pattern of noncompliance with incident reporting and other expectations of Incident Management Programs.
3. States should report their Incident Documentation Audit findings to CMS at least 90 days before the date it submits its new or renewal waiver application.
4. Findings reports should be presented to CMS to provide discrete compliance scores for each of the performance measures of Incident Management processes detailed above.
5. For all performance measures (detailed above), an 86-percent compliance score is expected. States should develop and implement plans of correction for all performance measure scores of less than 86 percent before CMS’s approval of new or renewal waiver applications.
6. Failure to implement appropriate corrective actions for substandard compliance scores may result in CMS sanctions, including but not limited to adverse decisions on new or renewal waiver applications.
7. At its discretion, CMS may impose immediate sanctions against States whose Incident Documentation Audits result in poor compliance scores or selected negative results that indicate that its waiver service recipients may be at risk of imminent harm.

C. AUDIT METHODS

1. States should rely on their electronic Incident and Investigation Database to select the required audit samples.⁹ The sample selection methods will be explicitly presented in reports of the audit findings.

⁹ The audit protocol assumes that all States have an electronic Incident Database.

2. Once incident samples are selected, the State (with the assistance of service providers and support coordinators) will gather required documents and documentation for the audit.

Such documents and documentation should include:

- i. reports of the incidents and any associated investigations;
 - ii. copies of any associated daily service notes or other documentation associated with the incident report;
 - iii. any meeting minutes from service providers' Incident Management Committees that are associated with the sample incidents;
 - iv. other documentation maintained by service providers associated with the sample incidents, including their responses, reviews, and corrective actions;
 - v. documentation and reports of service providers associated with the sample incidents related to their periodic reviews of incidents and investigations to identify trends and patterns;
 - vi. documentation of the State verifying its ongoing review of service providers' reports related to the providers' reported trends and patterns in incidents and investigations; and
 - vii. State documentation and reports associated with its periodic reviews of incidents state-wide to identify trends and patterns.
3. This documentation should be sorted and reviewed in accordance with the performance measures listed earlier, and findings should be documented on a standardized audit tool developed and approved by CMS as described in the State's approved HCBS waiver application.
 4. In addition to the above documentation, States should collect and review any documentation associated with its ongoing monitoring of the compliance of service providers and support coordination agencies with the major expectations and performance measures for Incident Management processes.

Such documentation should include sanctions taken against service providers and support coordination agencies that demonstrate patterns of noncompliance.
 5. To ensure the integrity of Medicaid Data Correlation Audits, CMS and States should maintain copies (paper or electronic) of all documentation collected and audit tools for at least 5 years.

6. States should ensure that the audit team is composed of professionals knowledgeable about incident management systems and their expectations and performance measures. These professionals should also be independent of State personnel charged with the direct implementation or management of the State's Incident Management processes.¹⁰

In concert with the above requirements, States should maintain current curriculum vitae of all professionals on their audit teams.

7. To preserve nonbiased audit findings and conclusions, States should ensure the explicit tracking of any alterations or substantive edits of draft reports of Incident Documentation Audits.
8. To ensure the timeliness and the relevance of their findings and conclusions, Incident Documentation Audits should be completed within 90 days of their initiation.

V. Medicaid Data Correlation Audits

A. SAMPLE REQUIREMENTS

1. Medicaid Data Correlation Audits should rely on samples of Medicaid service data related to waiver recipients.

The audit team should review these data to identify service reports that would appear to have warranted the filing of an incident report.

2. Medicaid Data Correlation Audits may be directed by CMS or States (either voluntarily or as required by CMS).
3. Medicaid Data Correlation Audits should focus on waiver service recipients whose care and supports are largely the responsibility of paid service providers, not family members or friends. These recipients should include:
 - i. individuals in residential services,
 - ii. individuals who receive in-home paid staff supports at least 40 hours a week, and
 - iii. individuals who receive day services at least 20 hours a week.¹¹

¹⁰ States may at their discretion contract out Incident Documentation Audits to independent consultants or consultant organizations that meet the above-listed requirements.

¹¹ This restriction is included because States do not usually require the reporting of incidents involving service recipients while in the care of family or friends.

4. Medicaid services data to be screened should include services associated with:
 - i. Allegations of abuse, neglect and/or exploitation;
 - ii. hospital emergency room visits;
 - iii. unplanned hospitalizations;
 - iv. ambulance services; and
 - v. urgent care center visits caused by accidental injuries.¹²
5. The time period for the data collected may vary based on the size of the applicable waiver service recipient sample population, but at a minimum it should include Medicaid services data for at least one quarter of a calendar year.

B. AUDIT REPORTING, COMPLIANCE SCORING, AND CORRECTIVE ACTIONS

1. Findings of Medicaid Data Correlation Audits should include state-wide findings as well as findings by Medicaid regional administration units (within the State).

Additionally, as applicable, findings should identify service providers that demonstrate a pattern of noncompliance with incident reporting and other expectations of Incident Management processes.
2. Finding reports should provide discrete compliance scores for each of the performance measures of Incident Management processes detailed above.
3. For all performance measures, CMS should establish an 86-percent compliance score. CMS should require States to develop and implement plans of correction for all performance measure scores of less than 86 percent before CMS approves any new or renewal waiver applications.
4. Failure to implement appropriate corrective actions for substandard compliance scores may result in CMS sanctions, including but not limited to adverse decisions on new or renewal waiver applications.
5. At its discretion, CMS may impose immediate sanctions against States whose Medicaid Data Correlation Audits result in poor compliance scores

¹² CMS may also wish to include service reports for individual waiver service recipients who have exceptionally high State Medicaid billings, exclusive of billings for State plan nursing, health aide, and clinical therapy or behavior support services.

or selected negative results that indicate that its waiver service recipients may be at risk of imminent harm.

C. AUDIT METHODS¹³

1. CMS and States should rely on States' state-wide Medicaid databases to draw the samples of Medicaid services data. The sample selection methods should be explicitly presented in the report of the audit findings.
2. Once the Medicaid services data are retrieved, CMS or the States should organize the data by service recipient and check the state-wide Incident and Investigation Database to determine which services have a corresponding incident report.
3. *For services data that have a corresponding incident report*, CMS or the States *should* request the provider agencies filing the report to submit documentation related to the incident and the provider(s)'s response to the incident.

Such documentation should include:

- i. a copy of the incident report and any associated investigations;
 - ii. a copy of any associated daily service notes or other documentation (including internal provider staff shift communication notes) associated with the incident/Medicaid service report;
 - iii. meeting minutes from service providers' Incident Management Review Committee that are associated with the sample incidents;
 - iv. other documentation maintained by service providers associated with the sample incidents, including the providers' responses, reviews, and any corrective actions; and
 - v. documentation and reports of service providers associated with the sample incidents related to the providers' periodic reviews of incidents and investigations to identify trends and patterns.
4. This documentation should be sorted and reviewed in accordance with the above-stated performance measures. The findings should be documented on a standardized audit tool developed and approved by CMS.
 5. *For services data that do not have a corresponding incident report*, CMS or the States should request explanations for the lack of a report from the

¹³ As referenced above, CMS may itself conduct Medicaid Data Correlation Audits. Alternately, States may conduct their own Medicaid Data Correlation Audits, either voluntarily or as required by CMS.

State, provider agencies, or service providers, as well as any other available documentation indicating that the incident received an appropriate response.

6. To assure the integrity of Medicaid Data Correlation Audits, CMS and the States should maintain copies of all documentation collected and audit tools for at least 3 years.
7. CMS or the States should ensure that the audit team is composed of professionals knowledgeable about incident management systems and their expectations and performance measures.
8. When States conduct their own Medicaid Data Correlation Audits, States should ensure that members of the audit team are independent of State personnel charged with the direct implementation or management of the State's Incident Management processes.¹⁴

In concert with the above requirements, States should be required to maintain current curriculum vitae of all professionals on the audit teams.

9. In addition, if States are conducting their own Medicaid Data Correlation Audits to preserve the nonbiased audit findings and conclusions, States should ensure the explicit tracking of any alterations or substantive edits of initially prepared draft reports of Incident Documentation Audits.
10. To ensure the timeliness and relevance of their findings and conclusions, Medicaid Data Correlation Audits should be completed and made publicly available within 120 days of their initiation.

¹⁴ States may at their discretion contract out Incident Documentation Audits to independent consultants or consultant organizations that meet the above-listed requirements.

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APPENDIX C

Model Practices for State Mortality Reviews

This appendix sets forth the Model Practices for State Mortality Reviews. As detailed below, effective mortality reviews involve timely reporting of all beneficiary deaths, including identification of the cause of death and the circumstances contributing to or associated with the death.

- I. Intended Outcomes of State Mortality Reviews
- II. Essential Participants and Activities for State Mortality Reviews
- III. The State Mortality Review Database

I. Intended Outcomes of State Mortality Reviews

- A. Accountable and timely reporting of all service recipient deaths
- B. Identification of the causes of deaths
- C. Identification of the immediate and longer term (up to 12 months before the death) circumstances and events that contributed to or were associated with deaths
- D. Identification of corrective actions that may eliminate or lessen the likelihood of circumstances and events that contribute to or are associated with the causes related to specific deaths
- E. Identification of trends and patterns in deaths that indicate needed systemic changes or reforms in community-based services that may reduce the risk of death and other adverse outcomes for service recipients
- F. Appropriate and timely implementation of identified corrective actions and systemic changes and reforms to reduce the risk of death and other adverse outcomes for service recipients
- G. Ongoing evaluation to ensure that implemented corrective actions and systemic changes or reforms have been effective in reducing the risk of death and other adverse outcomes for service recipients
- H. Periodic public reporting on the number, causes, and circumstances of deaths to ensure public transparency regarding the health, welfare, and safety of beneficiaries of community-based services

II. Essential Participants and Activities for State Mortality Reviews

- A. State Mortality Review processes should ensure the accountable and timely reporting of deaths, including checks on service provider and support coordination agencies' death reporting practices.

Service provider and support coordination agencies identified as having a pattern of delayed or failed death reporting or of filing reports that are misleading or incomplete should be subject to State sanctions, including fines, suspension of permission to enroll new participants, waiver contract termination, and decertification.

- B. State Mortality Review processes should ensure a preliminary review of the cause and circumstances of *all* reported deaths and identify the deaths warranting further State investigation and review. Such preliminary death reviews should be completed within 1 week of the date the death was reported.

As necessary, preliminary death reviews will include followup contact with the service provider(s) and support coordinator for additional information. Generally, preliminary death reviews will often occur before the State's receipt of the death certificate. Preliminary death reviews should not be officially closed until the death certificate has been received and reviewed.¹⁵

- C. State Mortality Review processes should ensure State investigations of deaths that are determined upon preliminary review to be unusual, suspicious, sudden and unexpected, or apparently preventable, including all deaths alleged or suspected to be associated with neglect, abuse, or criminal acts.

State death investigators should have a professional medical background (e.g., registered nurse, certified nurse practitioner, physician assistant, and physician) and have completed a nationally certified training program for conducting critical incident (including death) investigations.

- D. State Mortality Review processes should include a State Mortality Review Committee that has responsibility for comprehensive review of deaths identified as being unexpected, sudden and unusual or unnatural, caused by suspicious circumstances, associated with suspected or alleged provider misconduct or abuse or neglect, or any combination of these.

- E. State Mortality Review processes should ensure that their comprehensive death reviews include the review of relevant records and documents associated with the death, including:

¹⁵ Death certificates are often not available from State health departments until 90 days after the death, and autopsy reports are often not available until 120 to 180 days after the death.

1. service provider and support coordinator documentation, including (a) the person-centered service plan for the individual who is deceased, (b) notes related to service delivery (by both waiver and nonwaiver providers), and (c) any other service provider or State reviews or investigations of the death;
 2. incident reports related to the deceased in the 6 to 12 months before death;
 3. death certificates;
 4. autopsy and medical examiner or coroner reports;
 5. emergency medical personnel reports and documentation;
 6. medical records including physicians, specialists, hospital, and emergency room records related to the individual who is deceased in the 6 to 12 months before death;
 7. records and documentation of medical professionals who treated the individual who is deceased within 6 months of his or her death; and
 8. as available, any State or other agency investigation of the death.
- F. State Mortality Review processes should include working with other State and local authorities to establish protocols and procedures (including guardian or family caregiver consent) to ensure that the above-listed documents are made available in a timely manner.¹⁶
- G. State Mortality Review processes should ensure that autopsies are requested and performed for all deaths deemed to be unusual or suspicious or without a known cause of death, including all deaths whose circumstances suggest possible neglect, abuse, or criminal conduct.¹⁷
- H. State Mortality Review processes should ensure that State Mortality Review Committees establish appropriate procedures and practices to ensure that:

¹⁶ It is typically neither effective nor efficient to require service providers and support coordination agencies to gather death certificates, autopsies, and other medical records essential for the completion of comprehensive death reviews, as most often State officials have (or can obtain more readily) authorization to obtain these documents.

¹⁷ Uniformly ensuring autopsies as referenced above is frequently challenging. Families often do not wish to have autopsies performed. Medical examiners and coroners often refuse to perform autopsies of “natural” deaths regardless of the circumstances or the lack of a clear cause of death. And autopsies are costly and most States do not have a mechanism for reimbursing localities for these costs. Thus, State Mortality Review processes should make extra efforts in working with other State and local authorities to promote the conduct of autopsies of deaths that meet the above criteria.

1. the committee's membership includes an interdisciplinary group of medically credentialed and other professionals (including providers and advocates) who are knowledgeable of community-based services;
 2. the committee relies on explicit criteria to identify deaths that should be afforded comprehensive reviews by the committee;
 3. the committee meets sufficiently frequently to guarantee the timely and comprehensive reviews of all required deaths; and
 4. the committee members have timely access to all necessary documents and reports to assure comprehensive review of all required deaths.
- I. State Mortality Review processes should track service provider and support coordination agencies' implementation of recommendations for corrective actions emanating from the State's Mortality Review Committee.

Although such tracking systems may rely primarily on service provider and support coordination agencies' written reports of corrective actions taken, State Mortality Review processes should also require periodic onsite reviews to ensure that reported corrective actions have been appropriately implemented.

- J. State Mortality Review processes should ensure that appropriate actions (including fines, suspension of permission to enroll new participants, and waiver contract termination and decertification) are imposed against service providers and support coordination agencies found to have patterns of delayed or failed implementation recommendations issued by the State Mortality Review Committee.
- K. State Mortality Review processes should periodically, but at least biennially, evaluate the effectiveness of implemented recommendations for corrective actions to reduce the death rate (total, by cause, by provider) or to achieve other positive outcomes for service recipients or the service system (e.g., reduced emergency room visits, hospitalizations, and critical incidents).
- L. State Mortality Review processes should periodically, but at least biennially, do a trend analysis of deaths and issue any systemic interventions to ameliorate the conditions that resulted in the trend.
- M. State Mortality Review processes should provide at least biennial public reporting on the number, causes, and circumstances of deaths of individuals receiving community-based services, including the trends and patterns identified by the State Mortality Review process.

III. The State Mortality Review Database

- A. State Mortality Review processes should establish a State Mortality Review Database that, at a minimum, includes the following data elements:

1. name, age, race or ethnicity, disability type, and sex of the individual who is deceased;
2. community-based (waiver) services received by the deceased individual and the name(s) of the service provider(s);
3. narrative of the events leading up to the individual's death and the immediate circumstances of the death;
4. location of the death (e.g., individual's home, established day program, community setting, hospital emergency room, hospital, and hospice facility);
5. immediate and secondary causes of death;
6. if the death was . . .
 - i. expected due to a known terminal illness;
 - ii. associated with a known chronic illness;
 - iii. a sudden, unexpected death;
 - iv. due to unknown cause
 - v. due to an accident and, if so, the type of accident;
 - vi. due to self-inflicted injury or illness (e.g., suicide, serious self-injurious behavior);
 - vii. due to suspicious or unusual circumstances; and
 - viii. due to suspected or alleged neglect, abuse, or criminal activity.
7. whether an autopsy was conducted and, if so, a narrative of its findings;
8. findings of the *preliminary* reviews of all deaths by the State Mortality Review process;
9. findings and recommended corrective actions of the *comprehensive* death reviews by the State Mortality Review Committee of selected deaths as defined above; and
10. tracking information related to the implementation of recommended corrective actions issued by the State Mortality Review Committee.

B. State Mortality Review processes should make use of the State Mortality Review Database to identify trends and patterns in:

1. the demographics of the deceased individuals, their community (waiver) services, and their providers;
2. causes of death;
3. total death rates and death rates by cause of death, geographic region, and service provider per total number of service recipients with the same demographics;
4. a comparison of death rates with national mortality statistics and available mortality statistics for comparable community-based services in other States;
5. circumstances of death;
6. findings and recommendations of the State Mortality Review Committee; and
7. the appropriate implementation of recommendations issued by State Mortality Review Committees by service providers, support coordination agencies, and the State (as applicable).

APPENDIX D

Model Practices for State Quality Assurance

This appendix sets forth the Model Practices for State Quality Assurance. As detailed below, comprehensive quality assurance of community-based services includes the incident management, audit, and mortality review components discussed above and certain other elements of quality assurance.

- I. Essential Components of State Community-Based Services Quality Assurance
 - II. Quality Assurance Participants
 - III. Basic Operational Tasks of Quality Assurance
 - IV. Surveillance Capacities
- I. Essential Components of State Community-Based Services Quality Assurance
 - A. A critical incident management and investigation process
 1. Is ongoing
 - B. Mortality reviews
 1. Are ongoing
 2. Are conducted by State committees or external contractors
 - C. Oversight of individualized service planning and delivery
 1. Emphasizes person-centered planning
 2. Emphasizes individualized and relevant goals
 3. Emphasizes appropriate service recommendations
 4. Emphasizes practical action steps or interventions
 5. Includes random onsite service recipient audits annually that cover either 10 percent of waiver enrollees or a statistically significant sample (whichever is larger) of waiver enrollees
 - D. Identification and timely intervention for high-risk service recipients
 1. Includes ongoing clinical crisis management and prevention services
 - E. Assessment of community inclusion outcomes for service recipients
 1. Periodic onsite audits of community day services and employment services

F. Initial certification reviews of all new service providers and support coordination agencies

1. Mandated initial reviews that must be passed before the start of waiver service delivery

G. Assessment of service provider and support coordination agency performance

1. Are consistent with regulatory and professional standards
2. Are periodic, at least biennial, audits of providers of:
 - i. residential services,
 - ii. day services,
 - iii. employment, and
 - iv. personal care, nursing, behavioral support, and support coordination¹⁸

H. Audits of workforce safeguard assurances by providers

1. Include assessments of pre-employment screening and background checks
2. Include assessments of staff training
3. Include assessments of performance evaluation
4. Are periodic, at least biennial, audits of providers of:
 - i. residential services,
 - ii. day services,
 - iii. employment, and
 - iv. personal care, nursing, behavioral support, and support coordination¹⁹

I. Reviews of a provider's network adequacy in terms of capacity, stability, and service accessibility

1. Are annual State assessments, including service gap analyses

¹⁸ Some States allow providers and support coordination agencies that have least 2 years of operation within the waiver program and strong performance records to conduct these audits triannually.

¹⁹ Workforce safeguard audits may be incorporated in service provider and support coordination audits. They are listed separately because it is often more efficient to conduct these audits with teams of specialized auditors.

- 2. Have stakeholder participation
- J. Assessment of the fiscal integrity of service billing and reimbursement
 - 1. Includes ongoing State desk audits
 - 2. Includes periodic onsite audits of select service providers and support coordination agencies
- K. Compliance monitoring related to Federal fiscal and programmatic requirements
 - 1. Includes State desk audits of mandated reporting by service providers and support coordination agencies,
 - 2. Includes ongoing onsite audits of select service providers and support coordination agencies
- L. Reports or reviews issued by any local or State protection and advocacy entity related to complaints about abuse and neglect of individuals residing in group homes

II. Quality Assurance Participants

- A. Service recipients, family members, friends, legal conservators, or guardians
- B. Advocates
- C. Protection and advocacy entities
- D. State Councils on Developmental Disabilities
- E. University Centers for Excellence in Developmental Disabilities
- F. Service providers
- G. Case Management or Support coordination providers
- H. State government administrators of the Community-Based Service System
- I. Federal Government administrators of the Community-Based Service System
- J. Typically these participants work together in developing and implementing a State's quality assurance process, but each participant group also has certain primary roles in the process:
 - 1. Service recipients, families, and friends offer primary data regarding their personal experiences and satisfaction with the Community-Based Service System. They may also provide information to other participants in the quality assurance process in structuring and evaluating their quality

assurance activities. They also give information to the State through the grievance and appeal process and satisfaction surveys of how the Community-Based Service System affects the individual (e.g., adequacy of provider network, availability of services, choice of provider and services).

2. Advocates, including Disability Rights organizations, local or state-wide advocacy groups, protection and advocacy entities, State councils on developmental disabilities, and consumer advocacy associations, offer independent advice related to their views of emerging and ongoing quality assurance issues in the Community-Based Service System.
3. Universities, including University Centers for Excellence in Developmental Disabilities, can be a source for training and technical assistance to providers that will increase their capacity. Universities can also serve as a resource for establishing incident reporting systems and for establishing processes for analyzing information to identify trends.
4. Service providers and support coordination providers have an obligation to institute internal quality assurance auditing activities to evaluate their performance (including service recipient and family satisfaction) relative to regulatory and professional standards.

Robust and accountable internal quality assurance auditing programs developed and implemented by providers are the critical and often undervalued foundation of an accountable and effective quality assurance process for State's Community-Based Service System.

5. State government administrators have the overall quality assurance oversight obligation for:
 - i. service recipient health, well-being, and safety and
 - ii. the service system's performance in meeting Federal and State regulatory requirements and complying with professional standards for services.

Inherent in these responsibilities is the States' obligations to:

- i. attend to the satisfaction of service recipients, families, and friends with the service system and
- ii. ensure that service providers and support coordination agencies design and implement accountable and responsive internal quality assurance processes.

The State Medicaid agency is ultimately responsible for administration of the waiver, including oversight of the performance of waiver functions by

other State and local or regional non-State agencies and contracted entities. State government administrators should ensure that their own quality assurance auditing activities provide a reliable and valid evaluation of the performance of its Community-Based Service System consistent with Federal and State regulatory requirements and professional standards. These State-directed quality assurance auditing activities also provide a validation check for providers' internal quality assurance audit processes.

State-directed quality assurance activities typically include:

- i. initial and recurring licensing or certification evaluations of providers;
- ii. service recipient satisfaction surveys;
- iii. critical incident monitoring and investigations;
- iv. mortality reviews;
- v. overall assessments of the adequacy, accessibility, and nondiscrimination of the service provider and support coordination agency networks; and
- vi. certain administrative audits to ensure that the Community-Based Service System is compliant with State and Federal programmatic and fiscal requirements.

State-directed quality assurance audits and assessments also include assurance related to fundamental principles and values of community-based services waiver programs, including nondiscrimination, community inclusion, individualization of service planning, respect for the rights of individuals with disabilities to make their own decisions, and risk management. These assessments are often incorporated in ongoing, person-centered service assessments and service providers' and support coordinators' service delivery, consistent with the requirements of the State's approved waiver.

In addition, State quality assurance activities should include the capacity to identify and respond to trends in providers' internal quality assurance audits, as well as its own State-directed audits. Responding to these trends allows States to ensure timely corrective actions and, where necessary, regulatory reforms to respond to weaknesses in the Community-Based Service Systems before problems become more serious.

6. The Federal Government's role in quality assurance for States' Community-Based Service Systems depends substantially on data and reports of the States' own quality assurance activities.

Specifically, the Federal Government first and foremost should ensure that States' quality assurance processes, including mandates for provider-directed internal quality assurance procedures, operate effectively and efficiently to identify concerns and ensure needed remedial actions in response to their observations and conclusions.

Additionally, the Federal Government should have the capacity to undertake independent quality assurance investigations and audits in response to State quality assurance reports, citizen complaints, and concerns that may surface in Medicaid and Medicare data.

The Federal Government also has the unique capacity to identify and respond to trends in the quality assurance data among States and to use these observations to affect ongoing needed quality improvements in the Federal regulatory framework for State Community-Based Service Systems.

III. Basic Operational Tasks of Quality Assurance

- A. Quality assurance processes, whether in industry, education, or health care, have eight basic operational tasks:
1. data collection,
 2. data analysis,
 3. evaluating the effectiveness of the overall systems,
 4. determining findings and conclusions,
 5. identifying trends that need to be addressed,
 6. identifying corrective actions or remedies (as needed),
 7. implementing corrective actions or remedies, and
 8. evaluating the effectiveness of implemented corrective actions or remedies.
- B. Historically, State quality assurance processes for their Community-Based Services System have invested most of their time and resources on Task 1, data collection. Less time and fewer resources have been spent on Task 2, data review and analysis, and still less time on Task 4, determining findings and conclusions.

States may find they need to allocate more resources to Tasks 5 through 8, the identification, implementation, and evaluation of needed corrective actions that are essential to ensuring positive outcomes of their quality assurance efforts.

- C. This allocation of resources is inevitable in view of the disproportionate resources required to collect and analyze quality assurance data relative to other tasks. However, it is critical that the model for States' Community-Based Services Systems ensures that States allocate sufficient time and resources to ensuring the success of the State's quality system and addressing any intended corrective action outcomes of these programs. Without this allocation, quality assurance systems may generate impressive "processes" and reports but minimal positive outcomes.

Thus, the model should ensure that, for each component of the quality assurance process, States develop effective and practical action steps that address all eight tasks with sufficient attention to checks and balances on appropriate and effective corrective action outcomes.

IV. Surveillance Capacities

Surveillance capacities refer to a quality assurance program's "action" capabilities to ensure that it is able to collect reliable and valid data related to the quality assessments undertaken.

- A. State quality assurance processes rely on a number of different surveillance capacities that can be generally categorized in five types:
1. external reporting by service recipients, peers, families and friends, service providers and support coordinators (voluntary and mandatory), and protection and advocacy entities;
 2. desk/paper audits of service planning and service provision documentation;
 3. onsite data collection activities, including routine reviews, inspections, and investigations of service locations, service recipients, and allegations of abuse and neglect or other misconduct;
 4. reviews of provider and support coordinator reporting related to mandated reporting and service provision; and
 5. State-directed systemic reviews of the service system (often done to assess the overall provider network's stability, accessibility, and fiscal integrity of service billing and reimbursement).
- B. Specific data collection activities of quality assurance processes related to these surveillance capacities include (among others):
1. service recipient, peer, family, and friend reporting of concerns and complaints (e.g., informal and formal complaint and grievance systems);
 2. satisfaction surveys of service recipients and family and friends;

3. mandated reporting of critical incidents, deaths, and abuse and neglect;
 4. mandated provider reporting on the status of high-risk service recipients;
 5. mandated provider reporting of weather, fire, and other emergency situations; infection control concerns; involvement of law enforcement; disenrollment of service recipients; and others; and
 6. desk audits of service provider and support coordinator documentation, including:
 - i. person-centered service plans (PCSPs),
 - ii. service billings,
 - iii. internal quality assurance audit findings, and
 - iv. pre-employment screening and training for staff members.
- C. Person-centered quality reviews to ensure assessment and documentation of the individual's needs and documentation that substantiates services were rendered in the amount, frequency, duration, and scope required:
1. onsite inspections of community homes and other service provision locations (e.g., day programs and crisis and respite homes) to assess performance compliance with regulatory and professional standards (i.e., initial certification reviews and ongoing licensure reviews);
 2. onsite investigations of critical incidents and other allegations or concerns of performance deficiencies;
 3. mortality reviews (independent or State directed) including or in addition to trend analysis of unexpected or unanticipated deaths and trend analysis of deaths that were the result of abuse or neglect;
 4. onsite evaluations of service providers' and support coordinators' reporting of critical incidents, implemented corrective actions, PCSP development, service delivery, and billings; and
 5. meetings with advocates to identify emerging issues and trends in complaints and rights violations in conjunction with a review of the State's own complaint and appeal systems.

Appendix E

Related HHS Reports and Activities

OIG Office of Audit Services Related Reports

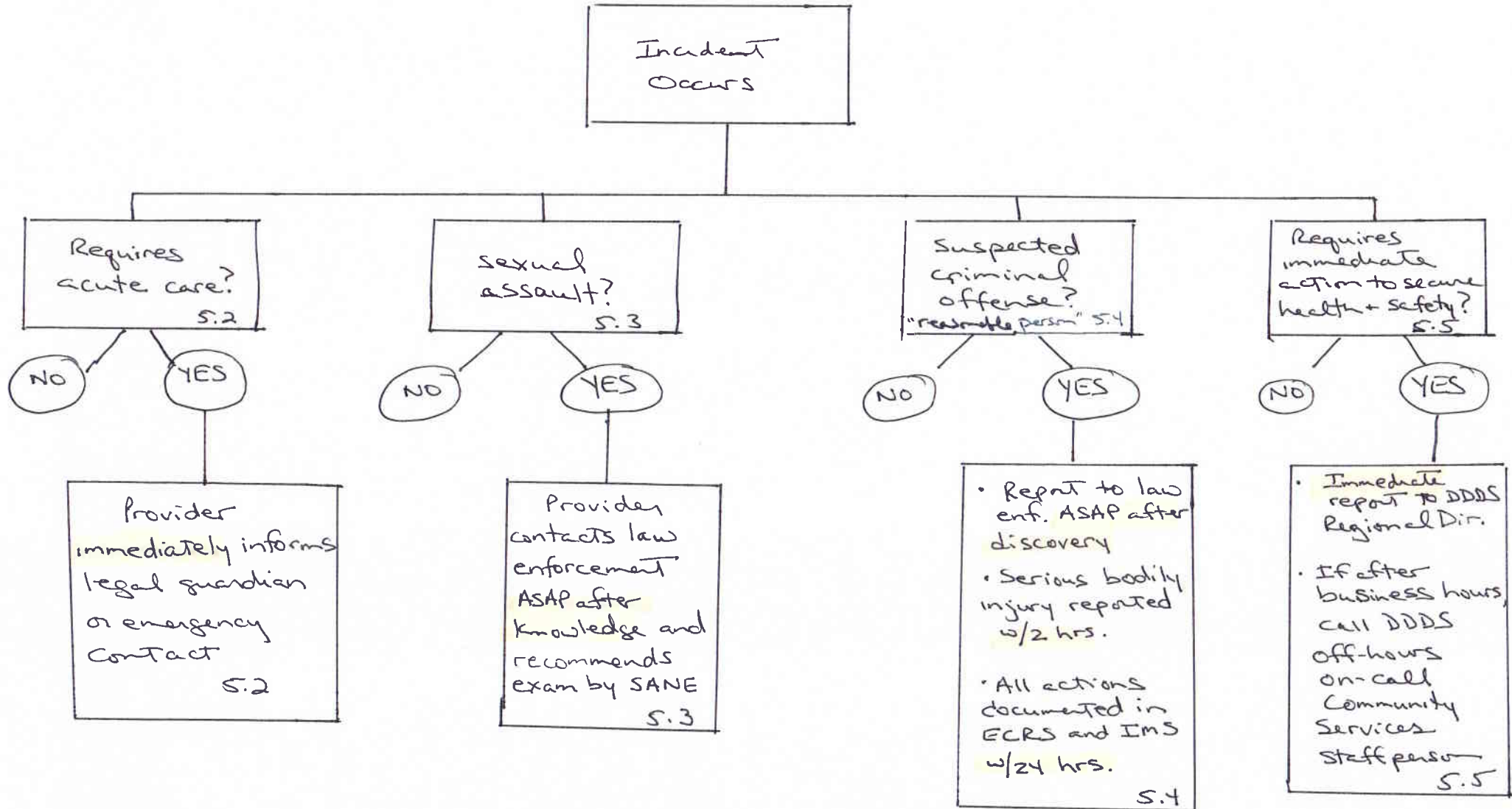
Report Title	Report Number	Date Issued
<i>Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	A-01-16-00001	August 2017
<i>Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance With Applicable Requirements</i>	A-01-17-00504	August 2017
<i>Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	A-01-14-00008	July 2016
<i>Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	A-01-14-00002	May 2016
<i>Review of Intermediate Care Facilities in New York with High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries</i>	A-02-14-01011	September 2015
<i>Oversight of Quality of Care in Medicaid Home and Community-Based Services Waiver Programs</i>	OEI-02-08-00170	June 2012

Administration for Community Living Related Activities

<i>Living Well: Model Approaches for Enhancing the Quality, Effectiveness and Monitoring of Home and Community-Based Services for Individuals with Developmental Disabilities</i>	https://www.grants.gov/web/grants/view-opportunity.html?oppId=292514
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<i>State Protection & Advocacy Systems</i>	https://www.acl.gov/programs/aging-and-disability-networks/state-protection-advocacy-systems
<i>State Councils on Developmental Disabilities</i>	https://www.acl.gov/programs/aging-and-disability-networks/state-councils-developmental-disabilities
<i>National Network of University Centers for Excellence in Developmental Disabilities Education, Research & Service</i>	https://www.acl.gov/programs/aging-and-disability-networks/national-network-university
<i>Self-Advocacy Resource and Technical Assistance Center (SARTAC)</i>	http://selfadvocacyinfo.org/

DDDS Proposed Regulations
 Sec. 5.0
 ("Safety of the Service Recipient")



Problem:
 "Reasonable person" std is a legal concept that requires guidance

DDDS Proposed Regulations Sec. 6 ("Reporting of Incidents")

①
Problem: The concept of AMNF in Sec. 6.D does not harmonize w/ critical, non-critical & reportable incidents.

AMNF ≠ RI
≠ Critical incident
≠ non-critical incid.

Is this a new subset of Critical?
What about remainder?

②
"Reasonable belief" is a legal standard that requires guidance.

Reasonable belief of abuse, mistreatment, neglect, financial exploitation (AMNF)
6.1

Report to DDDS via DDDS web-based reporting form, by phone, or in-person ASAP of AMNF 6.1

Written report for all reportable incidents via web-based incident reporting form w/ 24 hrs of first gaining knowledge of AMNF 6.2

Reportable incident occurred in DHCO setting?

NO

YES

DDDS OIR informs DHCO via web-reporting form w/ 48 hrs of incident report 6.3

Recipient vs. Recipient?

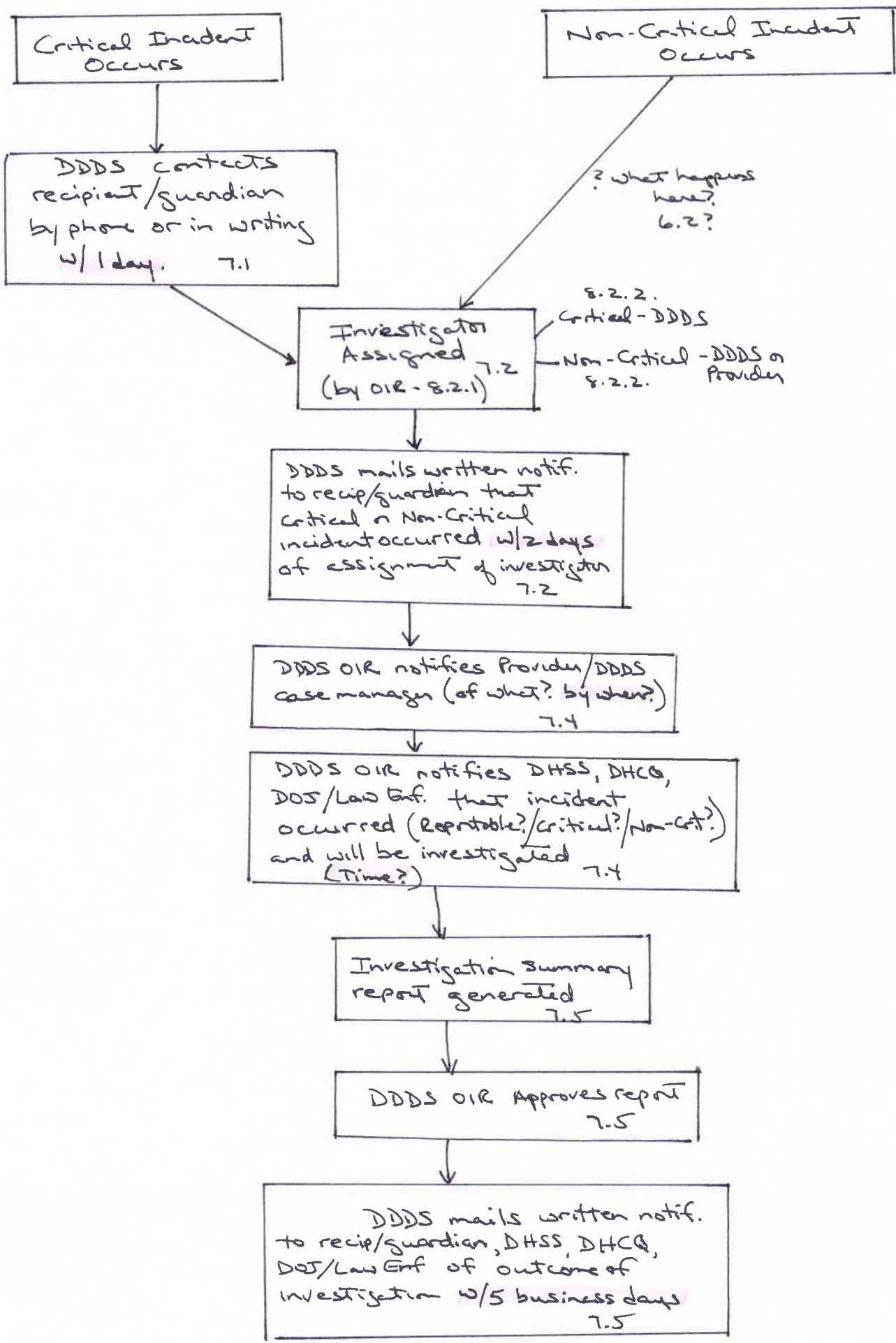
NO

YES

Provider reports incident via DHCO web reporting form w/ 48 hrs 6.4

See Sec. 8 w/ 2 days OIR conducts preel. investigation and assigns investigation (either DDDS or provider). 8.1

DDDS Proposed Regulations
Sec. 7.0 ("Who To Notify....")

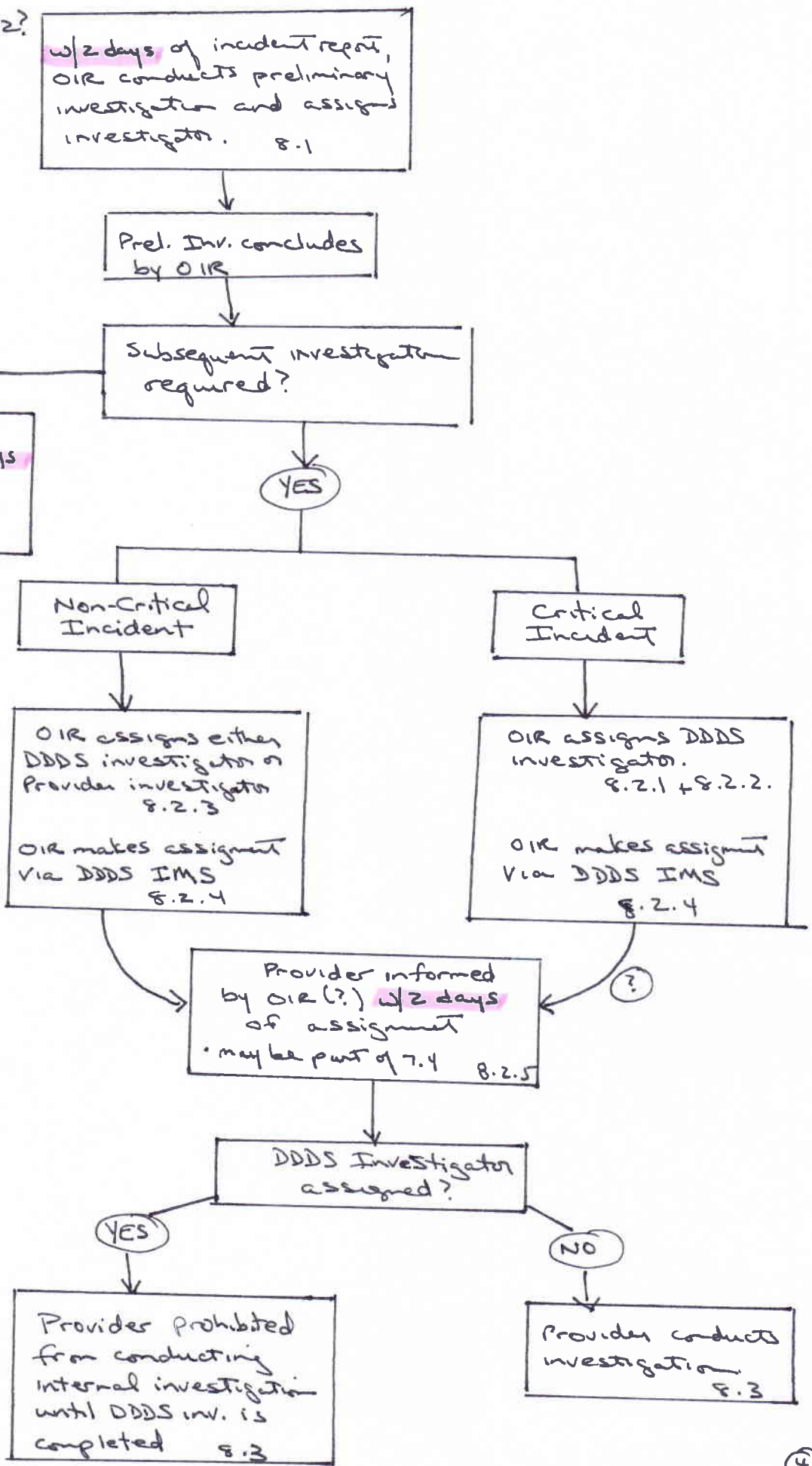


DDDS Proposed Regulations Sec. 8 ("Determination of Investigative Method")

Problems:

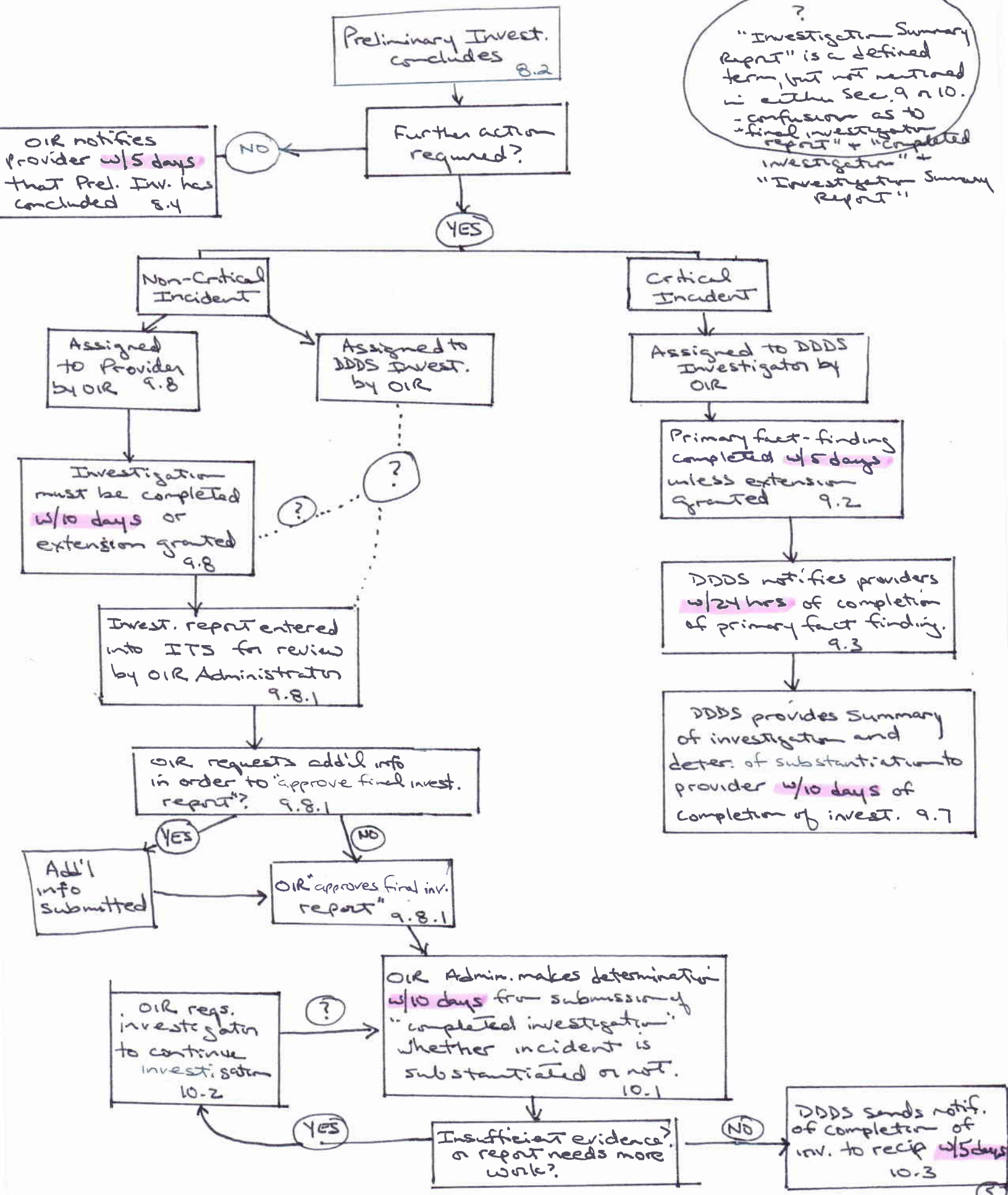
1. Within 2 days of what? 6.2?
 Receipt? Phone call?
 Written report?
2. Assignment of investigator only for any subsequent investigation?

What is the relationship b/ 8.4 and 9.2?

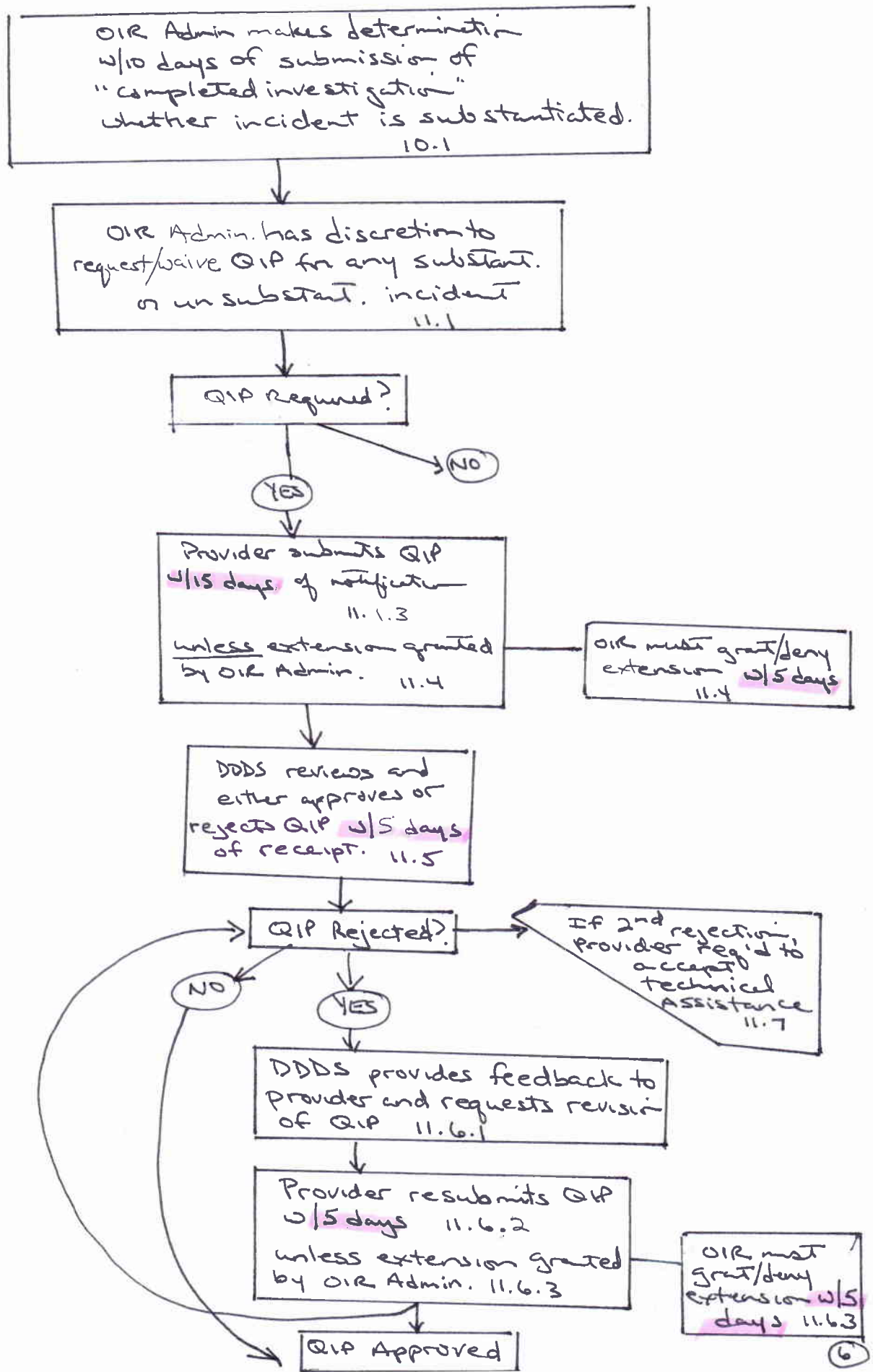


DDDS Proposed Regulations
 Sec. 9+10 (Conduct of Investigations/Post Inv. Analysis+Follow-up)

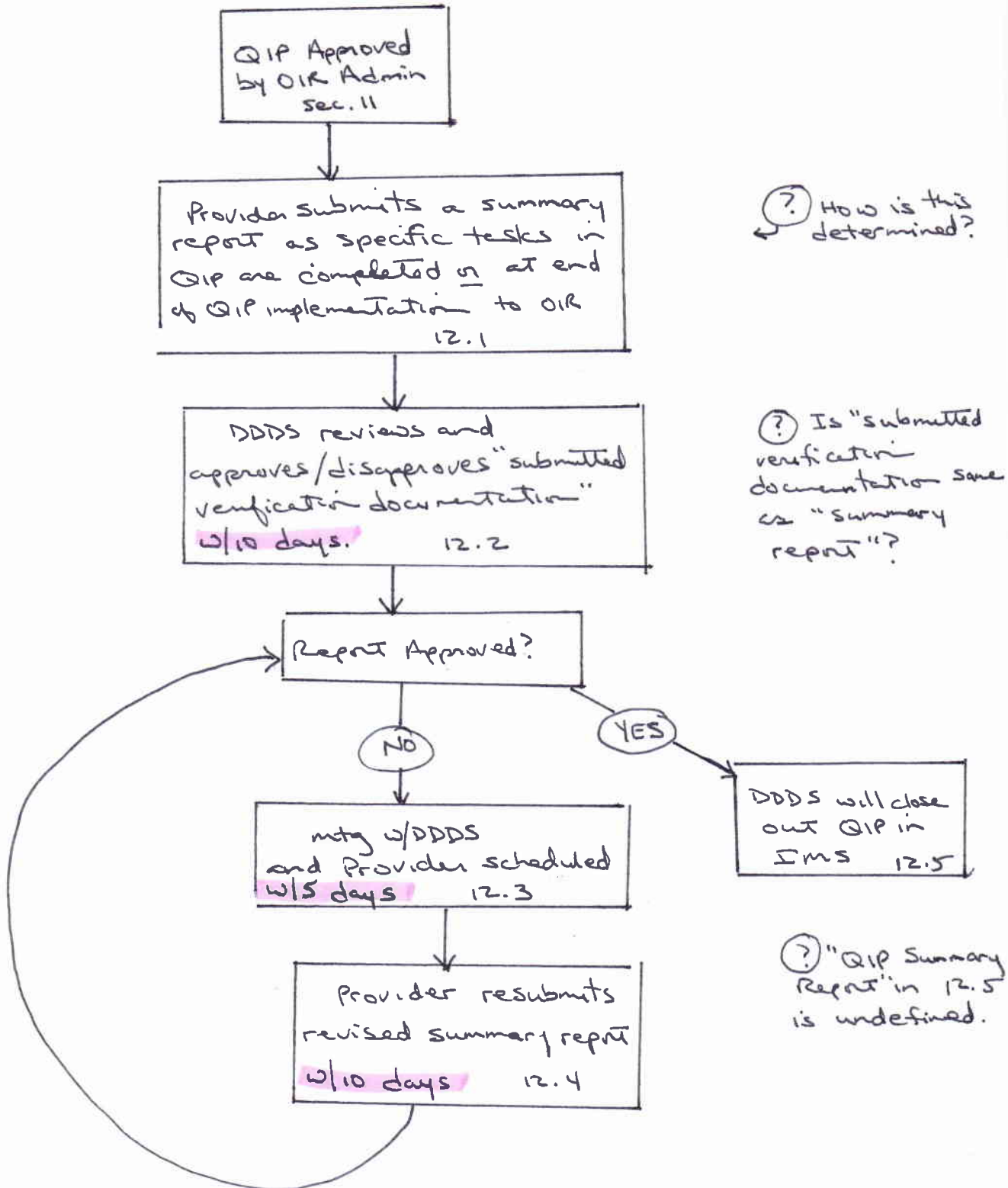
?
 "Investigation Summary Report" is a defined term, but not mentioned in either Sec. 9 or 10.
 - confusion as to "final investigation report" + "completed investigation" + "Investigation Summary Report"



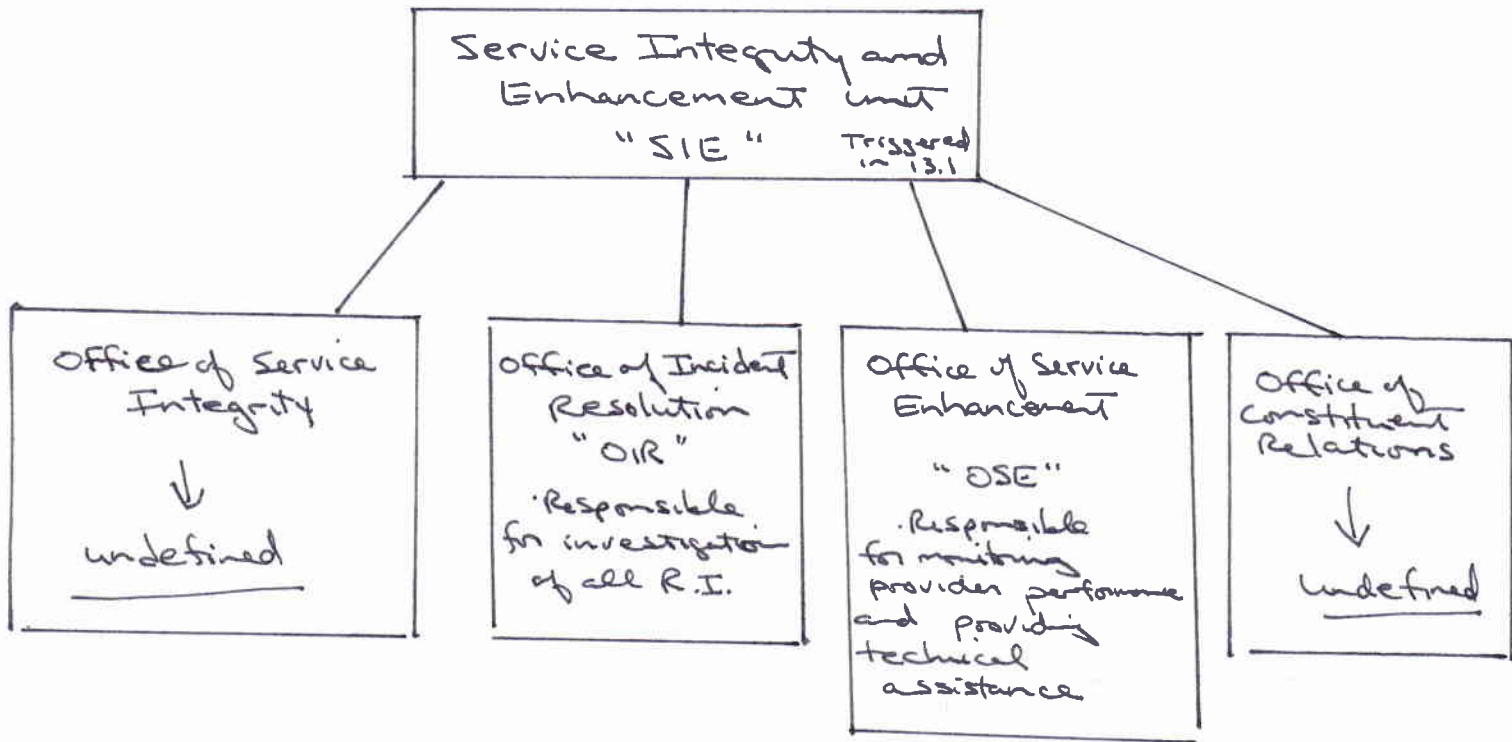
DDDS Proposed Regulations
Sec. 11 ("Quality Improvement Plans")



DDDS Proposed Regulations
Sec. 12 ("DDDS Verification of QIP Implementation")



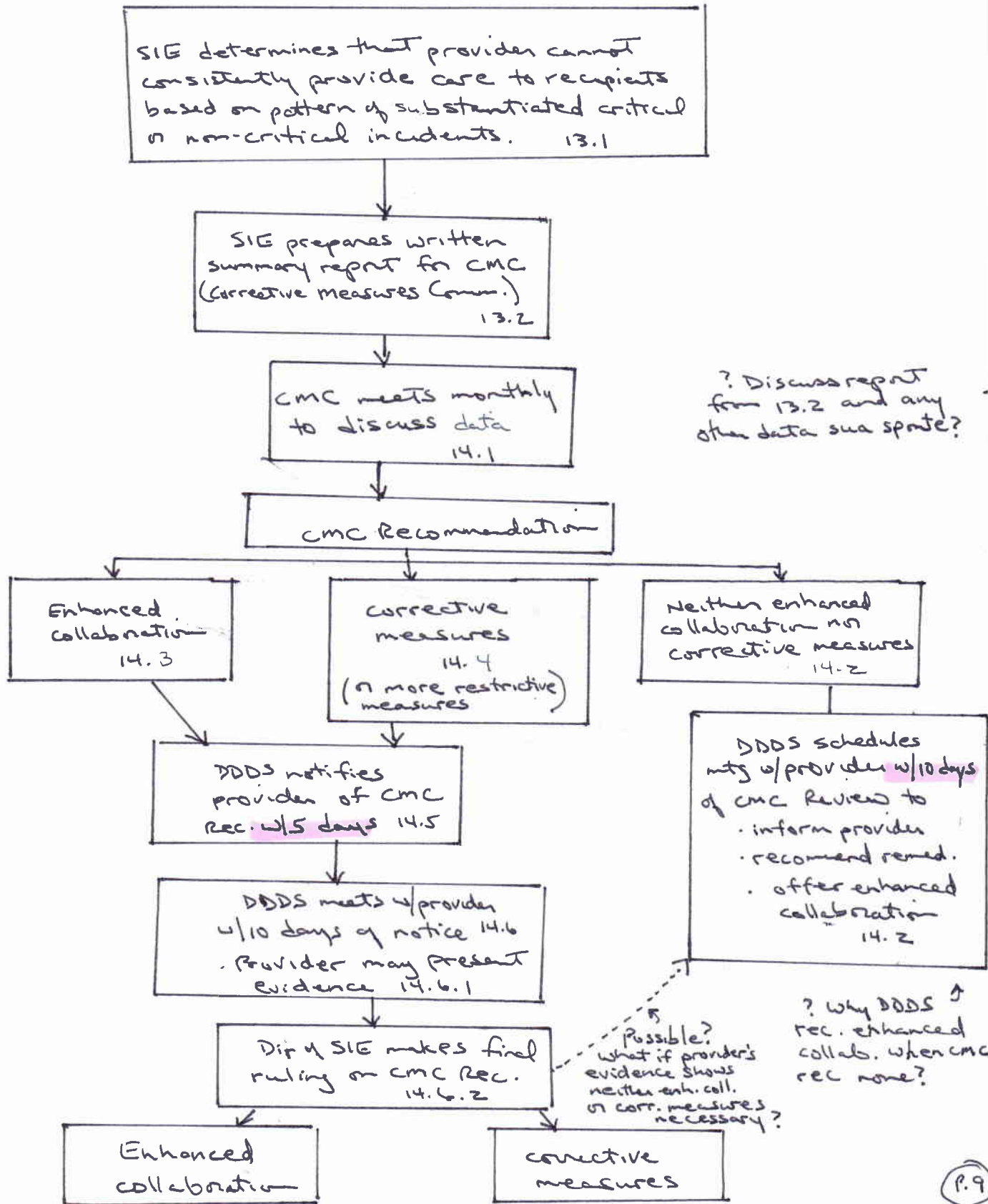
DDDS Proposed Regulations
Sec. 3.0 ("Definitions")



Problem:

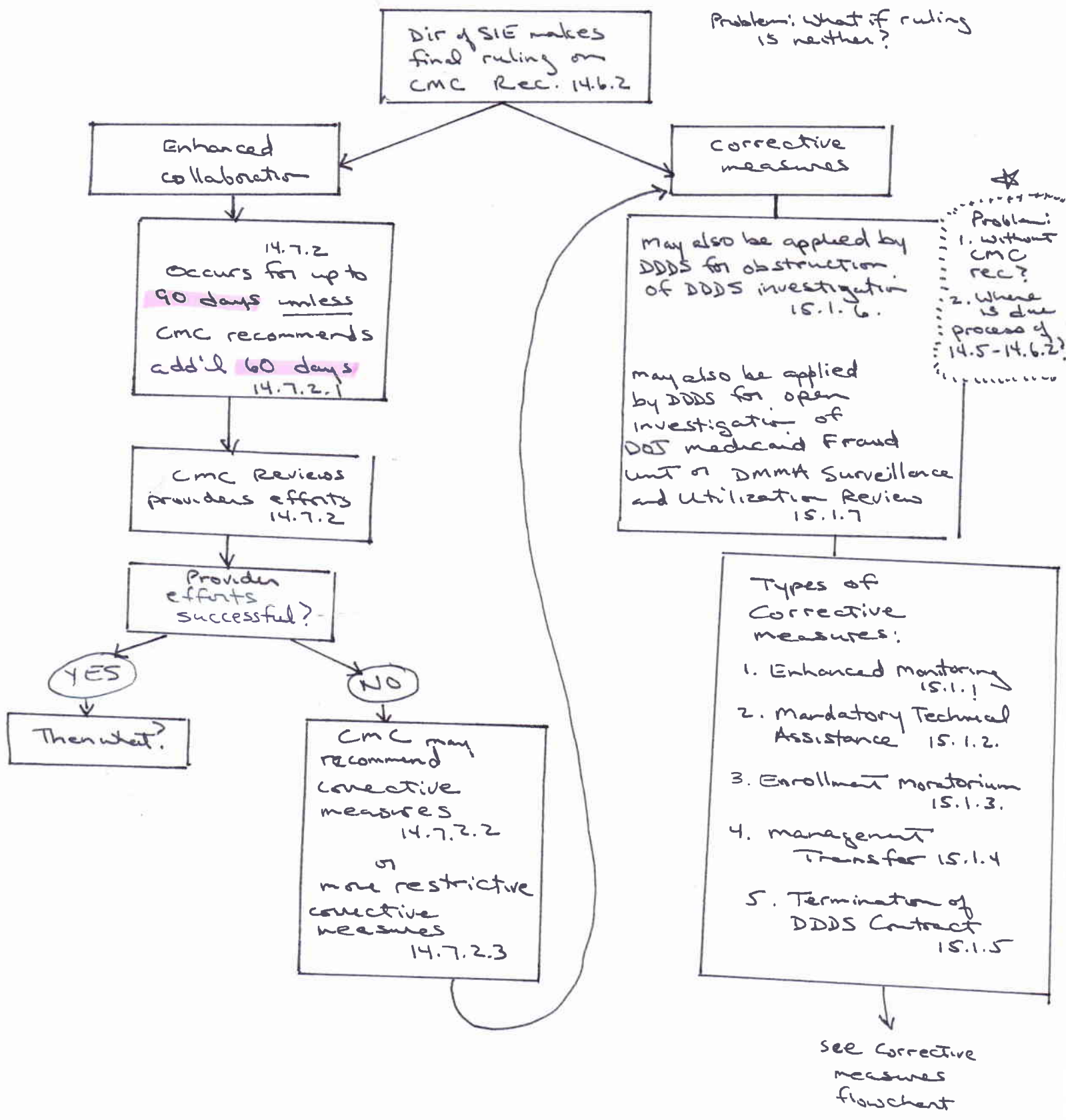
1. Undefined terms for Office of Service Integrity and Office of Constituent Relations mentioned in definition of SIE.

DDDS Proposed Regulations
 Sec. 13 + 14 ("Criteria for CMC Review" and "CMC Review and
 Enhanced Collaboration")



Bias Problem: Because DDS still offering remed. and enh. collab. even if CMC does not recommend, and there is no provision for DDS disagreement w/ enh. coll. or corrective measures

DDDS Proposed Regulations
 Sec. 14.6.2 and Sec. 15.1 ("Enhanced Collaboration" and Corrective measures")



DDDS Proposed Regulations
 Sec. 15 ("Corrective Measures")

Corrective Measure imposed by Dir of SIG
 - Mtg. Transfer and Term. of DDS Provider Contract/Agreement by "Div. Director" (DDDS Dir?)
 15.2

Letter sent to Provider from ? time? 15.2.1

Problem:
 • 15.2.1 references section 14.5.2 which does not exist. means 14.6.2?

Provider submits Corrective Measures Plan (CMP) w/ 15 days of receipt of letter 15.2.2.
 unless extension granted 15.2.4

Dir. of SIG will grant/deny extension w/ 5 days of written request 15.2.4

DDDS reviews CMP and approves/rejects w/ 10 days 15.2.5

CMP approved

CMP Rejected

Add'l info necessary

DDDS may request mtg w/ Provider 15.2.5
 DDDS requests revised CMP. 15.2.5

Provider submits revised CMP w/ 5 days 15.2.6.2.
 unless extension granted 15.2.6.3

Dir. of SIG will grant/deny extension w/ 5 days of written request. 15.2.6.3

CMP Rejected
 - Provider must accept mandatory Technical Assistance 15.2.7

DDDS Proposed Regulations
Sec. 16 ("On-going Review, Monitoring, and Conclusion of
Corrective Measures")

Provider submits
CMP

Corrective Measures Committee
(CMC) reviews provider's
activities and outcomes at
Soonest monthly meeting
after submission. 16.1

Problems
- Very unclear.
- Submission of what?
CMP? Approved CMP?
CMP status report?

Provider must
submit summary report 45 days
after each corrective
measure period 16.3
-
Provider may submit monthly
updates to CMC or
a summary at any time 16.2

CMC will review summary report
at next monthly meeting and
make recommendations to Dir. of SIE
16.4

Problem:
- Confusion
b/ 16.1 & 16.4.
- Are these the
same event?

Provider must
submit add'l
info. to CMC
16.4.1

Provider should
be released from
the corrective
measure
16.4.2

Provider must
continue cor.
measure for 90 days
or
"Step up" to next
level of CM
for failure to
complete all
CMP's
16.4.3

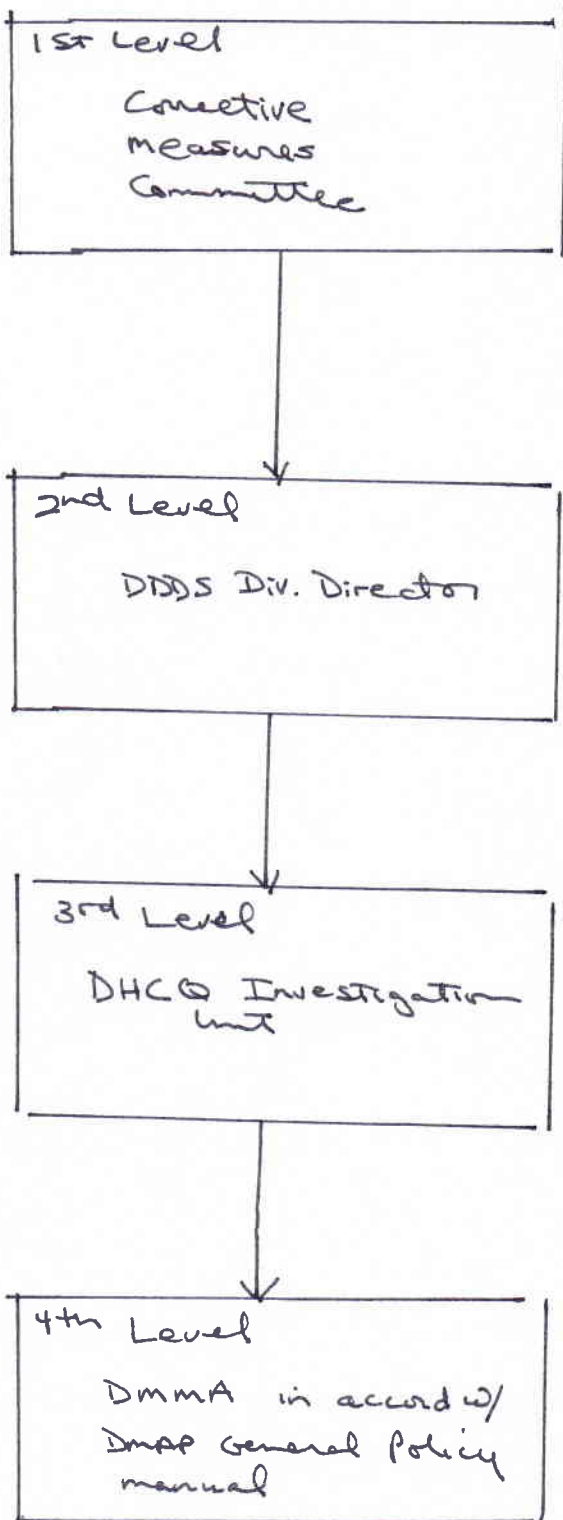
Provider shall
"fall back" to
previous level
of CM if CMP's
only partially
completed
16.4.4

(P.12)

W/5 days after meeting,
Dir of SIE notifies provider
of any requests or decisions
"after CMC reviews provider
reports." 16.5

Problems
- Dir of SIE should
be notifying provider
of Dir's decision.
- What is "step up"
and "fall back"?

DDDS Proposed Regulations Sec. 17 ("Appeals")



Issues:

1. Provider may only appeal corrective measures 17.1
 - At what point can appeal? 16.5? 15.2? 14.6.2? 10.1?
 - Appeal critical vs non-critical?
 - Appeal other final decisions of OIR?
2. Appeal process for 1st Level is unclear (17.2.2.2).
 provider must submit ? to ? w/in ? days of ?.
3. 1st Level: CMC already making initial determination of CM and sending this to Dir of SIG approval. (Sec. 16 process).
 - Should not be going back to CMC.
4. Who are the people in DHCA Inv. Unit and how do they differ from DDDS? All under DDDS?
5. Who are the people in DMMA and how do they differ from DHCA and DDDS?
6. Issues under appeal are often very serious. Independent appeal body and path to judicial appeal is important and necessary.

Kentucky Administrative Regulations Currentness
Title 907. Cabinet for Health and Family Services - Department for Medicaid Services
Chapter 1. Medicaid Services

907 Ky. Admin. Regs. 1:595

907 KAR 1:595. Model Waiver II service coverage and reimbursement policies and requirements

Section 1. Definitions. (1) “1915(c) home and community based waiver program” means a Kentucky Medicaid program established pursuant to and in accordance with [42 U.S.C. 1396n\(c\)](#).

(2) “Department” means the Department for Medicaid Services or its designee.

(3) “Federal financial participation” is defined in [42 C.F.R. 400.203](#).

(4) “Home health agency” means an agency that is:

(a) Licensed in accordance with [902 KAR 20:081](#);

(b) Medicare certified; and

(c) Medicaid certified.

(5) “Licensed practical nurse” is defined by [KRS 314.011\(9\)](#).

(6) “Model Waiver II services” means 1915(c) home and community based waiver program in-home ventilator services provided to a Medicaid-eligible recipient who:

(a) Is dependent on a ventilator; and

(b) Would otherwise require a nursing facility level of care in a hospital based nursing facility that will accept a recipient who is dependent on a ventilator.

(7) “MWMA” means the Kentucky Medicaid Waiver Management Application internet portal located at <http://chfs.ky.gov/dms/mwma.htm>.

(8) “Participant” means a recipient who qualifies for and is receiving Model Waiver II services in accordance with Section 2 of this administrative regulation.

(9) “Person-centered service plan” means a written individualized plan of services.

(10) “Private duty nursing agency” means a facility licensed to provide private duty nursing services:

(a) By the Cabinet for Health and Family Services, Office of Inspector General; and

(b) Pursuant to [902 KAR 20:370](#).

(11) “Recipient” is defined by [KRS 205.8451\(9\)](#).

(12) “Registered nurse” is defined by [KRS 314.011\(5\)](#).

(13) “Registered respiratory therapist” is defined by [KRS 314A.010\(3\)\(a\)](#).

(14) “Ventilator” means a respiration stimulating mechanism.

(15) “Ventilator dependent” means the condition or state of an individual who:

(a) Requires the aid of a ventilator for respiratory function; and

(b) Meets the high intensity nursing facility patient status criteria established in [907 KAR 1:022](#).

Section 2. Participant Eligibility and Related Policies. (1)(a) To be eligible to receive Model Waiver II services, an individual shall:

1. Be eligible for Medicaid pursuant to [907 KAR 20:010](#);

2. Require ventilator support for at least twelve (12) hours per day; and

3. Meet ventilator dependent patient status requirements established in [907 KAR 1:022](#).

(b) In addition to the individual meeting the requirements established in paragraph (a) of this subsection:

1. The individual or a representative on behalf of the individual shall:

- a. Apply for 1915(c) home and community based waiver services via the MWMA;
- b. Complete and upload into the MWMA a MAP - 115 Application Intake - Participant Authorization; and
- c. Complete and upload into the MWMA a MAP - 116 Service Plan - Participant Authorization prior to or at the time the person-centered service plan is uploaded into the MWMA; and

2. A registered nurse on behalf of the individual applying for services shall:

a. Complete and upload into the MWMA:

- (i) A MAP 350, Long Term Care Facilities and Home and Community Based Program Certification Form;
- (ii) A person-centered service plan; and
- (iii) A MAP-351A, Medicaid Waiver Assessment; and

b. Upload a MAP-10, Waiver Services - Physician's Recommendation, which shall be signed and dated by a physician.

(c) An individual's eligibility for Model Waiver II services shall begin upon receiving notification of approval from the department.

(2) For an individual to remain eligible for Model Waiver II services:

(a) The individual shall:

1. Maintain Medicaid eligibility requirements established in [907 KAR 20:010](#); and

2. Remain ventilator dependent pursuant to [907 KAR 1:022](#);

(b) A Model Waiver II level of care determination confirming that the individual qualifies shall be performed and submitted to the department every six (6) months; and

(c) A MAP-10, Waiver Services - Physician's Recommendation shall be:

1. Signed and dated by a physician every sixty (60) days on behalf of the individual; and

2. Uploaded into the MWMA after being signed and dated in accordance with subparagraph 1 of this paragraph, every sixty (60) days.

(3) A Model Waiver II service shall not be provided to a recipient who is:

(a) Receiving a service in another 1915(c) home and community based waiver program; or

(b) An inpatient of:

1. A nursing facility;

2. An intermediate care facility for individuals with an intellectual disability; or

3. Another facility.

(4) The department shall not authorize a Model Waiver II service unless it has ensured that:

(a) Ventilator dependent status has been met; and

(b) The service:

1. Is available to the recipient;

2. Will meet the need of the recipient; and

3. Does not exceed the cost of traditional institutional ventilator care.

Section 3. Provider Participation Requirements. To participate in the Model Waiver II program, a:

(1) Home health agency shall:

(a) Be a currently participating Medicaid provider in accordance with [907 KAR 1:671](#);

(b) Be currently enrolled as a Medicaid provider in accordance with [907 KAR 1:672](#); and

(c) Meet the home and community based waiver service provider requirements established in:

1. [907 KAR 1:160](#); or

2. [907 KAR 7:010](#); or

(2) Private duty nursing agency shall:

(a) Be a currently participating Medicaid provider in accordance with [907 KAR 1:671](#);

(b) Be currently enrolled as a Medicaid provider in accordance with [907 KAR 1:672](#); and

(c) Be a licensed private duty nursing agency in accordance with [902 KAR 20:370](#).

Section 4. Covered Services. (1) The following shall be covered Model Waiver II services:

(a) Skilled nursing provided by:

1. A registered nurse; or

2. A licensed practical nurse; or

(b) Respiratory therapy.

(2) Model Waiver II services shall be provided by an individual employed by or under contract through a private duty nursing agency or home health agency as a:

(a) Registered nurse;

(b) Licensed practical nurse; or

(c) Registered respiratory therapist.

Section 5. Payment for Services. The department shall reimburse a participating home health agency or private duty nursing agency for the provision of covered Model Waiver II services as established in this section. (1) Reimbursement shall be based on a fixed fee for a unit of service provided for each covered service referenced in Section 4 of this administrative regulation with one (1) hour equal to one (1) unit of service.

(2) The fixed fee for skilled nursing services provided by:

- (a) A registered nurse shall be thirty-one (31) dollars and ninety-eight (98) cents for each unit of service;
 - (b) A licensed practical nurse shall be twenty-nine (29) dollars and ten (10) cents for each unit of service; and
 - (c) A registered respiratory therapist shall be twenty-seven (27) dollars and forty-two (42) cents for each unit of service.
- (3) Reimbursement shall not exceed sixteen (16) units of service per day.
- (4) Payment shall not be made for a service to an individual for whom it can reasonably be expected that the cost of the 1915(c) home and community based waiver program service furnished under this administrative regulation would exceed the cost of the service if provided in a hospital-based nursing facility.

Section 6. Maintenance of Records. (1) A Model Waiver II service provider shall maintain:

(a) A clinical record for each participant, which shall contain:

1. Pertinent medical, nursing, and social history;
2. A person-centered service plan;
3. A copy of the MAP 350, Long Term Care Facilities and Home and Community Based Program Certification Form signed by the participant or the participant's legal representative at the time of application or reapplication and each recertification thereafter;
4. Documentation of all level of care determinations;
5. All documentation related to prior authorizations including requests, approvals, and denials;
6. Documentation that the participant or legal representative was informed of the procedure for reporting complaints; and
7. Documentation of each service provided that shall include:
 - a. The date the service was provided;
 - b. The duration of the service;

c. The arrival and departure time of the provider, excluding travel time, if the service was provided at the participant's home;

d. Progress notes, which shall include documentation of changes, responses, and treatments utilized to evaluate the participant's needs; and

e. The signature of the service provider;

(b) Each MAP-10, Waiver Services - Physician's Recommendation submitted regarding the participant in accordance with Section 2 of this administrative regulation; and

(c) Incident reports as required by Section 7 of this administrative regulation if an incident with the participant occurs.

(2)(a) Except as provided in paragraph (b) of this subsection, a clinical record or incident report shall be retained for at least six (6) years from the date that a covered service is provided.

(b) If the participant is a minor, a clinical record or incident report shall be retained for three (3) years after the participant reaches the age of majority under state law, if that is a longer time period than the time period required by paragraph (a) of this subsection.

(3) Upon request, a provider shall make information regarding service and financial records available to the:

(a) Department;

(b) Cabinet for Health and Family Services, Office of Inspector General or its designee;

(c) United States Department for Health and Human Services or its designee;

(d) General Accounting Office or its designee;

(e) Office of the Auditor of Public Accounts or its designee; or

(f) Office of the Attorney General or its designee.

Section 7. Incident Reporting. (1)(a) There shall be two (2) classes of incidents.

(b) The following shall be the two (2) classes of incidents:

1. An incident; or

2. A critical incident.

(2) An incident shall be any occurrence that impacts the health, safety, welfare, or lifestyle choice of a participant and includes:

(a) A minor injury;

(b) A medication error without a serious outcome; or

(c) A behavior or situation that is not a critical incident.

(3) A critical incident shall be an alleged, suspected, or actual occurrence of an incident that:

(a) Can reasonably be expected to result in harm to a participant; and

(b) Shall include:

1. Abuse, neglect, or exploitation;

2. A serious medication error;

3. Death;

4. A homicidal or suicidal ideation;

5. A missing person; or

6. Other action or event that the provider determines may result in harm to the participant.

(4)(a) If an incident occurs, the Model Waiver II provider shall:

1. Report the incident by making an entry into the MWMA that includes details regarding the incident; and

2. Be immediately assessed for potential abuse, neglect, or exploitation.

(b) If an assessment of an incident indicates that the potential for abuse, neglect, or exploitation exists:

1. The incident shall immediately be considered a critical incident;
2. The critical incident procedures established in subsection (5) of this section shall be followed; and
3. The Model Waiver II provider shall report the incident to the participant's registered nurse and participant's guardian, if the participant has a guardian, within twenty-four (24) hours of discovery of the incident.

(5) If a critical incident occurs, the:

(a) Individual who witnessed the critical incident or discovered the critical incident shall immediately:

1. Act to ensure the health, safety, and welfare of the at-risk participant; and
2. Report the critical incident by making an entry in the MWMA portal including details of the incident; and

(b) Model Waiver II provider shall:

1. Conduct an immediate investigation and involve the participant's registered nurse in the investigation; and
2. Prepare a report of the investigation, which shall be recorded in the MWMA portal and shall include:
 - a. Identifying information of the participant involved in the critical incident and the person reporting the critical incident;
 - b. Details of the critical incident; and
 - c. Relevant participant information including:
 - (i) A listing of recent medical concerns;
 - (ii) An analysis of causal factors; and
 - (iii) Recommendations for preventing future occurrences.

(6) If a critical incident does not require reporting of abuse, neglect, or exploitation, the critical incident shall be reported via the MWMA within eight (8) hours of discovery.

(7) If a death of a participant occurs, a Model Waiver II provider shall submit to the MWMA mortality data documentation within fourteen (14) days of the death including:

- (a) The participant's person-centered service plan at the time of death;
- (b) Any current assessment forms regarding the participant;
- (c) The participant's medication administration records from all service sites for the past three (3) months along with a copy of each prescription;
- (d) Progress notes regarding the participant from all service elements for the past thirty (30) days;
- (e) The results of the participant's most recent physical exam;
- (f) All incident reports, if any exist, regarding the participant for the past six (6) months;
- (g) Any medication error report, if any exists, related to the participant for the past six (6) months;
- (h) A full life history of the participant including any update from the last version of the life history;
- (i) Names and contact information for all staff members who provided direct care to the participant during the last thirty (30) days of the participant's life;
- (j) Emergency medical services notes regarding the participant if available;
- (k) The police report if available;
- (l) A copy of:

1. The participant's advance directive, medical order for scope of treatment, living will, or health care directive if applicable; and
2. The cardiopulmonary resuscitation and first aid card for any provider's staff member who was present at the time of the incident that resulted in the participant's death;

(m) A record of all medical appointments or emergency room visits by the participant within the past twelve (12) months; and

(n) A record of any crisis training for any staff member present at the time of the incident that resulted in the participant's death.

(8) A Model Waiver II provider shall report a medication error by making an entry into the MWMA.

Section 8. Use of Electronic Signatures. The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in [KRS 369.101](#) to [369.120](#).

Section 9. Federal Financial Participation. The department's coverage of and reimbursement for Model Waiver II services pursuant to this administrative regulation shall be contingent upon:

(1) Federal financial participation for the coverage and reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage and reimbursement.

Section 10. Appeal Rights. (1) An appeal of a negative action regarding a Medicaid recipient shall be appealed in accordance with [907 KAR 1:563](#).

(2) An appeal of a negative action regarding a Medicaid beneficiary's eligibility shall be appealed in accordance with [907 KAR 1:560](#).

(3) An appeal of a negative action regarding a Medicaid provider shall be appealed in accordance with [907 KAR 1:671](#).

Section 11. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "MAP - 115 Application Intake - Participant Authorization", June 2015;

(b) "MAP 350, Long Term Care Facilities and Home and Community Based Program Certification Form", June 2015

(c) "MAP-10 Waiver Services - Physician's Recommendation", June 2015;

(d) "MAP - 116 Service Plan - Participant Authorization", June 2015; and

(e) "MAP-351A, Medicaid Waiver Assessment", July 2015.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law:

(a) At the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.; or

(b) Online at the department's Web site at <http://www.chfs.ky.gov/dms/incorporated.htm>.

Credits

Adopted effective September 16, 1998; Amended effective December 2, 2011; Technical amendment effective September 30, 2013; Amended effective February 5, 2016.

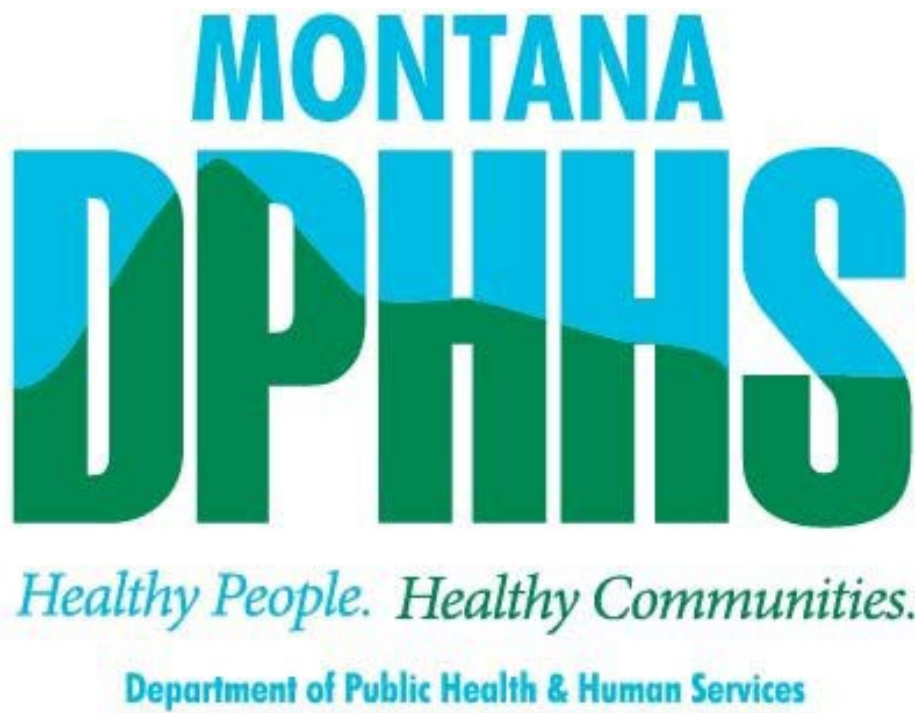
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907 Ky. Admin. Regs. 1:595, 907 KY ADC 1:595

End of Document

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**DEVELOPMENTAL DISABILITIES PROGRAM
INCIDENT MANAGEMENT PROCEDURES MANUAL**



February 1, 2013

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Introduction

Incident Management Principles

People should have a quality of life that is free of abuse, neglect, and exploitation. A provider agency's incident management system must emphasize prevention and staff involvement in order to provide safe environments for the people they serve.

Quality starts with those who work most closely with people receiving services.

The incident management procedures for the State of Montana Developmental Disabilities Program (DDP) are in effect when a defined incident occurs during the course of delivery of DDP funded services including Children's, Adult, and Self Direct services.

This procedure manual is intended to provide guidance for both DDP staff and provider agencies to support and ensure persons health and safety while receiving services. It identifies and addresses requirements for staff and functions of the incident management system (IMS) put forth by the Developmental Disabilities Program.

It is the policy of the Developmental Disabilities Program that the implementation of a plan of action will be required to prevent the recurrence of similar incidents, along with other activities that allow provider agencies to be proactive in their responsibilities to reduce the risk of harm to persons receiving services.

Incident Management System: Purpose

The purpose of the Developmental Disabilities Program incident management system is:

- To identify adverse events, potential jeopardy, and factors related to risk;
- To notify key people involved in the planning and support of the person;
- To trigger a response to protect the person and minimize further risk to the persons and others;
- To have the ability to collect and analyze information about persons, services, providers, and the service delivery system; and
- To have the capacity to identify patterns and trends in order to guide service improvement efforts.

Confidentiality

Incident reports and investigations are confidential. An incident of abuse and neglect involving a child is subject to the confidentiality provisions of [41-3-205](#) , MCA. An incident of abuse, neglect and exploitation involving a person with a developmental disability is subject to the confidentiality provisions of [52-3-813](#) , MCA.

Section 1: INCIDENT DEFINITIONS/CATEGORIES/NOTIFICATION LEVELS

An important component of the Developmental Disabilities Program (DDP) incident management system is the classification of incidents persons may experience while receiving services. For the purpose of the incident management system policy, incidents are classified into three (3) categories: **CRITICAL INCIDENTS**, **REPORTABLE INCIDENTS** and **INTERNAL INCIDENTS**.

All incident reports (IR's) are entered into an electronic web-based data management system (DMS) approved by the Department of Public Health and Human Services of the State of Montana. All critical, reportable, and internal incidents will be reviewed by the incident management committee as described below.

CRITICAL INCIDENTS (data management system notification level “high”):

A critical incident is one that has compromised the safety and well-being of a person as identified in the incident categories. A critical incident is an event that requires an immediate and appropriate response to protect the person and minimize risk, as well as immediate notification to key people. All critical incidents require an investigation.

REPORTABLE INCIDENTS (data management system notification level “medium”):

A reportable incident is one that can compromise the safety and well-being of a person as identified in the incident categories. A reportable incident is an event that requires timely and appropriate response to protect the person and minimize risk, as well as timely notification to key people.

INTERNAL INCIDENTS (data management system notification level “low”):

All other unusual incidents that are not listed under critical or reportable notification level are internal incidents. The discovery of incidents (incidents that occur in the absence of paid staff) can be reported in this category.

****NOTE****

Any incident report can be investigated if warranted.

NOTIFICATIONS

- Critical incidents will be reported as soon as possible and within 8 hours. Critical incidents must be entered into the data management system within 48 hours or 2 working days.
- Reportable and internal incidents will be entered into data management system within 48 hours or 2 working days.
- Notifications are made to legal representatives, other team members, DDP, advocates and other service provider agencies per Appendix C (Notification Reporting Requirements) as needed or per the plan of care.

****NOTE****

All suspected abuse, neglect and exploitation must be reported to Adult Protective Services, Child Protective Services or law enforcement, whichever is applicable. The names of those who report critical incidents of suspected abuse, neglect or exploitation are not to be released, unless required by law or regulation.

MANDATORY REPORTERS UNDER MONTANA LAW INCLUDE:

41-3-201(1) MCA, CHILD ABUSE OR NEGLECT REPORTS

- (2) Professionals and officials required to report are:
 - (f) a foster care, residential, or institutional worker; or
 - (j) an employee of an entity that contracts with the department to provide direct services to children.

52-3-811 MCA, ADULT PROTECTIVE SERVICES

- (3) Professionals and other persons required to report are:
 - (h) a person providing services to an older person or a person with a developmental disability pursuant to a contract with a state or federal agency; and
 - (i) an employee of the department while in the conduct of the employee's duties.

The data management system (DMS) does not list ABUSE/ NEGLECT/ EXPLOITATION/ CIVIL RIGHTS VIOLATION as an actual event but is treated as a cause of other events whether witnessed or discovered. The event in the DMS is "Injury" and then in the General Information section, you are asked if the injury was a result of suspected abuse or neglect, select abuse/neglect and the notification becomes high or critical.

Below are the definitions of ABUSE/NEGLECT/EXPLOITATION/CIVIL RIGHTS VIOLATION.

Abuse

[52-3-803 \(1\)](#), MCA "Abuse" means:

- (a) the infliction of physical or mental injury, or
- (b) the deprivation of food, shelter, clothing, or services necessary to maintain the physical or mental health of an older person or a person with a developmental disability without lawful authority. A declaration made pursuant to [50-9-103](#) constitutes lawful authority.

Sexual Abuse

[52-3-803 \(11\)](#), MCA

"Sexual abuse" means the commission of sexual assault, sexual inter-course without consent, indecent exposure, deviate sexual conduct, or incest, as described in Title 45, chapter 5, part 5.

Neglect

[52-3-803 \(7\)](#), MCA

"Neglect" means the failure of a person who has assumed legal responsibility or a contractual obligation for caring for an older person or a person with a developmental disability or who has voluntarily assumed responsibility for the person's care, including an employee of a public or private residential institution, facility, home, or agency, to provide food, shelter, clothing, or services necessary to maintain the physical or mental health of the older person or the person with a

developmental disability.

Self-Neglect For the purpose of this manual, "self-neglect" means failure of a person to meet their own needs and/or accept offered services.

Exploitation "Exploitation" means:
[52-3-803 \(3\)](#), MCA (a) The unreasonable use of an older person or a person with a developmental disability or of a power of attorney, conservatorship, or guardianship with regard to an older person or a person with a developmental disability to obtain control of or to divert to the advantage of another the ownership, use, benefit, or possession of or interest in the person's money, assets, property by means of deception, duress, menace, fraud, undue influence, or intimidation with the intent or result of permanently depriving the older person or person with a developmental disability of the ownership, use, benefit, or possession of the person's money, assets, or property;
(b) an act taken by a person who has the trust and confidence of an older person or a person with a developmental disability to obtain control of or to divert to the advantage of another the ownership, use, benefit or possession of or interest in the person's money, assets, or property by means of deception, duress, menace, fraud, undue influence or intimidation with the intent or result of permanently depriving the older person or person with a developmental disability of the ownership, use, or benefit of the person's money, assets or property.

Mental Injury "Mental injury" means an identifiable and substantial impairment
[52-3-803 \(6\)](#), MCA of a person's intellectual or psychological functioning or wellbeing.

Physical Injury "Physical injury" means death, permanent or temporary
[52-3-803 \(10\)](#), MCA disfigurement, or impairment of any bodily organ or function.

A civil rights violation is defined as any incident that occurs when a person or another person alleges that a civil right of the person has been violated. The incident must be referred to the agency that has jurisdiction to investigate allegations of rights violations. The rights of all persons include the fundamental human, civil, constitutional and statutory rights.

This is coded in the ABUSE section in the data management system as a civil rights violation and therefore is a critical incident.

PERSON TO PERSON ABUSE REPORTS

Where the reporting staff or supervisor has reasonable cause to suspect that a person receiving DDP funded services has been subjected to abuse, sexual abuse, neglect, or exploitation as defined by the Montana Elder and Persons with Developmental Disabilities Abuse Prevention Act (52-3-801, et. Seq., MCA), and the alleged perpetrator is suspected to be another person receiving services, the incident is required to be reported to the department. These incidents are classified as "Person to Person Altercations" with the cause of abuse. THESE ARE INCIDENTS OF ABUSE and require critical investigations.

INCIDENT DEFINITIONS

****NOTE****

THE CATEGORIES OF INCIDENTS LISTED ARE THE ONLY ONES TO BE USED FOR THIS POLICY.

INJURY –

Injury is generally defined as damage inflicted to the body. For the purposes of this policy, injuries include:

- Abrasion
- Airway obstruction
- Allergic reaction
- Bite/sting
- Bleeding
- Blister
- Bruise
- Burn
- Choking
- Concussion
- Cut
- Other – see examples below:
 - Loss of fingernail/toenail due to trauma;
 - Loss of tooth/teeth due to trauma;
 - Hypothermia
- Dislocation
- Fracture
- Frostbite
- Hematoma
- Hyperthermia
- Infection
- Laceration
- Lesion
- Loss of consciousness
- Pain
- Poisoning
- Pressure Ulcer
- Puncture
- Rash/hives
- Redness
- Scrape
- Scratch
- Sprain/Strain
- Sunburn
- Swelling/Edema

Self-Injurious Behavior, Pica and Seizure behaviors are causes of injuries and not events and should be clearly marked in data management system under "cause" of an injury or suspected injury. Illness of a person, in and of itself, generally is not to be reported as an injury, but can be reported under "Other – Serious Illness".

Besides being classified by type of injury, injuries are also classified by the level of the severity of the injury. The reporting classifications are:

Critical (notification level "high"): any injury of known or unknown origin that requires an emergency room or physician visit that results in a hospital admission and/or any injury from suspected abuse or neglect. In the DMS under "injury severity" drop down box select "severe (hospital, ER/admission)".

Reportable (notification level "medium"): injuries requiring treatment by staff or onsite medical personnel such as first-aid, treatment with a PRN pain medication (not over-the-counter medications). In the DMS under "injury severity" drop down box select "moderate (nurse/physician treatment)" or "minor (first aid)".

Internal (notification level "low"): an incident or injury that is temporary and results in either no injury or very minor injury requiring no treatment. Examples include: shallow scratch which does not break the skin; minor skin irritation which does not open the skin; using over-the-counter pain medications or hot/cold packs. In the DMS under "injury severity" drop down box select "very minor."

MEDICATION ERROR –

Per the National Coordination Council for Medication Error Reporting and Prevention: “A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or person.” Internal medication errors are physician or pharmacy errors that are discovered but not administered to the person. All other medication errors are considered reportable **unless** the error causes the outcome of the incident to elevate the incident to a critical notification level. Critical level incidents in this category include: hospitalization, death, or incidents that are caused by suspected abuse or neglect.

Although the data management system includes a field for coding medication severity levels, the DDP will not be using that field.

- **Charting Error** - Medication charted prior to the person taking the medication; medications given to persons and not charted; failure to chart refusals; charting for a co-worker; and/or the use of ditto marks, erasing entries on the Medication Administration Record (MAR), using “white out” on the MAR.
- **Omission** - Medication not given to person; not obtaining refills on time and/or; sufficient quantities not available. A refusal of medication is also an omission.
- **Order Expired** - Medication given beyond the “stop order” and/or medication given past an expiration date.
- **Transcription errors**
 - Wrong dose or the dose on the MAR does not match the dose on the prescription and/or pharmacy label;
 - Wrong person or the name on the MAR does not match the name on the prescription and/or pharmacy label;
 - Wrong medication or the name of the medication on the MAR does not match the medication listed on the prescription and/or pharmacy label;
 - Omission or new medication that was prescribed was not written on the MAR;
 - MAR entry shows the wrong route or the route for giving the medication does not match the doctor’s order written on the prescription and/or pharmacy label;
 - Wrong time or the time(s) for medication administration is not the same as indicated on the prescription and/or pharmacy label.
- **Wrong dose**
 - Person given the wrong dose of medication.
- **Wrong person**
 - A medication was given to the wrong person.
- **Wrong medication**
 - The wrong medication was given to the person or a medication was prescribed or given to a person with an allergy to that medication.
- **Wrong route**
 - A medication was given by the incorrect route.
- **Wrong time**
 - The medication was actually given at a time that is different than that written on the MAR or outside of the predefined time interval from its scheduled administration time. (outside the window for administration).
- **Other**
 - Physician or pharmacy errors.

- o Medium/texture/consistency or medication not given in proper form.
- o Position: Medication specifically prescribed to be given to person when sitting upright in wheelchair not when sitting in recliner
- o Storage issues: Administration of a drug that was stored incorrectly or for which the physical or chemical dose (integrity of the drug) has been compromised.
- o Finding medication in an area not specifically indicated for medication storage or handling.

****NOTE****

Regardless of whether a person has experienced adverse side effects and/or their health/welfare is in jeopardy, some types and/or patterns of medication errors emerging from regular trend analysis of all medication errors may raise the incidents to a critical incident classification. As a result, service providers should respond as such and initiate investigations into those circumstances.

RESTRAINTS RELATED TO BEHAVIOR --

- Restraint related to behavior – Physical restraint may only be used as an emergency procedure as described in ARM Title 37, chapter 34, subchapter 14, Positive Behavior Support and all instances of the use of physical restraint must be reported as a critical incident.
- Mechanical restraint as described in ARM Title 37, chapter 34, subchapter 14, Positive Behavior Support may only be used upon written order by a licensed physician for medical reasons. It is not necessary to report the use of mechanical restraint ordered by a licensed physician for medical reasons but all other uses of mechanical restraint must be reported as a critical incident.

RESTRAINT OTHER (UNAUTHORIZED USE OF RESTRICTED OR PROHIBITED PROCEDURES)

Restricted or Prohibited Procedures – The unauthorized use of restricted or prohibited procedures as described in ARM Title 37, chapter 34, subchapter 14, Positive Behavior Support must be reported as a critical incident.

****NOTE****

The following are not considered restraints when used in accordance with the person's plan of care:

- Devices used to provide support for the achievement of functional body positions and equilibrium that have been prescribed by an appropriate health care professional;*
- Stretcher belts or gait belts intended to prevent a person from accidentally falling;*
- Equipment that does not restrict or prevent movement or the normal use/functioning of the body or body parts to which it is applied;*
- Helmets as a protective device;*
- Mechanical supports to provide stability necessary for therapeutic measures, such as immobilization of fractures, administration of intravenous or other medically necessary procedures;*

- *Holding a person's limb(s) or body to provide support for the achievement of functional body positions and equilibrium;*
- *Any specific medical, dental or surgical procedure that has been prescribed by an appropriate health care professional; or*
- *Car seats, high chairs, playpens or items generally used by parents and considered to be used for a child's general health and safety do not fall into this category, unless abuse, neglect or exploitation are suspected.*

DEATH –

The permanent cessation of all vital bodily functions is a critical incident with high notification and requires investigation.

“OTHER” INCIDENTS AS LISTED IN DATA MANAGEMENT SYSTEM –

- **ACCIDENT - NO APPARENT INJURY –** if not due to suspected abuse, neglect or exploitation may be considered as internal or low notification.
- **ALCOHOL/DRUG ABUSE –** if not due to suspected abuse, neglect or exploitation may be considered as internal or low notification.
- **ALTERCATION –**
 - Any altercations resulting in harm to another person requiring treatment at a medical facility, is a critical incident for both the aggressor and the victim reports. *These incidents are classified as “Person to Person Altercations” and therefore, THESE ARE INCIDENTS OF ABUSE and require critical investigations.*
 - Any altercation where there is a temporary disfigurement and does not require treatment at a medical facility is a reportable incident for both the aggressor and victim reports.
 - Any altercation where there is no temporary disfigurement and/ or physical contact is an internal incident.

This category covers any incident where the altercation is directed at another person and presents a serious risk of physical or mental harm to the other person. For the purposes of this manual, “person to person” refers to both people receiving DDP funded services.

- Person to Person Altercation– Alleged Victim – To be used when a person is the alleged victim of an altercation by another person.
- Person to Person Altercation – Alleged Aggressor – To be used when the person is the alleged aggressor of an altercation against another person.
- Person to Staff – To be used when the person is the alleged aggressor of an altercation against a provider agency staff person.
- Person to Other – To be used when the person is the alleged aggressor to another individual not in services or a staff, such as a family member, neighbor or stranger.
- **ASSAULT –** An attack BY a staff or community member to a person. This must be reported to APS/CPS and law enforcement immediately. This is a critical incident and requires an investigation.

- **ABSENT WITHOUT LEAVE (AWOL)/MISSING PERSON (UNACCOUNTED FOR ABSENCE)** – If a person's whereabouts are unknown and there is suspected abuse, neglect, or exploitation or whose supervision needs or pattern of behavior is a concern for reasons of safety and well-being, or beyond a time normally expected as outlined in the person's plan of care, it is considered a critical incident or high notification.
- **BEHAVIORAL ISSUE** – (Do Not Use.)
- **CHANGE OF CONDITION** – (Do Not Use.)
- **COMPLAINT AND/OR POSSIBLE LITIGATION** – (Do Not Use.)
- **CONTRABAND** – (Do Not Use.)
- **POSSIBLE CRIMINAL ACTIVITY/MISCONDUCT** – If not due to suspected abuse, neglect or exploitation, is considered reportable or medium notification.
- **EXPLOITATION** – (see Abuse/Neglect/Exploitation definition) – when exploitation is suspected, you must select either Abuse or Neglect in the General Information section of the DMS; for type, select “Other” with “exploitation” typed in.
- **FIRE** – this is a critical incident regardless of cause.
- **HOSPITALIZATION** – any unplanned/unscheduled admission to a hospital or any unplanned/unscheduled psychiatric hospitalization is a critical incident.
- **LAW ENFORCEMENT INVOLVEMENT** – any incident involving a person where law enforcement has been contacted is considered a reportable incident.
- **PROPERTY DAMAGE** – for any damage exceeding \$50.00 in value is a reportable incident.
- **SECURITY BREACH** – (Do Not Use.)
- **SENSITIVE SITUATION** – (Do Not Use.)
- **SERIOUS ILLNESS** – this category is selected when a person visits a doctor or visits a same day care type facility and it does not result in admission to a hospital, for either medical or psychological illnesses. Any unplanned medical doctor visits (outside of routine care). Any unplanned medical doctor visit is a reportable incident.
- SUICIDE-**
 - An incident involving an act (attempt) to harm or injure with the stated intent to end one's own life is considered critical incident.
 - An incident involving a verbal threat to harm or injure oneself with the intent to end one's own life is considered a reportable incident.
- **THEFT/LARCENY ATTEMPT** – can be coded in the DMS as either a perpetrator or victim of theft/larceny. Depending on the information provided, this may be considered an internal incident.
- **POTENTIAL INCIDENT/NEAR MISS** – any event which has the potential for severe injury or any other harm to a person which is narrowly avoided and needs to be addressed to ensure protection from harm is an internal incident.
- **OTHER** –
 - **PRN MEDICATION** – PRN Medication to reduce or eliminate a behavior is strictly prohibited unless prescribed by a physician for a medical reason and an approved protocol signed by the physician is in place. PRN Medication is coded in data management system under “Other” and “PRN use” in the sub-category. This is a reportable incident.

*****Documentation of Life Events*****

There may be situations where an event may be a one-time occurrence that does not meet the threshold of a defined incident but should nevertheless be documented. Life events can be documented in many places including behavior plans, progress notes, case management notes and the person's social history as well as communication logs, and not just incident reports.

If that event begins to reoccur, it could indicate a pattern or trend that needs to be reviewed. All team members involved in a person's care will be prompted to begin looking at this data and determining if a change in services or supports is indicated.

Section 2: PROVIDER REQUIREMENTS

Provider agencies must have policies and procedures to accomplish the following:

1. Protection from harm

- Take immediate action to either remove persons from a harmful situation or to otherwise protect persons from harm.
- Provide prompt staff intervention when knowledge of harm, or the potential for harm, occurs.
- Provide immediate medical assessment and/or treatment of a person if needed following an incident.
- Any injury(s) suspected to be caused by abuse or neglect must be classified as an allegation of abuse or neglect for reporting purposes and must be immediately examined by a medical professional, where appropriate.
- Assure all direct care staff (hired by family or agency) and volunteers are trained in Montana's Incident Management Policy and Procedures, the reporting of abuse, neglect or exploitation, and the mandatory reporter requirements. Staff must be trained to respond to, report, and document incidents as required in this manual. On-line training is available in the data management system for submitting Incident Reports (IR's).
- Identify any potential conflict of interest and have alternative personnel available to conduct investigations if a conflict exists.
- Provide an orientation packet describing their incident management process to persons and/or family members and legal representatives in a user friendly and easily understood format.

2. Procedures for reporting incidents when they occur

- Promptly identify and report incidents, as described herein.
- Provide the immediate review of the incident for purposes of initially classifying the event and determining the need for a critical incident investigation.
- Provide timely and accurate notification of the incident to appropriate state, provider and any contracted staff, legal representatives, public officials and representatives from other agencies. (See Appendix C for additional information)
- Enter Incident Reports (IR) into data management system within 48 hours or 2 business days from the time the incident occurred.
- Assure any person who, without false intent, reports an incident or makes an allegation of suspected abuse, neglect or exploitation will be free of any form of retaliation.
- Cooperate with investigators requesting information including making staff available for interviews within the timeframes for investigation. Failure to comply with access requirements will result in corrective actions that may lead up to sanctions.
- Notify the Developmental Disabilities Program, DPHHS Licensure Bureau, Adult Protective Services, Child Protective Services, and/or law enforcement of the occurrence of a critical incident when incidents fall within their jurisdiction for an investigation.

3. Establish an Incident Management Committee

- Establish an incident management committee. Provider agencies are required to designate a staff person (preferably an employee with some level of supervisory or management capacity) as the Incident Management Coordinator for the organization.
- Identify the role, function, and membership of the committee, including routine review and assessment of all internal, reportable and critical incidents, monitoring trends of incident report information, and developing policies and procedures designed to protect and prevent harm to persons.
- Require weekly meetings of the agency's incident management committee if any incidents have occurred. If meetings do not occur the coordinator will send notification to the committee members.
- Assure that reports of incidents and any required documentation including incident reports, trend analysis reports and any investigation reports are kept confidential. The names of those who report critical incidents of suspected abuse, neglect or exploitation are not released, unless required by law or regulation.

4. Review incidents and take action

- Initiate and conduct a critical incident investigation when a critical incident has been reported.
- Promptly assign agency staff to conduct critical incident investigations. All critical incidents must be investigated by agency staff who have been trained in investigations through training approved by the Department.
- Complete the critical incident investigation no later than ten (10) working days from the time the incident occurs. An extension may be granted to the initial 10-working-day period. The extension must be requested of, and approved in writing by, the Developmental Disabilities Regional Manager. Any written request and subsequent regional manager approval must be attached to the completed FIRF (see Appendix F).
- Review any IR entered in the data management system regardless of the reporting entity.
- There will be circumstances arising where the critical incident investigation will also be conducted by an entity external to the organization or in tandem with another provider where a person is being served jointly by two or more providers. Disability Rights Montana also may conduct an independent investigation and has access to certain records, pursuant to 42 USC Sec.15043.
- Cooperate fully with law enforcement, Adult Protective Services, DPHHS Licensure, or any other outside agency which may have statutory jurisdiction over the investigation of an incident. The agency will conduct their own internal review of the incident regardless of the outcome of any outside investigation. The agency is only to review the facts known at the time without impeding outside agency's investigations. The provider agency must make staff available for interviews within reasonable timelines for the investigation.

****NOTE****

If the victim or a witness recants their testimony the incident must still be investigated.

- Document a full investigation using the Final Investigation Report Form (FIRF). A triage review must be documented using the Triage Review Form (TRF). The Administrative Review of an investigation, including a Triage, must be attached to the IR in the data management system for review.

5. Follow up of review and or action taken

- Conduct reviews of all incidents and implement action plan requirements and recommendations, which may include personnel action when warranted to prevent the recurrence of similar incidents.
- Establish procedures for data collection through the data management system and conduct trend analysis as a means to develop appropriate support and service plans for the person(s) to prevent more serious incidents from occurring.
- Assure Incident Report and Administrative Review (AR) information are kept in the person's confidential records.
- Assure that policies and procedures were followed during the course of investigations and noted in the administrative review section of the investigation, including removing the employee who is an alleged perpetrator from contact with the person during an investigation of suspected abuse, neglect or exploitation.
- Forward, at the conclusion of the investigation, a copy of the investigation report (FIRF or TRF) to the following:
 - Agency's board of directors;
 - Other executive staff, as appropriate; and
 - Quality improvement specialist.
- Make the investigation documentation (FIRF or TRF) available to the parties listed below:
 - DPHHS/DDP executive staff including: director of the Developmental Disabilities Program, the community services bureau chief, regional manager of the region in which the incident occurred; and
- As appropriate, designated legal staff for the department, and other agencies as required by law or regulation.
- Assure that the person and/or legal representative and case manager are notified of the outcome of the investigation by providing a redacted copy of the Administrative Review (AR), for any investigation within 5 days of its completion.

* While a report may contain reference to the information concerning the incident received from other residents or persons receiving services, personal information about health status and other personal matters of those other residents or persons receiving services that may appear in a report must be redacted. In addition, employment related actions taken by a provider in relation to an employee who is alleged to be responsible for the harm to the person must also be redacted from a report.

Section 3: NON-PROVIDER AGENCY RESPONSIBILITIES

Targeted Case Management Responsibilities

The case manager (CM) has a core responsibility to assure that a person receives quality services as identified through the plan of care. When incidents occur, the CM has the responsibility to assure that the issues/needs of the person are addressed promptly and correctly, and ultimately to reduce the risk of harm to the person. This can be accomplished through the team process. The CM is responsible for the following in the incident management system.

- Submit an IR in data management system if an incident is observed or discovered;
- Review and sign off on Incident Reports for their caseloads and comment/follow-up if necessary;
- CM will ensure any significant incident information is documented in the social history for permanency;
- Provide information and if necessary clarification to persons and/or legal representative explaining the purpose of incident management in a manner that is easily understood;
- Receive and review Incident Management weekly minutes & monthly trend data and analyze for possible revision to the plan of care;
- When a high risk review level (as described below under “*High Risk Review*”) has been identified, the CM will review the plan of care with the team to address the incidents and determine if a revision to the plan is necessary;
- Assess the person’s level of risk and then address person’s ability to manage the risk with the team;
- Attend weekly incident management committee meetings as assigned;
- Participate in Triage Review initiated by DDP staff; and
- Receive Administrative Review information from the provider following an investigation and follow-up if necessary with the team.

Waiver Children’s Case Management (WCCM) Responsibilities

The case manager (CM) has a core responsibility to assure that a child receives quality services as identified through the plan of care. When incidents occur, the CM has the responsibility to assure that the issues/needs of the child are addressed promptly and correctly, and ultimately to reduce the risk of harm to them. This can be accomplished through the team process. The CM is responsible for the following in the incident management system.

- Submit an IR in data management system if an incident is observed or discovered.
- Review and sign off on Incident Reports for their caseloads and comment/follow-up if necessary.
- Provide information and if necessary clarification to families explaining the purpose of incident management in a manner that is easily understood.
- When a high risk review level (as described below under “*High Risk Review*”) has been identified, the CM will review the plan of care with the team to address the incidents and determine if a revision to the plan is necessary.

- Participate in Triage Review initiated by DDP staff.
- Receive Administrative Review information from the provider following an investigation and follow-up if necessary with the team.

Quality Improvement Specialist Responsibilities

The quality improvement specialists (QIS) of DDP have core responsibilities in the receiving, reviewing and evaluating the IR's submitted by provider agencies in the data management system. In addition, the QIS will investigate certain critical incidents. The following are the QIS responsibilities:

- Submit IRs in data management system when incidents are observed or discovered.
- Receive, review, and sign off on all IRs.
- Receive and review all investigations.
 - Participate, when assigned by the regional manager, in the provider agency's incident management committee meetings.
- Participate in Triage Review, as assigned.
- Receive and review Incident Management weekly minutes, monthly trend data and high risk reviews.
 - Assess the person's level of risk and the person's ability to manage the risk with the team.
 - Assess the service provider's efforts to ensure the health and safety of the person, and make recommendations or take action as appropriate.
 - Conduct critical incident investigations for incidents involving emergency/unplanned hospitalization and a person's death, or when assigned by the regional manager due to a conflict of interest or a pattern of incidents requiring further review.
- Conduct a procedural review for critical incident investigations involving abuse, neglect or exploitation when the incident is referred to the appropriate agency for their statutory investigation.
- Complete assigned investigations within ten (10) working days. In cases where the ten days cannot be met, an extension to the timeline can be granted by the regional manager. This request must be in writing. Upon completion the QIS will submit the investigation to the regional manager for review.
- Complete an Investigation Review Form (IRF) of all provider agency critical investigations submitted via the FIRF. Any investigatory procedure issues noted in the IRF will be addressed with the provider agency.
- The QIS has the authority to issue Quality Assurance Observation Sheet (QAOS) to providers as corrective action measures as needed.
- Following the completion of a full investigation, the QIS will forward the Investigation Review Form and any Quality Assurance Observation Sheets (QAOS) to Central Office for outcome tracking.
- For self-directed services, the QIS will:
 - Triage/investigate incidents classified as critical.

- QIS will be available through the regional office to provide technical assistance if requested by the person or the family self-directing their services.

Regional Manager Responsibilities

The Regional Manager's (RM) responsibilities for incident management are as follows:

- Assign the QIS to complete critical incident investigations or request other Developmental Disabilities Program (DDP) staff or an additional QIS to complete an investigation due to conflicts of interest or other necessary circumstances.
- Participate in a Triage Review or assign a designee, as warranted.
- Grant extensions on investigations as requested in writing on a case by case basis.
- Request further follow-up or investigation of an incident.
- Complete the Administrative Review when the critical incident investigation is conducted by the QIS. The Administrative Review Form (AR) will be made available to the bureau chief along with the supporting documents.
- Based upon this review, DDP may request further follow-up or investigation of the incident.
- Conduct monthly trend analysis meetings with the QIS's of regional reports generated from data management system or reports from the DDP central office and determine appropriate follow-up on trends.

DDP Central Office Responsibilities

The DDP central office staff persons, in their various capacities, are responsible for the following activities:

- The DDP is responsible for developing, disseminating, and revising the Investigator's Training Manual to all persons who will be trained to conduct critical incident investigations.
- The central office staff will enter IR's for self-directed services in the data management system.
- The central office staff including but not limited to DDP director, community supports bureau chief, program support bureau chief, crisis prevention specialist, and state medical director, will meet monthly to review trending data and report back to the regional office of any concerns.
- Central office staff will present incident management trend summaries to the quality council.
- The medical director will review medication errors, injury trends and other medical related concerns as needed.
- The medical director will review all death investigations, including the TRF or FIRF and QIS Death Investigation Review Checklist (QDIRC), and participate on the mortality review committee. Findings from the committee will be shared with the appropriate field staff.
- Assure that all critical incidents involving deaths remain open until after the morality review committee has met and until recommended closure is received from the central office. (Note: this may require granting extension(s) to staff until all information is

received and until after the Morality review committee has met or if mortality review committee requests additional information based upon their findings.)

Responsibilities for Self-Directed Services with a Fiscal Intermediary

- All staff working for a person receiving self-directed DDP funded services is required to report critical incidents by submitting an incident report (paper copy) to central office following the timelines in this manual.

****NOTE****

Staff who are hired by the family and being paid by DDP funds are mandatory reporters. They are required to make timely and accurate notification of incidents to DDP, APS/CPS or law enforcement, as needed.

- Take immediate action to move the person from a harmful situation or to otherwise protect persons from harm.
- Provide prompt staff intervention when knowledge of harm, or the potential for harm, occurs;
- Provide immediate medical assessment and/or treatment for a person receiving self-directed services if needed following an incident.
- Any injury(s) suspected to be caused by abuse or neglect must be immediately examined by a medical professional and classified as an allegation of abuse or neglect for reporting purposes.
- The person or family choosing to self-direct services must participate and cooperate with the person conducting the investigation.
- All self- direct staff is to be trained on the DDP incident management system on recognizing incidents, notification procedures and the completion of an incident report.

Section 4: INCIDENT MANAGEMENT COORDINATORS and COMMITTEES

All incidents identified as critical, reportable and internal will be reviewed weekly through the provider agency's incident management committee.

Provider agencies are required to designate a staff person (preferably an employee with some level of supervisory or management capacity) as the incident management coordinator for the organization.

Duties of the Incident Management (IM) Coordinator

- Provide technical assistance to staff members regarding the agency's incident management system including completion of the Incident Report Form and other needed documentation.
- Ensure IR's are filled out completely, accurately, and coded correctly in the DMS.
- Ensure that organizations/authorities external to the organization receive notification (verbal and/or in writing) of critical incidents as defined by this policy.
- Coordinate training regarding the application of the DDP incident management requirements.
- Approve IR's in the data management system within 48 hours or 2 working days after the incident management committee meeting and include the committee's recommendations. Any additional information or corrections will be noted in the comment section of the incident report.
- The IM coordinator will contact the person's case manager, to discuss the need to hold a team meeting to discuss the pattern or trend of incidents in order to assure health and safety. This will be noted in the IM minutes.
- Follow-up to ensure that all recommendations were followed and completed.
- Serve as a member of the agency's incident management committee.
- Send minutes to the committee weekly for review prior to the next meeting.
- Maintain the minutes of the meetings and distribute the minutes to the QIS and CM.
The minutes will include:
 - Names, titles and agency represented of those in attendance;
 - List of all incidents since previous meeting;
 - Documentation of the incident management committee's findings, recommendations, implementation of recommendations, and results/effects of actions implemented which are also added to the comments in the IR in the data management system; and
 - Any outstanding follow-up from previous incidents not already discussed.
- The IM Coordinator will attach the Administrative Review to the IR in data management system.
- Compile and disseminate monthly Incident Management Trend Summary of all incidents, and documentation of actions taken, no later than 10 working days after the last day of the month. Trend reports are sent to the QIS, to case management supervisors to be distributed to the appropriate person's case manager, and provider agency's Board of Directors. This report must include the following information:
 - Total number of incidents per category (Critical, Reportable, Internal);
 - Types of incidents;

- Types of incidents by person name;
 - Incidents by total number of injuries;
 - Severity of injuries;
 - Location where injuries and other incidents occur;
 - Times, if applicable, in which injuries and other incidents occur;
 - Specific employees involved in the incident;
 - Specific persons involved in the incident; and
 - Other trends deemed as being appropriate, based on the needs of persons and the mission of the Service Provider.
- Prepare monthly trend reports and analyses of incident data which includes high risk review data and submit to the provider agency's incident management committee.

High Risk Review

The high risk review for any person who meets one (1) or more of the criteria listed below is required within 10 working days (the incident management committee may also determine that more frequent high risk reviews are indicated):

- Three (3) or more critical incidents during the preceding month or five (5) or more critical incidents during the preceding three (3) months;
- A serious or severe injury due to substantiated allegations of staff abuse, neglect, or exploitation; or
- A pattern or trend of reportable incidents involving a person over a three (3) month period that requires a more thorough review and assessment of the person's needs.

The incident management committee also has the discretion to recommend a high risk review for a person who does not meet the minimum criteria as defined above.

Membership and Functions of the Incident Management Committee

- The incident management committee membership must include:
 - The executive director/CEO or the executive director/CEO's designee;
 - Incident management coordinator;
 - Representatives of each of the service provider's operational program units;
 - A case management representative; and
 - The quality improvement specialist assigned to work with the agency is an optional member and will attend meetings, as warranted.
- The incident management committee must meet at least weekly. If there are no incidents to review, then the committee does not need to meet as scheduled and the IM coordinator will send notifications to other committee members and document the reason why.
- At each meeting, the committee is required to review all IR's that have been reported since the last scheduled meeting.
- The review is focused on the following and IM committee meeting minutes must include:
 - Provider name, date of meeting, members in attendance, date of incidents and level of incidents;
 - Review of what occurred and the staff response and follow-up actions;

- Determination of whether already recommended corrective/preventive actions were implemented;
- Consideration of what (if any) additional corrective and/or preventive actions are warranted that would provide additional positive supports to the service recipient and staff;
- Consideration of whether the person's plan of care should be amended based on information developed as a result of this process or through a high risk review. If so, the planning team is to be convened;
- The minutes must reflect that trends have been reviewed and analyzed and;
- The committee will review past incidents to ensure completion and remediation of unresolved concerns have been addressed and documented in the weekly minutes.

****NOTE****

For all incidents (critical, reportable, internal) the recommendations from the incident management committee must go into data management system on the IR.

Section 5: TYPES OF REVIEWS AND INVESTIGATIONS

Full Investigation (FIRF)

A full investigation is conducted for ALL critical incidents where abuse, neglect and/or exploitation is suspected. A full investigation can also be conducted for incidents elevated to critical and exceed the review of the Triage Review form. The full investigation process will generally follow those outlined in the Investigator's Manual. Appendix A: Key Stages to Conducting Critical Incident Investigations, is a quick reference guide. Following the investigation which is reviewed at the weekly IMC, the administrative review will be completed and attached to the incident report in the data management system.

Full investigations completed by the provider agency or DDP are to be documented using the FIRF.

Triage Review (TRF)

The Triage Review form, commonly known as the "Triage", can be used as the review/investigation of any critical incidents where abuse, neglect and/or exploitation ARE NOT suspected. This review can be used by provider agency staff or DDP staff. The provider agency will determine whether or not a more complete investigation is warranted, however DDP can require a more complete investigation. If no further investigation is warranted, the Triage review will be the completed investigation for this incident and will be documented using the TRF. The Triage Review form will be reviewed at the IM committee meetings and an Administrative Review will be completed and attached to the IR in the data management system.

Administrative Review (AR)

The Administrative Review form (AR) will be completed by the agency's administration or the regional manager depending on who completed the investigation to assure all policies and procedures were followed, appropriate recommendations were made and actions were taken to assure health and safety. This level of review is done for all critical of investigations (Full or Triage) and must be attached to the incident report in the DMS. The IM committee will monitor and follow up on the AR recommendations at IM committee meetings to ensure they are implemented. The AR will not be closed until the recommended action outcomes are completed and documented.

Death (QDIRC)

If the critical incident is a person's death, in addition to the investigation (either Full or Triage) done by the provider agency or the QIS, the Death Investigation Review Checklist, only done by the QIS, is forwarded to the mortality review committee.

Procedural Review (PR)

The QIS will conduct a Procedural Review (PR) of any suspected abuse, neglect, or exploitation incidents to determine if rules, policies and programmatic procedures are in place and being followed to protect persons from harm as outlined in the PR. This will be done regardless of whether outside entity investigations are being conducted. This includes law enforcement (LE), Adult Protective Services (APS), Child Protective Services (CPS), Bureau of Indian Affairs (BIA), DPHHS Licensing Bureau, etc., which are required by statute or

regulation to conduct an investigation into the incident. *QIS will cooperate with LE and APS when conducting an investigation or a procedural review.*

Investigation Review (IRF)

The quality improvement specialist conducts an Investigation Review for all critical incident investigations conducted by the provider agency. The QIS documents the review of all submitted materials on the Investigation Review form (IRF).

Appendix A: KEY STAGES TO CONDUCTING CRITICAL INCIDENT INVESTIGATIONS

CRITICAL INCIDENT INVESTIGATION SUMMARY GUIDE

STAGE OF INVESTIGATION	RESPONSIBILITY	KEY TASKS/ACTIVITIES
1. Incident Identified INTAKE & PRESERVE EVIDENCE	SITE SUPERVISORS AGENCY MANAGEMENT	1. Assure health/safety of all persons. 2. Provide medical treatment. 3. Secure the scene (as necessary). 4. Identify, keep witnesses separate. 5. Secure documentary evidence.
2. Arrive at scene IDENTIFY/COLLECT EVIDENCE	INVESTIGATOR(S)	1. Review activities of intake and preservation with management. 2. Review incident with Reporter. 3. Identify/collect physical and demonstrative evidence. 4. Sort/classify/interview witnesses, obtain written statements. 5. Identify and collect other documentary evidence.
3. Review/Reconcile ANALYSIS & PRESENTATION of EVIDENCE	INVESTIGATOR(S)	1. Review/assess evidence collected. 2. Conduct background interviews (as necessary). 3. Conduct follow-up interviews (as necessary). 4. Conduct final reconciliation of evidence. 5. Prepare Final Investigation Report using standard report format.
4. Final Decision-Making RECOMMENDATIONS and/or REQUIREMENTS ACTION PLAN & ADMINISTRATIVE REVIEW	AGENCY MANAGEMENT INCIDENT MANAGEMENT COMMITTEE	1. Review competency/quality of investigation. 2. Determine final conclusions of the investigation. 3. Determine recommendations, requirements and action plans. 4. Implement recommendations, requirements and action plans. 5. Submit completed IR and other required documentation to the DDP.
5. DDP Competency Review QUALITY REVIEW	DDP QUALITY IMPROVEMENT SPECIALIST	1. Completes audit of investigation using Investigation Review Form. 2. Review and monitor implementation of recommendations and action plan.

Key Stages to Conducting Critical Incident Investigations

Standard protocols are used to identify, collect, and analyze evidence available during an investigation. There are five (5) key stages to any investigation:

1. Intake and Preservation of Evidence (including the identification and initial reporting of the event);
2. Identification and Collection of Evidence;
3. Analysis (reconciliation) and Presentation of Evidence;
4. Recommendations and Action Plan; and
5. Quality Improvement (conclusions, recommendations/requirements and corrective action).

STAGE 1: INTAKE AND PRESERVATION OF EVIDENCE

Once an incident has been identified as meeting the criteria for a critical incident that will be investigated, and a decision has been made as to any external investigation being conducted, provider agency site supervisors and/or other management staff are responsible to assure the following activities occur:

- Assure that the health and safety of all persons (persons, staff, and visitors) is addressed immediately;
- Seek immediate, medical treatment for allegations involving any physical injury, change in medical status, or sexual abuse regardless of whether or not a victim or a witness recants their testimony, and secure the scene. If possible, management staff will secure the scene by locking the area so no one is admitted until the investigator(s) arrives. If this is not possible, then the management staff should properly photograph and diagram the scene; and
- Identify, keep, and separate any witnesses. While it is not always possible to separate witnesses prior to being interviewed by the investigator(s), at minimum, management staff should explain to witnesses the need to not talk about the incident until interviewed by the investigator(s). This helps to minimize the potential that memories will be altered or changed (even unintentionally).

****NOTE****

It is recommended that all interviews be electronically recorded, as long as interviewees agree to the recording of the interviews and sign a permission form (see Forms).

It is also recommended that 2 people be present when interviewing witnesses or victims.

- Interviews with persons alleged to be sexually abused must be interviewed by a member of the same sex or have a member of the same sex present at all times during the interview.
- There may also be times when agency management will make a decision to require staff to remain after normal work hours have ended in order to interview witnesses for the purposes of the investigation.

- Secure documentary evidence. Management will assure that documentary evidence is maintained in a secure location until the investigator(s) can take possession of the materials. Documentary evidence can include any business record produced by the organization: the person's primary record (medical or otherwise), log books, incident reports, medication records, medical reports, staff schedules, training records, personnel records, financial records, etc.

STAGE 2: IDENTIFICATION AND COLLECTION OF EVIDENCE

Upon assignment of the investigation, the investigator(s) will arrive at the scene in order to begin the identification and collection of evidence. The investigator(s) has primary responsibilities to assure the following occurs:

- Review activities of intake and preservation with agency site supervisors and/or management responsible for conducting steps in Phase 1. Review the initial steps taken by people discovering or witnessing the incident, and upon receiving report of the incident, what management's response was. There should also be a transition of evidence (the chain of custody) initially preserved by management including any documentary evidence and names of potential witnesses (reporter, victim, alleged target, other witnesses with direct or circumstantial evidence, etc.).
- Review incident with the reporter. The investigator(s) should clarify with the reporter that the reporter did indeed report the incident, and verify what exactly the report initially communicated. The formal investigatory interview regarding the incident will take place at a later time.
- Identify and collect physical and demonstrative evidence. While physical evidence will not always be secured for every incident, collect physical evidence as necessary, take photographs and prepare diagrams, along with any other demonstrative evidence relevant to the incident. Focus on these tasks first when possible prior to interviewing witnesses. This is done primarily to assure that when the investigator(s) begins to conduct the investigatory interviews with witnesses they are in the best position to create a comprehensive interview with each person. Release the physical evidence as soon as possible back to normal use.
- Sort, classify, and interview witnesses; obtain written statements from witnesses. Sort witnesses by name in the following categories: Victim(s), Witness(s) with Direct Evidence, Witness(s) with Circumstantial Evidence, Alleged Persons of Interest. When possible, interview the reporter first, followed by the alleged victim, then witnesses with direct evidence, and witnesses with circumstantial evidence. Try to conduct the interview with the alleged perpetrator(s) last.
Written statements will be obtained from witnesses at the conclusion of the interview, and should be taken prior to concluding the investigatory interview.
- Identify and collect other documentary evidence. This information can include any business records of the organization related to the persons, employees, financial activities, or other administrative processes including activities of the Board of Directors of the corporation. Based upon the emergence of issues during the investigation, the investigator(s) may need to request additional information beyond

what was initially identified and provided. Photocopies of any documentary evidence determined to be relevant to the investigation should be made and maintained as a part of the investigation file.

STAGE 3: ANALYSIS AND PRESENTATION OF EVIDENCE

Once the investigator(s) has identified and collected all evidence relevant to the investigation, the process of reviewing the evidence and reconciling this information needs to begin. In order to best accomplish responsibilities related to this phase of the investigation, it is important to understand and apply some of the core rules associated with **Reconciliation of Evidence**. These are as follows:

- Is the witness's story consistent over time? Generally, a witness's story that is consistent over time will be seen as more credible than a witness whose story changes key facts/information over time.
- Can independent corroboration of a person's version of the incident be established which generally enhances credibility of that person's testimony?
- Is the physical evidence available in the investigation consistent or inconsistent with testimony given by witnesses? Where physical evidence is consistent with a witness statement, more value is given to that version of the event.
- Based upon the witness's location with respect to the incident itself (physical proximity and the environment), how will his/her capacity to make observations be affected? Are there possible environmental barriers that will affect a witness's capacity to see/hear?
- What are the witness's own capacities to see and hear? Are there impairments to either the sense of seeing or hearing?
- What was the witness's level of focus and attention during the course of the incident?
- What is the witness's relationship to other people involved in the incident: This relates to what may be seen as potential bias on the part of a witness because of the nature of a relationship they have with another party involved in the incident.

Core activities associated with the Analysis phase of the investigation include:

- Review and assess evidence collected. Identify all pieces of evidence where there is consistency and separate from the evidences where inconsistencies emerge.
- Conduct background interviews as necessary. These are conducted with persons who may be able to provide clarifying information regarding evidence in an investigation, not with identified witnesses to the incident itself.
- Conduct follow-up interviews with witnesses as necessary. These interviews are with witnesses to the incident itself and are primarily designed to clarify evidence or other questions that arise during the investigation.
- Conduct final reconciliation of evidence using the bulleted "Rules for Reconciling Evidence" identified above.
- Prepare and submit Critical Incident Final Investigation Report to DDP.
- Attach the Administrative Review (AR) to the IR in data management system.

STAGE 4: RECOMMENDATIONS/REQUIREMENTS AND ACTION PLAN

- Provider agency management, in conjunction with their incident management committee, will review the FIRF to determine final conclusions, recommendations and any requirements based on the findings of the investigations, and an action plan to implement those recommendations/requirements including timeframes for completion. This Administrative Review must be completed within ten (10) working days of the completion of the investigation.
- When the quality improvement specialist (QIS) conducts an investigation, a regional manager, will complete the Administrative Review within ten (10) working days after the completion of the QIS investigation.

The core activities of this phase of the investigation include:

- Review all components of the critical incident investigation for competency and quality. The investigation should have been conducted meeting the standards associated with speed, thoroughness, objectivity and provides all necessary information to draw reasonable conclusions and make appropriate recommendations/requirements.
- Develop recommendations/requirements and an action plan based on the findings of the investigation and conclusions drawn from that process:
 - Confirmed based on evidence – most likely the incident occurred as initially submitted – there is a preponderance of information to support the conclusion;
 - Not confirmed based on evidence – incident most likely did not occur as submitted;
 - Inconclusive – evidence neither supports nor disproves the incident occurred and cannot reach a conclusion.
- Any recommendations/requirement and subsequent action plans developed should reflect not only decisions specific to the incident itself but must also reflect assessment of other identified systemic issues related to the incident occurring, including antecedents (reasons why the incident occurred) and post-incident interventions.
- Implement recommendations, requirements and an action plan. The assignment of specific action plan items and target dates for completion are established and the provider agency is making a commitment to assure these recommendations and action plans are actually implemented.
- Determine whether there was a preponderance of evidence to support one of the following conclusions or findings regarding the investigation:
 - Closed
 - To Be Continued (there is not enough evidence to reach a conclusion).

STAGE 5: QUALITY REVIEW – Investigation Review Form (IRF)

- Using the Investigation Review Form (IRF), the QIS will review each investigation following the receipt of the final investigation report. If any deficiencies are discovered, the provider will be notified. (If the investigation is done by the QIS, the RM will complete the review.)
- The QIS will monitor the implementation of the recommendations/requirements and action plan as part of the quality assurance process.

Appendix B: INSTRUCTIONS FOR COMPLETING AN INCIDENT REPORT USING THE GENERAL EVENT REPORT (GER) IN THE DATA MANAGEMENT SYSTEM

The observer/discoverer of incident completes the General Event Report (GER) for any situation that meets the definition of a critical, reportable or internal incident.

Where there is more than one person involved in the incident, a report will be filled out for each person. The report for each person will focus on the actions of that person and the steps taken by the provider on behalf of that person.

NOTE: You must complete all required fields marked with a red asterisk (*). There are additional fields that the State of Montana deems as required but the field is not followed by an asterisk (*) in data management system. For the purposes of these instructions, note all required fields are marked with an asterisk (*).

Steps to fill out a GER:

1. From the First Page or Dashboard click on the 'New' link in the GER module.
2. Select the appropriate program location from the list.
3. Select the particular person from the list. This will open a new GER on that person.
4. In the profile information section, select the Reporting Date* for the incident.
5. Event information:
 - *In the event date field use the calendar button to select the date when the event occurred (it defaults to the current date).
 - *If the event occurred outside of the agency's physical location, choose the appropriate locations from the drop-down menu in the 'if not at responsible program' section.
 - * Describe what happened before the event: Use observable measureable terms to describe the environmental conditions, cues given, etc.
 - *Complete location address (if on site you can check the box for same as program address as it will auto fill).
6. Add Event: Chose the appropriate event type in the Add Event section. This will generate another window with a more specific event information form for each eventtype.
 - * For each Event added, specific details of the event will be required.
Please use observable and measureable terms in describing the event. Keep in mind others will be reading the report and trying to envision the event occurring. Describe who was involved and other witnesses. When other persons who receive services are involved in the incident, use their initials. You will need to fill out a separate incident form for the other person(s) involved.

When completed with the event field choice click 'Add' to add to GER.

➤ Injury

- *Type: If other is chosen in any of the questions, please specify in the 'if Other' box.
- *Cause
- *This event was observer/ discovered
- *Time of Injury
- *Specific location
- *Treated By
- *Injury severity
- *Body part(s)
- *Injury summary
- *"Witnessed," where the staff person was present or involved in the incident; or

*“Discovered,” where a staff identifies an incident but was not present, was not involved, or where the incident is “suspected.”

*You may also use the body diagram to select specific body part(s) affected by the injury.

*Provide as much detail in the injury summary section as known.

➤ Medication Error

*Type

*Medication as ordered

- Name
- Dose
- Measurement unit
- Frequency
- Route
- Time

*Medication as given

- Name
- Dose
- Measurement unit
- Frequency
- Route
- Time

*First error date

*Last error date

*Total errors

*Cause of error

*Reason/explanation for error

*Medical attention required

*Error discovered date

*Error discovered time

*Person(s) responsible

Severity level 1-10 (Do Not Use)

➤ Restraint Related to Behavior (this field is NOT used for PRNs)

IF marking “No” do the following:

*Begin time

*End time

*End date

*Status

*Injury caused by restraint

*Monitoring, at least every 30 minutes

*Exercise at least 10 min every hour

*Person applying

*In charge during

*Restraint summary

IF marking “Yes” do the following:

*Select behavior

*You may pick multiple behaviors

- *If behavior is not listed, select “add new behavior” and enter behavior

*Intervention

*Choose the intervention(s) preformed

- *If intervention is not listed, select “add new intervention” and enter intervention preformed

- *Behavior details
- *Name description
- *Antecedent
- *Intervention details
- *Name description
- *Behavior event
- *Check the box by the table indicating behaviors
- *Event date
- *Begin time
- *End time
- *Intensity
- *Notification level
- *Comments
- Restraint Other
 - *Restraint type
 - Chemical
 - *Mechanical
 - *Physical
 - *Other
 - *Begin time
 - *End time
 - *Location
 - *Restraint summary
- Death
 - *Time
 - *Cause
- Other
 - *Event type
 - *Event subtype (if applicable)
 - *Person was (if applicable)
 - *Event time
 - *This event was
 - *Location
 - *Event summary

7. *General Information

- *Add Necessary information in the General information section.
- *Abuse suspected: yes or no
- *Notification Level based upon DDP definitions High (critical), Medium (reportable), Low (internal)

8. *Notification

Click on the 'Add Notification Info' button. This will open a pop up window for adding notification information. Fill out the notification details and click on the 'Add' button at the bottom of the form.

9. *Complete the actions Taken or Planned section:

- *Describe any staff actions to immediately protect from harm;
- *Describe any immediate staff actions to make the environment safe;
- *Describe any actions to provide first aid or seek emergency medical assistance; and
- *Identify supervisors and/or other persons notified of the incident.

Appendix C: NOTIFICATION REPORTING REQUIREMENTS FOR CRITICAL, REPORTABLE, AND INTERNAL INCIDENTS

<u>Type of Critical Incident</u>		<u>Case Manager</u> (per ARM 37.34.1501)	<u>Legal Representative or Next of Kin</u> <i>*unless directly involved in the alleged incident</i>	<u>Adult Protective Service*</u> (per MCA 52-3-811) Person is age 18 or older	<u>Child Protective Service</u> (per MCA 41-3-201) Person under age 18	<u>County Attorney</u> (per MCA 52-3-811) Person is age 18 or older	<u>Long Term Care Ombudsman</u> (per MCA 52-3-811) Person is age 18 or older	<u>DPHHS Licensure Bureau</u> Person in Licensed DD Group Home or Licensed Foster Home
Allegation of Abuse, Neglect, Exploitation	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.	If the person is not a resident in a long term care facility, report to APS or local affiliate, as soon as possible, w/in 8 hours of witnessed incident.	Report to the Centralized Intake Bureau Hotline (1-866-820-5437) as soon as possible. w/in 8 hours of witnessed incident.	If the report involves a suspected act or omission of the department, report to the county attorney of the county in which the person resides or in which the acts that are the subject of the report occurred.	If the person is a resident in a long-term care facility, report the matter to the long-term care ombudsman appointed under the provisions of 42 U.S.C. 3027(a)(12) and to AS.	Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.
Allegation of Person to Person Altercations resulting in Abuse, Neglect, Exploitation	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.	If the person is not a resident in a long term care facility, report to APS or local affiliate, as soon as possible, w/in 8 hours of witnessed incident.	Report to the Centralized Intake Bureau Hotline (1-866-820-5437) as soon as possible. w/in 8 hours of witnessed incident.	If the report involves a suspected act or omission of the Department, report to the county attorney of the county in which the person resides or in which the acts that are the subject of the report occurred.	If the person is a resident in a long-term care facility, report the matter to the long-term care ombudsman appointed under the provisions of 42 U.S.C. 3027(a)(12) and to AS.	Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.
Civil Rights Violation	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.				If the person is a resident in a long-term care facility, report the matter to the long-term care ombudsman appointed under the provisions of 42 U.S.C. 3027(a)(12) and to AS.	Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.

<u>Type of Critical Incident</u>		<u>Case Manager</u> (per ARM 37.34.1501)	<u>Legal Representative or Next of Kin</u> <i>*unless directly involved in the alleged incident</i>	<u>Adult Protective Service*</u> (per MCA 52-3-811) Person is age 18 or older	<u>Child Protective Service</u> (per MCA 41-3-201) Person under age 18	<u>County Attorney</u> (per MCA 52-3-811) Person is age 18 or older	<u>Long Term Care Ombudsman</u> (per MCA 52-3-811) Person is age 18 or older	<u>DPHHS Licensure Bureau</u> Person in Licensed DD Group Home or Licensed Foster Home
Restraint Related to Behavior Restraint Other	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.	If abuse is suspected, and if the person is not a resident in a long term care facility, report to APS or local affiliate, as soon as possible, w/in 8 hours of witnessed incident.	If abuse is suspected, Report to the Centralized Intake Bureau Hotline (1-866-820-5437) as soon as possible. w/in 8 hours of witnessed incident.		If the person is a resident in a long-term care facility, report the matter to the long-term care ombudsman appointed under the provisions of 42 U.S.C. 3027(a)(12) and to AS.	Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.
Death	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.					Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.
Fire	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.					Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.
Suicide Attempt	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.	If the person is not a resident in a long term care facility, report to APS or local affiliate, as soon as possible, w/in 8 hours of witnessed incident.	Report to the Centralized Intake Bureau Hotline (1-866-820-5437) as soon as possible. w/in 8 hours of witnessed incident.			Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.

<u>Type of Critical Incident</u>		<u>Case Manager</u> (per ARM 37.34.1501)	<u>Legal Representative or Next of Kin</u> <i>*unless directly involved in the alleged incident</i>	<u>Adult Protective Service*</u> (per MCA 52-3-811) Person is age 18 or older	<u>Child Protective Service</u> (per MCA 41-3-201) Person under age 18	<u>County Attorney</u> (per MCA 52-3-811) Person is age 18 or older	<u>Long Term Care Ombudsman</u> (per MCA 52-3-811) Person is age 18 or older	<u>DPHHS Licensure Bureau</u> Person in Licensed DD Group Home or Licensed Foster Home
Hospitalization	QIS, w/in 8 hours of witnessed incident, IR written in data management System within 48 hours or 2 working days.	w/in 8 hours of witnessed incident, IR written in data management System within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.					Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident.
Unaccounted for Absence	QIS, w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days	w/in 8 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days	Verbal notice ASAP but no later than 8 hours after incident.					Must be reported to the local DPHHS licensing office within w/in 8 hours of witnessed incident
	IR written in data management system within 48 hours or 2 working days.	w/in 48 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP but no later than 8 hours after incident.					Must be reported to the local DPHHS Licensing Office within w/in 8 hours of witnessed incident.
Medication Errors	IR written in data management system within 48 hours or 2 working days.	w/in 48 hours of witnessed incident, IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP and no later than 8 hours after incident.					Must be reported to the local DPHHS Licensing Office within twenty-four (24) hours of the incident's occurrence.
Other Reportable and Internal Incidents	IR written in data management system within 48 hours or 2 working days.	IR written in data management system within 48 hours or 2 working days.	Verbal notice ASAP and no later than 8 hours after incident.					

Appendix D: MONTANA DDP INCIDENT MANAGEMENT POLICY ACROYNMS

A/N/E	ABUSE, NEGLECT, or EXPLOTATION
APS/CPS	ADULT PROTECTIVE SERVICES/CHILD PROTECTIVE SERVICES
AR.....	ADMINISTRATIVE REVIEW
ARM/MCA	ADMINISTRATIVE RULES OF MONTANA/ MONTANA CODE ANNOTATED
BIA	BUREAU OF INDIAN AFFAIRS
CM/WCCM.....	CASE MANAGER/WAIVER CHILDREN'S CASE MANAGER
DDP	DEVELOPMENTAL DISABILITIES PROGRAM
DPHHS	DEPARTMENT OF HEALTH AND HUMAN SERVICES
DMS	DATA MANAGEMENT SYSTPEM APPROVED BY THE DEPARTMENT
FIRF	FINAL INVESTIGATION REPORT FORM
GER	GENERAL EVENT REPORT IN THERAP
IMC	INCIDENT MANAGEMENT COMMITTEE
IMS	MONTANA'S INCIDENT MANAGEMENT SYSTEM
IR	INCIDENT REPORT
IRF	INVESTIGATION REVIEW FORM
LE	LAW ENFORCEMENT
MAR	MEDICATION ADMINISTRATION RECORD
PR.....	PROCEDURAL REVIEW
PRN	AS NEEDED (MEDICATION GIVEN ON AN AS NEEDED BASIS)
QDIRC	QIS DEATH INVESTIGATION REVIEW CHECKLIST
QIS.....	QUALITY IMPROVEMENT SPECIALIST
RM	REGIONAL MANAGER
SCOMM	SECURE COMMUNICATION (OR EMAIL) IN DATA MANAGEMENT SYSTEM
SIB	SELF-INJURIOUS BEHAVIOR
TRF	TRIAGE REVIEW FORM

Appendix E: FORMS



**MONTANA DEVELOPMENTAL DISABILITIES PROGRAM
FINAL INVESTIGATION REPORT FORM (FIRF)**

Agency(s) Involved:			
Name(s) & Title of Investigator:			
Date Investigator Assigned:		Time:	
Date Incident Occurred:		Time:	
Date Incident Reported:		Time:	
Alleged Victim(s):			
Alleged Perpetrator(s):			
Reporting Person and title(s):			
Witnesses Involved:			

	Agencies Notified	BY Whom	Date/Time	Method
<input type="checkbox"/>	Law Enforcement:			
<input type="checkbox"/>	Parent/Legal Representative:			
<input type="checkbox"/>	Case Manager:			
<input type="checkbox"/>	QIS:			
<input type="checkbox"/>	APS/CPS:			
<input type="checkbox"/>	Licensing/QAD:			
<input type="checkbox"/>	Provider:			
<input type="checkbox"/>	Other:			

Method of Notification: 1-Phone 2-Fax 3-Email 4-Mail 5-Personal Contact

Describe Allegation at the Time of the Assignment:

1. Were there injuries to the victim? Yes No N/A
2. Are the injuries to the victim consistent with the allegation? Yes No N/A
3. Did the injuries result in hospitalization? Yes No N/A

Describe Immediate Actions Taken: [Click or tap here to enter text.](#)

Date Investigator Visited the Site: _____ Time: _____ N/A

Summary

Evidence Summary/Scope of Investigation Questions answered (Includes: staff training, policies followed, protocols, plans of care, and person's safety):

- | | | | |
|--|-----|----|-----|
| 1.) Was there adequate staff present to ensure health and safety? | Yes | No | N/A |
| 2.) Was the staff adequately trained in the components of the person's plan of care to ensure health and safety? | Yes | No | N/A |
| 3.) Did the staff follow the provisions in the plan of care? | Yes | No | N/A |

Investigator Recommendations/Provider Agency Follow-Up Actions:

Administrative Review Attached:

Name of Investigator(s):	Date:



DEVELOPMENTAL DISABILITIES PROGRAM
Triage Review Form (TRF)

FOR INVESTIGATING CRITICAL INCIDENTS:
MAY BE USED FOR ALL CRITICAL INCIDENTS EXCEPT INCIDENTS OF ABUSE, NEGLECT OR EXPLOITATION.

Review Team Members Participating:	Case Manager(s): Provider Staff(s): QIS(s): Regional Manager: Other:	<table border="1" style="width: 100%; height: 100px;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>										
Agency Name: _____ Person's Name: _____		Date Incident Occurred: _____										
<u>Description of Incident as Known:</u> _____ _____												

Summary of Review:

Recommendations/Requirements/Actions Taken:

Administrative Review Attached:

No further investigation warranted
 Full Investigation (FIRF) needed and assigned to

Triage Review Team Chair

Date

Review Status:

To be continued Closed



**DEVELOPMENTAL DISABILITIES PROGRAM
ADMINISTRATIVE REVIEW**

(To be completed at the conclusion of a Final Investigation or Triage Review)

Agency Name:	
Person's Name:	

Date Investigative Report Received: _____ FIRF Triage
Description of the Incident as reported:

- | | | |
|--|-----|----|
| 1.) Were the provider agency and DDP policies followed in this incident? | Yes | No |
| 2.) Were notifications made within appropriate timeframes? | Yes | No |
| 3.) Were protections provided to victim(s)? | Yes | No |
| 4.) Was the investigation thorough and included enough information to answer the investigatory questions adequately? | Yes | No |
| 5.) Was the investigation completed within required timeframes? | Yes | No |
| 6.) Was the incident a result of a failure to follow federal regulation, Montana statute, the Administrative Rules of Montana, and /or the provider agencies' policy? | Yes | No |
| 7.) Was there adequate staff present to ensure health and safety? | Yes | No |
| 8.) Was the staff adequately trained in the components of the person's plan of care to ensure health and safety? | Yes | No |
| 9.) Did the staff follow the provisions in the place of care? | Yes | No |
| 10.) In the conduct of this investigation, were all applicable federal regulations, Montana Statutes, Administrative Rules of Montana, and/or provider agency policies followed? | Yes | No |

Administrative Findings: Confirmed based on evidence
Not confirmed based on evidence
Inconclusive

Provider Agency Recommendations:

Provider Agency Requirements:

Provider Actions Taken Based on Investigation:

Agency Administrator/Chair of IMC (or RM for QIS Investigation)

Date

Review Status:

To be continued Closed

DEVELOPMENTAL DISABILITIES PROGRAM
Investigation Review Form (IRF)

Agency Name:		Date of Incident:	
Person Name:			

1. Did the incident require an investigation? Yes No
 Comments:

2. As required by policy, were the following people notified of incidents within the required time frames?

Law Enforcement	Yes	No	N/A		
Did LE investigate?				Yes	No add comment below
Child/APS	Yes	No	N/A		
Did CPS/APS investigate?				Yes	No add comment below
DDP Staff	Yes	No	N/A		
Case Manager	Yes	No	N/A		
Legal Representative	Yes	No	N/A		
Advocate	Yes	No	N/A		
Licensure	Yes	No	N/A		
Comments:					

3. If the incident involved any physical injury, change in medical status or alleged sexual abuse, was the alleged victim examined by a non-agency medical professional?
 Yes No N/A
 Comments:

4. Was the Incident Report written with all required fields included and submitted within the required timeframes?
 Yes No
 Comments:

5. Were all apparent conflicts of interest between the assigned investigator and witnesses identified prior to assigning the investigator?
 Yes No
 Comments:

6. Was the alleged perpetrator(s) involving allegations of abuse, neglect, or exploitation separated from contact with persons during the investigation?
 Yes No N/A
 Comments:

7. Was evidence collected and secured?
 Yes No
 Comments:

8. Were all potential witnesses interviewed?
 Yes No
 Comments:

9. Were written statements taken?
 Yes No

Comments:

10. Were interviews recorded?

Yes No

Comments:

11. Was the incident reviewed, investigated and documented within required timeframe?

Yes No

Comments:

12. Was the investigation completed and submitted within the required timeframes?

Yes No

Comments:

13. Was the investigation submitted on the appropriate form?

Yes No

Comments:

14. Was the investigation signed and dated by the assigned investigator(s)?

Yes No

Comments:

15. If DDP made exception to the findings and/or conclusions of the investigation, was the agency notified? (Note the exception and agency response.)

Yes No

Comments:

16. Is there evidence available to show that the agency has taken or is taking actions to complete requirements/recommendations/action plans?

Yes No

Comments:

17. Was the Administrative Review attached to the Incident Report in data management system? (Note if investigation is closed or is to be continued.)

Yes No

Comments:

18. QAOS issued:

Yes No

Comments:

Signature of QIS completing Review

Date



DEVELOPMENTAL DISABILITIES PROGRAM
Procedural Review (QIS)
for any suspected A/N/E

Date Incident Occurred: _____ Person: _____
 QIS Assigned to Review: _____ Agency: _____
 Date Investigative Report Received: _____

Rules:

- | | | | |
|--|-----|----|-----|
| 1.) Were protections provided to the victim(s)? | Yes | No | N/A |
| 2.) DDP policies/procedures and ARM requirements followed? | Yes | No | |
| 3.) Were there injuries to the victim? | Yes | No | N/A |
| 4.) Did the injuries result in hospitalization? | Yes | No | N/A |
| 5.) Were notification(s) made within required timeframes? | Yes | No | |

Agency Policies:

- | | | | |
|--|-----|----|-----|
| 6.) Was agency policy followed in this incident?
If No, please explain: | Yes | No | |
| 7.) Was staff properly trained, orientated and qualified?
If No or N/A, please explain: | Yes | No | N/A |

Programmatic Procedures:

- | | | |
|---|-----|----|
| 8.) Was the Plan of Care followed as written?
If No, please explain: | Yes | No |
|---|-----|----|

Additional Observations and Recommendations:

Summary:

- | | | | |
|---|-----|----|-------------|
| 9.) Was follow-up requested? | Yes | No | Date: _____ |
| 10.) QAOS sent regarding this incident? | Yes | No | |
| 11.) Has follow-up been completed? | Yes | No | |

Signature of QIS completing Review

Date

Review Status:

To be continued Closed



DEVELOPMENTAL DISABILITIES PROGRAM

Witness Statement

DATE: _____ TIME: _____

LOCATION: _____

NAME OF WITNESS: _____

TITLE OF WITNESS: _____

EMPLOYER OF WITNESS: X _____

STATEMENT:

*Witness signature and date required at the end of statement.
Interviewer signature and date required at the end of statement.*

Any blank space should be X'd out.
DEVELOPMENTAL DISABILITIES PROGRAM
WITNESS STATEMENT SUPPLEMENT

PAGE _____ OF _____

STATEMENT (CONTINUED):

Witness signature and date required at the end of statement.
Interviewer signature and date required at the end of statement.
Any blank space should be X'd out.



DEVELOPMENTAL DISABILITIES PROGRAM
Consent for Recorded Interview

DATE: _____ **TIME:** _____

LOCATION: _____

NAME OF WITNESS: _____

TITLE OF WITNESS: _____

EMPLOYER OF WITNESS: X _____

I consent to having my interview with _____,
Quality Improvement Specialist, recorded electronically.

Witness Signature

Date



MONTANA DEVELOPMENTAL DISABILITIES PROGRAM
QIS Death Investigation Report and Checklist

Name of Deceased: _____
Date of Birth: _____
Date/Time of Death: _____
City: _____ Provider: _____
QIS conducting investigation: _____

DDP notified of Death (within 8 hours, date and time, by whom, method):

QIS DEATH INVESTIGATION REPORT

- 1) Summary of Decedent's Services and Life Situation:
- 2) Description of Circumstances and Events Leading up to Death Event:
- 3) Description of Death Event:
- 4) Conclusions (Policies Followed, Staff Intervened Appropriately, etc.):
- 5) Recommendations for Provider:

PERSON RECORDS:

- Most current full plan of care and amendments
- Most recent Incident Reports (T-Logs as Appropriate)
- Provider Case Notes/T-Logs (at least one week prior to death)
- Current list of medications (if not in plan of care)
- Medication Administration Record (previous two months)
- Case Manager's Case Notes
- Updated medical condition if changes since plan of care

MEDICAL:

- Care plan for medical condition
- Procedures regarding specific medical needs (ie. feeding protocol, seizure protocol, etc.)
- Guardianship (Court Documents)
- Names and address, if possible of:
 - Primary Care Physician: _____
 - Other Medical Professionals: _____
 - Hospital (Includes ER and/or Urgent Care): _____

END-OF-LIFE DECISIONS/DNR ISSUES:

- Terminal Illness/Diagnosis
- Order
 - Comfort One
 - Living Will
 - Hospice

PROFESSIONAL CARE RECORDS:

- Any medical information available such as office notes, hospital records
- Ambulance Trip Report
- Police or MHP Report
- Death Certificate
- Coroner's Report (with autopsy report if done)

Signature of QIS completing Review _____

Date _____

2017

ODP Certified Investigator's Manual

Pennsylvania Department of Human Services,
Office of Developmental Programs

This manual provides guidance on conducting certified incident investigations through the Certified Investigator's Program managed by the Bureau of Supports for People with Intellectual Disabilities, Office of Developmental Programs

**Institute on Protective Services at
Temple University Harrisburg
through contract with the
PA Department of Human Services,
Office of Developmental Programs**



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INTRODUCTION

The Commonwealth of Pennsylvania serves individuals who have intellectual and/or other developmental disabilities. These individuals receive services from a vast network of over 800 private and public service and support providers throughout the state.

In accordance with the Mental Retardation Bulletin on Incident Management, #6000-04-01 issued by the Pennsylvania Department of Human Services, Office Developmental Programs (ODP), this manual was developed to provide continuing guidance to Certified Investigators, agency Administrators and Managers, and others on how to properly conduct certified investigations.

The mission of the Office of Developmental Programs (ODP) is to support Pennsylvanians with developmental disabilities to achieve greater independence, choice and opportunity in their lives. As part of this mission, ODP is committed to providing the necessary tools and resources to conduct quality investigations into incidents of abuse, neglect and other significant events that occur in the lives of individuals with developmental disabilities.

Underlying the principles outlined in the Bulletin, it is the expectation and responsibility that individuals supported through the ODP system deserve not only quality services and programs, but are to be “protected from harm,” particularly from incidents involving abuse, neglect, exploitation, and rights violations. In order to accomplish this principle, the Incident Management Bulletin outlines key roles and responsibilities service providers are to have in place to more effectively manage incidents involving harm, or the potential for harm, involving individuals receiving services.

The Incident Management Bulletin also requires that investigations will be conducted by investigators who become certified based on the content of this manual. These investigations are known as Certified Investigations. An important part of the Incident Management system is ensuring that trained and certified investigators are available who possess technical competencies in conducting investigations, but who also understand the core principles and values outlined in the prerequisite course, *Protecting People from Harm: Incident Management and the Investigation Process*.

MODULE 1: CONCEPTS AND DEFINITIONS

(See Appendix I for a full Glossary of definitions)

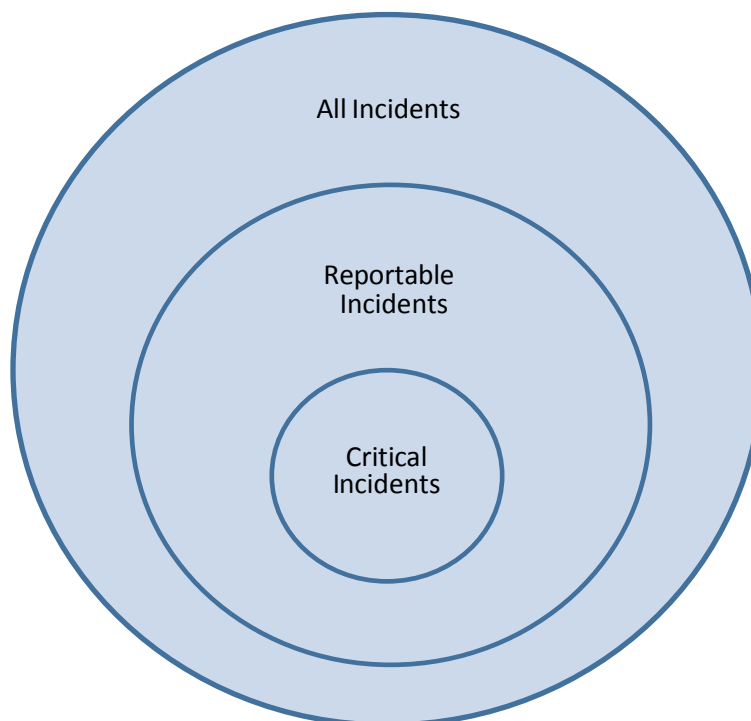
In order to develop skills in conducting competent, quality, investigations, it is not only important to know the definitions of key concepts and vocabulary commonly used, but also to properly apply these terms when conducting investigations.

First and foremost, an **incident** is an event with **potential to adversely impact an individual's health, safety, or rights**. **Incident Management** is the response to an event, intended to ensure the adequate, appropriate, and effective protection of the health, safety, and rights of the individual.

The incident management process involves **classifying incidents**. Incidents are generally classified based on two criteria:

1. Type of incident (e.g. injury, medication error, abuse, neglect, restraints, death, etc.); and
2. Severity of harm (or potential harm) experienced by the individual(s).

Classifying incidents not only by type of incident, but also by severity of harm allows us to better define incident management responsibilities including how, when, and to whom to report incidents, and outline requirements service providers must satisfy to ensure the health, safety, and welfare of individuals receiving services. Well-written regulations and policy must clearly define the types of incidents that need to be, at minimum, identified and reported via an incident management system. Incident definitions should be written using measurable, observable language easily understood by a number of individuals throughout our human service and healthcare systems, especially individuals receiving services and direct support staff.



Certified Investigations are one part of the comprehensive quality management process that organizations providing services in Pennsylvania's intellectual disability and autism systems are required to have in place. The purpose of quality management in Pennsylvania's intellectual disability system is to advance the quality of life of individuals served and supported. One part of doing this involves minimizing risk to individuals, employees, and the community through efforts in the areas of reduction in the number of employee injuries, complaints, satisfaction surveys, hiring practices, etc. Part of risk management is to assure that through the application of standardized incident management processes, systematic safeguards are in place to protect individuals receiving services from events that place them at risk. The incident management processes include the expectation that investigations at the provider, Administrative Entity, and State levels be conducted by certified investigators. This will ensure that all incidents that require investigation receive a systematic investigation that meets established standards. The illustration below shows the relationship between certified investigations, incident management, risk management, and quality management.



ODP Certified Investigator's Manual

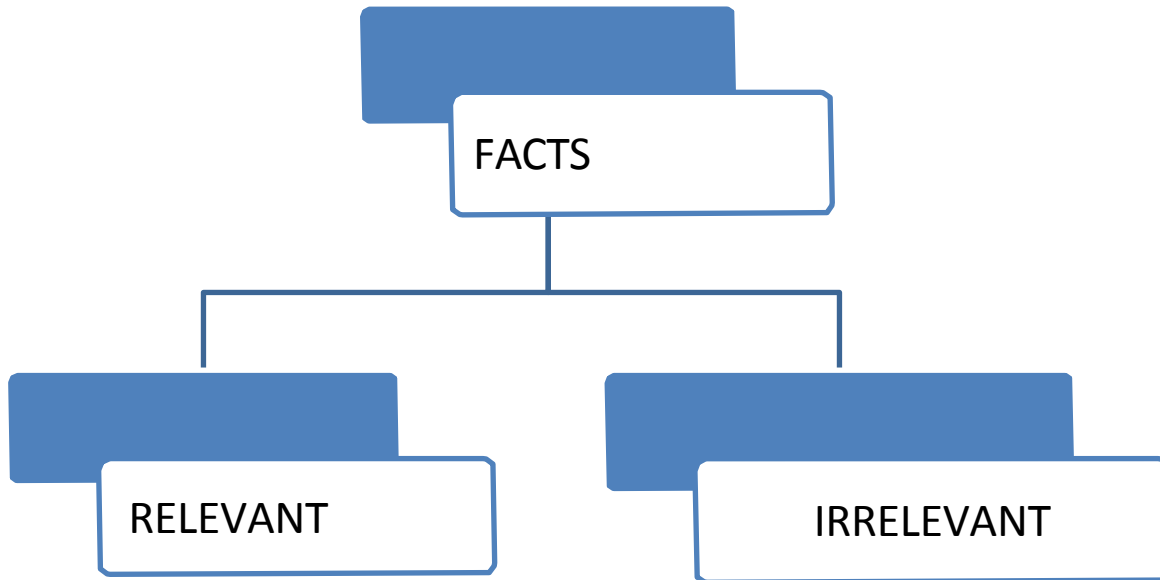
Critical incidents require an **investigation** to occur. An **investigation** is defined as *the process of identifying, collecting, and assessing facts (evidence) in a systematic manner*. The purpose of an investigation is to objectively describe and explain what did (or did not) occur at a given place and time. The ODP *Incident Management Bulletin* identifies the types of incidents requiring investigations:

Chart 1: Reportable Incidents Requiring Investigation

Primary Category	Secondary Category	Entity Responsible for Investigation
Abuse	All	Provider
	Improper or Unauthorized Use of Restraint	Provider and AE
Neglect	All	Provider
Rights Violation	All	Provider
Misuse of Funds	All	Provider
Death	When an individual is receiving services from a provider/entity	Provider and ODP and/or DOH (AE Participation as Requested by ODP)
Hospitalization	Accidental Injury	Provider
	Unexplained Injury	Provider
	Staff to Individual Injury	Provider
	Injury Resulting from Individual to Individual Abuse	Provider
	Injury Resulting from Restraint	Provider and AE
Emergency Room Treatment	Unexplained Injury	Provider
	Staff to Individual Injury	Provider
	Injury Resulting from Individual to Individual Abuse	Provider
	Injury Resulting from Restraint	Provider and AE
Injury Requiring Treatment beyond First Aid	Staff to Individual Injury	Provider
	Injury Resulting from Individual to Individual Abuse	Provider
	Injury Resulting from Restraint	Provider and AE
Individual to Individual Abuse	Sexual Abuse	Provider

Identifying, Sorting, and Classifying Evidence

One of the primary roles of an investigator is to **identify, sort, and classify** available evidence.



Facts are defined as *pieces of information (evidence) available to the investigator*. During evidence collection, the certified investigator collects all facts available in the investigation. The process of sorting facts occurs when the certified investigator reviews and reconciles all of their facts. The first level of sorting relates to identifying what evidence is **relevant** to the investigation. **Relevant evidence** is a fact that **potentially** describes or explains an event. Facts that do not have this potential are considered **irrelevant**.

Once evidence is identified as being **relevant**, the second level of classifying evidence is to decide the **TYPE** and **FORM** the evidence takes. There are two **types of evidence** that emerge in any investigation:

DIRECT EVIDENCE

Evidence in the form of testimony from a witness who was present for the incident and experienced the fact in question through sight, hearing, touch, taste, or smell (i.e. testimony of a witness that they saw the target having sexual intercourse with the individual).

CIRCUMSTANTIAL EVIDENCE

Evidence which is not directly from an eyewitness or participant, and as a result requires some reasoning to prove the fact in question (i.e. testimony of a witness who did not see the actual sexual intercourse taking place but saw the target pulling up his pants when they walked into the room).

Evidence is also classified by the form it takes. The four forms of evidence are:

Testimonial Evidence

- A witness' communication to an investigator, in verbal form or the equivalent (sign language, gestures, behaviors, etc.), of their memories of their experiences or observations related to the time and place of the incident under investigation - a story.

Documentary Evidence

- Anything written down, on paper or electronically.
- One important form of documentary evidence produced during an investigation includes written statements prepared by witnesses preserving testimony provided to the investigator.
- Other examples of relevant documentary evidence to be identified and collected during an investigation are the business records of an organization and the investigator's notes.

Physical Evidence

- Objects or things such as an injury, weapon, fluids, environmental factors (such as noise levels, temperature, lighting), etc. relevant to the time/place of an incident allegedly occurring.
- Also represents the **absence of things** that otherwise should reasonably be present or available based on the testimony of witnesses, e.g. the absence of injury that should be present if testimony is accurate.
- Spatial relationships among things are another important aspect of physical evidence available for assessment in an investigation (location of people in a room, the placement of furniture, distance of witnesses to the incident itself, etc.). However, since missing items and spatial relationships among items rarely can be collected, the next form of evidence is used to create and preserve a record of physical evidence.

Demonstrative Evidence

- Evidence that represents or preserves a piece of physical evidence.
- The way in which physical evidence identified in an investigation is preserved.
- Examples of demonstrative evidence include photographs, diagrams, x-rays, CAT scans, etc.

Digital Evidence

- Information from an electronic source that is stored or transmitted in digital form.
- Examples of digital evidence include emails, text messages, social media posts, blogs, information stored on smart phones, etc.

Sometimes even when a Certified Investigator has a good understanding of the types and forms of evidence, they will encounter a piece of evidence that they are unsure how to correctly classify. In these instances, it is important for the Certified Investigator to remember the purpose of an investigation: to objectively describe and explain what did (or did not) occur at a given place and time. Classification of the piece of evidence as to its precise type or form is secondary in importance to the Certified Investigator collecting and/or preserving the piece of evidence for use in gaining a full understanding of the incident under investigation.

Legal Standards of Burden of Proof

Legal standards of burden of proof define the level of evidence necessary to prove an assertion, or in the case of a Certified Investigation, an allegation. Certified Investigators utilize the Preponderance of Evidence standard when conducting investigations. This standard of evidence generally applies to civil or administrative proceedings requiring that conclusions of fact be based on the ***weight of the evidence***. Other definitions characterize the preponderance test as the fact finder being convinced that the conclusion of fact chosen is ***“more likely than not,”*** or that 51% or more of the evidence supports one conclusion of fact over another.

This standard of evidence is utilized in two ways during the Certified Investigation process:

- First the CI will utilize the Preponderance of the Evidence standard to evaluate which of two seemingly contradictory facts, gathered in the investigation, is most likely to be a reflection of what occurred during the incident. This will be further discussed in the section on Reconciling Evidence.
- The second way is by those conducting the Administrative Review to determine the weightiness of the overall evidence in order to make a final determination regarding the incident.

A second legal standard of burden of proof to understand is the **Beyond a Reasonable Doubt** standard. This is the burden of proof needed to be satisfied in criminal proceedings in order to determine a defendant guilty. It is generally defined to mean no "reasonable doubt" can exist in the mind of a reasonable person that the defendant is guilty. Doubt can still exist, but only to the extent that it does not affect a reasonable person's belief that the defendant is guilty.

The certified investigation process does **NOT** utilize a Beyond a Reasonable Doubt standard. It is important, though, to understand this standard for cases that involve law enforcement. The CI should be careful about making any determinations based on law enforcement's findings or determination to investigate. It is critical to remember that the criminal justice system utilizes a Beyond a Reasonable Doubt standard of evidence which is far higher than the Preponderance of Evidence standard in Certified Investigations. It may occur that law enforcement determines that they have insufficient evidence to pursue a case further or even refuses to investigate a case that could be confirmed to a Preponderance of the Evidence standard through a Certified Investigation.

MODULE 2: THE RULES OF SPEED, THOROUGHNESS, AND OBJECTIVITY

The *rules of evidence* followed by investigators when conducting investigations generally relate to one of three critical elements: **OBJECTIVITY, SPEED, and THOROUGHNESS.**

All three of these elements must be adhered to throughout the entire investigation process. If they are not, the quality of the Certified Investigation suffers, which can lead to a myriad of issues, including:

- The final determination made by the Administrative Review team may not be based on complete, objective, or accurate information.
- Follow-up actions may not be made with all the information necessary to ensure that the actions will have the best chance of mitigating future risk.
- The quality and validity of the investigation and the resulting follow-up actions could be called into question in grievances of employment actions or even in legal proceedings.

1. OBJECTIVITY

A key element of quality investigations are the rules associated with objectivity. Objectivity in the broadest sense is the ability to describe or perceive something without being influenced by personal emotions and experiences, bias or opinion. Fact-finding investigations must be conducted from what will be viewed by others as an objective, unbiased, “third-party” or “arms-length” approach.

The rules associated with objectivity in an investigation will be applied in a number of ways throughout the investigation process including:

- a. Choosing and assigning the investigator to conduct the investigation (part of Stage 1 of the Certified Investigation process)
- b. Reconciling evidence, e.g. objectivity of witnesses, including the nature of relationships between witnesses, motives a witness may have to influence the outcome of an investigation (part of Stage 3 of the Certified Investigation process)
- c. Arriving at the final determination of the investigation, based on objective assessment of where the preponderance of evidence lays (part of Stage 4 of the Certified Investigation process)
- d. Determining and implementing decisions regarding the outcomes and recommendations of investigations (part of Stage 4 of the Certified Investigation process)

The investigator (as well as people managing the investigation process in an organization) must be aware of the potential for bias that may emerge in a number of different ways during the investigation. Efforts should be made to minimize this issue as effectively as possible. If the investigator becomes aware that there is a potential risk to their ability to be objective, they should immediately notify their organization's management. Their organization's management will be able to determine the best course of action. The same action should be taken by the investigator if they think others may perceive them as not being able to be objective.

When the rules of objectivity in an investigation are not applied properly, the investigation (and

subsequent decisions made as a result of that process) will be seen by others as questionable. This in turn opens the door for grievances and legal challenges involving the appropriateness of the conclusions reached.

An objective investigation identifies and collects **all potentially relevant** facts or evidence. Conflicting evidence must be followed-up and reconciled. The vast majority of investigations involve significant circumstantial evidence from which inferences are drawn. The use of unproven suspicions (the “gut feeling”) and assumptions must be set aside. For example, even when an employee has received counseling or discipline in the past about similar work behaviors, in the current instance or incident under investigation, “guilt” must not be automatically assumed. In this context, each incident is unique, and should be treated as such. This is what helps to maintain the foundation of objectivity during the investigation process.

2. SPEED

Another critical value associated with rules of evidence that quality investigations are judged by is *speed*. The rules of evidence related to *speed* exist because of what is considered the “half-life” of evidence. **All** evidence changes character over time. The properties, characteristic, condition, etc. that a piece of evidence has today will evolve and become different tomorrow.

One example related to the rules of speed in an investigation is initiating and completing investigations in a timely manner. Incident management regulations define the number of days in which investigations must be completed. PA Title 55, Subchapter Q, §6000.961. related to Incident Management requires that the final section is to be submitted through the Enterprise Incident Management system (EIM) within 30 days of the incident being recognized or discovered.

In regard to the rule of speed, regulatory timeframes should be viewed only as the outer limits to conducting the investigation. Investigations should be done as efficiently as possible.

It is important to note that for some types of investigations, obtaining and analyzing health-related documents or other evidence may take several weeks to complete, e.g. hospital discharge summaries, autopsies or coroner reports, and in some cases where witnesses are not immediately available, actual witness statements. If an organization determines they will not be able to meet the 30-day reporting timeframes for completion of the final section, notification of an extension is to be made to the Administrative Entity and the regional office of ODP by means of EIM prior to the expiration of the 30-day period.

Management of physical evidence is another critical component of speed in an investigation. Delaying the collection of physical evidence, such as a liquid on the floor, may result in it not only changing “shape,” e.g. someone comes along and starts to clean it up, but ultimately the liquid disappears through evaporation.

Sometimes physical evidence is altered unintentionally due to a person’s actions, often because of prior training that conflicts with rules for preserving evidence in an investigation. Cleaning the site prior

to the investigator arriving at the scene to identify and collect evidence not only alters, but also possibly destroys, potential evidence that may be crucial to the investigation.

Another example pertaining to physical evidence and speed of an investigation is the potential that individuals may deliberately alter or destroy physical evidence in order to redirect blame or to protect another person(s). When an investigation is delayed, more opportunity arises for this type of behavior to occur.

Witness testimony may also be altered or lost when investigations are delayed. Witness memories change or fade over time. As humans we have the ability to replay memories in our minds. As a result, those memories can inadvertently be altered over time, causing the original experiences/observations to be changed. "Rehashing" the incident with others can also inadvertently cause memories to change, as well as intentionally "colluding" with another person to "get the stories straight." Collusion is the secret agreement between two or more people for a fraudulent, illegal or deceitful purpose. Because of these factors, it is critical to initiate witness interviews as close to the time of assignment as possible, e.g. *the first witness interview should occur no more than 24 hours after assigning the CI the investigation*. The CI must *complete all initial witness interviews within ten days of assignment*. As noted previously, regulatory timeframes should be viewed only as the outer limits to conducting the investigation. Interviews should be done as efficiently as possible.

Some incident investigations identify problems related to clinical or direct support staff failure to communicate and document information such as progress notes, shift logs, behavioral data, etc. The failure of staff or a consultant to perform their jobs correctly directly contributes to (or may actually cause) the occurrence of the incident under investigation. Delays in an investigation give people the opportunity to "cover their tracks" and get the necessary paperwork in place that otherwise would not have been there if the investigation began sooner. Delaying an investigation also provides opportunity for documents to disappear or be altered.

In an investigation, one cannot predict with certainty that any of the above will occur, yet the consequences are great when delays happen and the opportunity for evidence to be altered or tampered with is presented. Even allowing the question to be raised, that evidence may have been altered or changed because of delays in the investigation, creates greater uncertainty than an investigation initiated and completed within reasonable time frames.

At times, an investigation will be conducted when there is also a law enforcement investigation being conducted. The fact that there is a law enforcement investigation being conducted in no way affects an investigator's obligation to conduct an investigation utilizing the principle of speed. The only time that an investigator should deviate from the investigative timeline is when law enforcement specifically requests for the investigator to delay an investigative step in order not to interfere with the criminal investigation. If asked to do so, documentation must exist as to why the investigator is not conducting the investigative step in accordance with the rules of evidence collection provided in this manual. Additionally, the investigator should keep in regular contact with law enforcement in order to know when they can complete their investigation, as the fact that law enforcement is involved does not eliminate the need for all investigative steps to be conducted by the CI.

3. THOROUGHNESS

Thoroughness of an investigation relates to the level of detail generated by the investigator throughout the entire process of identifying, collecting, preserving, and analyzing evidence. All potentially relevant evidence should be identified by the CI, collected and/or preserved, and considered in the evidence analysis process. Producing an investigation considered “thorough” can be measured in a number of different ways. These are addressed throughout this manual. Some examples of how thoroughness is judged in an investigation include:

Preserving Evidence

- a. Was the scene secured after the incident was reported so the investigator had the opportunity to properly identify and collect potentially relevant physical evidence that might be present? If the scene was not secured, why?
- b. Were photos of injuries (or potential injuries, e.g. bruising that might appear hours later) taken properly, including photos taken over a period of several days showing the condition of the site allegedly injured over time? Or, was there only one photo taken showing only the bicep of someone's arm with a small bruise on it?
- c. Were witnesses separated after the incident was reported in order to minimize their ability to talk about the event with one another? Or instead, were staff given a “Witness Statement” form to complete and sat together in the staff lounge completing their reports?

Collecting Evidence

- a. Regardless of whether the scene was secured, did the investigator assess the location where the incident occurred for physical evidence? Were photos taken and diagrams prepared of the environment to create demonstrative evidence?
- b. Were all witnesses with potentially relevant evidence identified and interviewed?
- c. Did the investigator personally review documents (such as the individual's record, personnel file of the alleged target, etc.) for relevant pieces of documentary evidence? Or instead, did the investigator call the Program Manager of the location where the incident occurred and ask them to fax a pre-determined set of documents?
- d. At times, investigations will be conducted when there is also a law enforcement investigation being conducted. The fact that there is a law enforcement investigation being conducted in no way affects an investigator's obligation to conduct a thorough investigation. When evidence is not available to the investigator due to law enforcement's involvement, the investigator should document this and refer to the police report as documentary evidence. If the police report does not acknowledge evidence that was collected, the investigator must follow up with law enforcement to inquire about any evidence that was collected. It cannot be assumed that law enforcement has thoroughly examined the scene for physical evidence, collected the appropriate testimonial evidence, utilized demonstrative evidence, or obtained relevant documentary evidence. The CI is responsible for utilizing thorough evidence collection techniques.

Analyzing Evidence

- a. The CI must consider all relevant evidence in the analysis process that is done in Stage 3 of the investigation.
- b. The CI must thoroughly examine conflicting evidence in an effort to resolve contradictions using the rules for reconciling evidence described in Module 8 of this manual.

Certified Investigation Report

- a. Was a summary of evidence prepared correlating the direct and circumstantial evidence available to answer the question(s) of the investigation, or was there simply a line-by-line reiteration of witness testimony used for the summary?
- b. When providing information regarding the investigation protocols used to identify, collect, and preserve evidence, were statements included referencing issues such as the scene not being secured properly so people reviewing the investigation in the future clearly understand potential problems with evidence?
- c. Was the overall report prepared in a clear, concise, logical manner with appropriate detail, or was the report presented in a disorganized manner?

During the course of conducting certified investigations, the CI may come across situations in which they are unable to collect a specific piece of potentially relevant evidence. For example, the victim, target or other witness may refuse to provide testimony. If this type of situation arises, even if the CI is unable to collect the evidence after multiple attempts, they should continue their investigation and should be as thorough as possible in identifying, preserving, and collecting all other potentially relevant evidence. This way, they will likely still be able to develop a good understanding of the incident even in the absence of that one piece of evidence. The absence of specific evidence does not negate the CI's responsibility to conduct an investigation that is as thorough as possible. The CI's attempts to collect the evidence should be described in the Certified Investigation Report (CIR).

MODULE 3: STRUCTURING THE COMPETENT INVESTIGATION

Standard protocols are used to identify, collect and analyze evidence available to an investigation. There are generally four stages of activities occurring in any investigation: **intake and preservation** of evidence, **identification and collection** of evidence, the **analysis and presentation** of the evidence collected, and **quality review including implementation of recommendations and corrective actions**. The following chart represents a consolidated view of these stages. Included in the chart are the activities associated with each stage (which are discussed in detail in subsequent modules), along with the responsible party.

STAGE OF INVESTIGATION	RESPONSIBILITY	KEY TASKS AND ACTIVITIES
<p style="text-align: center;"><u>Stage 1</u> INTAKE PRESERVE EVIDENCE (Incident Identified)</p>	<p style="text-align: center;">Agency Point Person Site Supervisors Agency Management</p>	<ol style="list-style-type: none"> 1. Assure safety and well-being of people; provide medical treatment as necessary. 2. Secure the scene. 3. Identify, keep, separate witnesses. 4. Remove alleged target(s) from contact with individuals receiving services 5. Secure documentary evidence. 6. Assign Certified Investigator
<p style="text-align: center;"><u>Stage 2</u> IDENTIFY COLLECT (At Scene)</p>	<p style="text-align: center;">Certified Investigator</p>	<ol style="list-style-type: none"> 1. Check on the safety and well-being of the alleged victim. 2. Review activities of intake and preservation with management. 3. Review incident with Reporter. 4. Identify and collect physical and demonstrative evidence. 5. Sort, classify, and interview witnesses. 6. Obtain written statements. 7. Identify & collect other documentary evidence.
<p style="text-align: center;"><u>Stage 3</u> ANALYSIS PRESENTATION (Review and Reconcile)</p>	<p style="text-align: center;">Certified Investigator</p>	<ol style="list-style-type: none"> 1. Review and assess evidence collected. 2. Conduct background interviews. 3. Conduct follow-up interviews. 4. Conduct final reconciliation of evidence. 5. Prepare Certified Investigation Report, Sections I-IV.
<p style="text-align: center;"><u>Stage 4</u> ADMINISTRATIVE REVIEW (Conclusion of the Investigation)</p>	<p style="text-align: center;">Agency Management</p> <ul style="list-style-type: none"> • Incident and/or Risk Management Committee • Human Rights Committee • Agency Board of Directors <p>Note: CI should be involved in Stage 4 to provide technical guidance regarding the evidence.</p>	<ol style="list-style-type: none"> 1. Review competency and quality of investigation. 2. Complete Section V of the CIR including: <ol style="list-style-type: none"> a. Determine finding: confirmed, not confirmed, or inconclusive. b. Determine recommendations and action plans. c. Implement recommendations and action plans.

Based on the previous chart, there are a number of critical steps organizations must have in place to support and conduct a competent investigation process. Three areas of preparation, identifying skills of a quality certified investigator, preparing for the investigation, and writing the investigatory question, are detailed below.

1. Qualities of Certified Investigators

The Certified Investigator (or investigators) is of critical importance in any organization. The investigator must have a reputation for honesty and credibility, and have the ability to provide reassurance to individuals involved in the incident. The investigator must possess critical thinking skills and think like a historian in creating an investigation that is thorough, organized, and competently conducted because any evidence generated through the investigation may become evidence in a government inquiry or future grievance or lawsuit. The organization should anticipate that at some future time the investigator may have to appear before a hearing officer, arbitrator, administrative law judge, or even a jury if litigation results. In this context, the investigator must be able to present him or herself as an authoritative and credible witness.

The *Incident Management Bulletin* requires agencies to use only Certified Investigators. How do you determine who becomes a Certified Investigator in the organization while at the same time balancing the need for objectivity? Options may include:

- a. Agency Incident or Risk Manager
- b. Agency Point Person
- c. Member(s) of direct care staff management
- d. Human Resource staff member(s)
- e. In-house legal counsel
- f. Independent, certified investigator from outside the organization, especially if:
 - Circumstances warrant the use of an investigator independent from the organization
 - In-house resources of the organization are limited (e.g. size of organization, geographic considerations) that makes it difficult to assign staff the responsibility of becoming certified investigators or conducting certified investigations

Based on resources and structure of the organization, it is generally a good idea to have at least two or three people in the organization trained to conduct investigations. Based on *The National Center on Outcome Resources – Community and Quality: A Guide to Incident Management and Quality Life Outcomes*, there are eight characteristics for a good investigator:

- a. High ethical standards
- b. Comprehensive knowledge of DD/ID system
- c. Excellent communication skills
- d. Versatile interviewing techniques
- e. Good judgment about when to call for the assistance of experts
- f. Understanding external reporting responsibilities and due process
- g. Curiosity
- h. A personality that does not suffer too enormously from not being the most popular member of the organization

Candidates to become CIs should self-evaluate to determine their own strengths related to this list and communicate their needs related to professional growth in these areas. Management should also use the above list of characteristics when considering which staff are best qualified to become CIs.

Any internal investigation must have the support of senior management. In essence, the investigator functions directly under the authority of the Chief Executive Officer of the organization. Service providers should carefully address policies and procedures relating to the types of information shared on a regular basis with members of the Board of Directors regarding incident management and investigations. Employees also need to understand their role and responsibilities relating to participation in the investigation process.

The investigator must have the authority to manage the investigation process including deciding when and where to conduct the investigation, what issues to pursue, and which individuals to interview. Depending on the complexity of an organization, different departments and individuals may be involved in the investigation, which can sometimes result in more than one person attempting to direct the investigation.

At the same time, however, the CI should never feel that they are alone in the investigation process. The organization's management must be willing to provide support as needed in cases where the CI encounters unique or difficult situations. For example, if the CI finds that they are unable to collect testimonial evidence from the target, victim, or other witness for whatever reason, the CI may need their management's support in explaining to the witness the importance of cooperating with the investigation and/or in deciding when to move on with the remainder of the investigation without the that specific piece of evidence.

On a very practical level, the assigned CI must have and be provided the time to conduct a quality investigation. All principles of an investigation including objectivity, speed and thoroughness can be compromised when the CI has overwhelming competing requirements on their time. Additionally, a CI should not be assigned who is expected to have an upcoming leave request which will interfere with the timeliness of their investigation.

When there are multiple investigators, either internal or external to the organization involved with a specific incident investigation, it is critical to identify the person functioning as the "lead investigator" and communicate that to the other parties involved in the investigation.

2. PREPARING FOR THE INVESTIGATION

Once an incident is reported, the determination is made that the incident requires an investigation (per the *Incident Management Bulletin*), and the investigator is assigned, it is helpful for the investigator to prepare a strategy for the investigation. Some basic strategies to consider include:

- a. Establish timelines for the process; include the steps to be taken and a projected completion date.
- b. Determine the question(s) the investigation needs to answer based on the description of the incident contained in the initial incident report.

- c. Identify the required tasks (e.g. identify and collect physical and demonstrative evidence, interview witnesses, etc.) that need to be completed, generally in a sequential manner, for the investigation. Be aware of how each phase of the investigation leads to or supports the next step in the process.
- d. Remain flexible. Sometimes one part of the process takes longer to complete than expected or there may be additional issues may arise that need to be incorporated and addressed by the investigation.
- e. Plan the chronology of witness interviews; identify potential witnesses and classify them according to their relationship to the incident. A CI should conduct witness interviews as follows:
 - Victim(s)
 - Witnesses with direct evidence
 - Witnesses with circumstantial evidence
 - Target(s)

You may also choose to intentionally change the recommended order and interview one witness over another because, for example, the first witness is not immediately available or you want to limit opportunities to influence witness testimony. Numerous variations on this scenario exist, so think carefully about the nature of relationships between witnesses. When varying from the recommended order, the CI must document the investigative reason for the variance.

- f. Put together an investigative toolkit before starting the investigation. Items for the tool kit include but are not limited to: tape measure, digital camera, notebooks, medical ruler, paper bags, tape, pens/Sharpies, non-rewritable CDs, caution tape, body chart forms, rubber gloves, alcohol wipes, hand sanitizer, blank graph paper, inter-office envelopes, and zip-lock baggies.
- g. The need to modify the investigation plan may occur based on the progress and feedback received during the investigation. Modifications may include:
 - Attending to the timing of the investigation; be cognizant of delays that could lead to the destruction of evidence or loss of key witnesses.
 - Determining whether new leads must be investigated.
 - Filling gaps and oversights in your plan.
 - Uncovering evidence of other incidents or misconduct requires the CI to report an incident that has not been previously reported. Separate incidents cannot be “rolled” into the same investigation unless they are directly related to the incident allegation being investigated.
- h. Anticipate parts of the investigation that could cause further trauma or discomfort to the alleged victim and develop a plan to address how evidence can be collected with minimal disruption to the life of the alleged victim.
- i. Determine what will be said to employees and individuals outside of the organization (e.g. family members, media, etc.) inquiring whether an investigation is taking place. Laws and regulations involving privacy (for individuals receiving services and employees), as well as the need to manage “public relations” may impact how this is handled. Because of the potential unique implications related to each incident under investigation, it is recommended that a policy is created and implemented regarding inquiries about incidents. The policy should include who handles communications, what will be communicated, and the appropriate audience for the communication.
- j. Organizational policies should be developed addressing how the documents collected and

created as a part of the investigation are to be maintained.

- k. Establish who is responsible for the administrative review process of the Final Certified Investigation Report, including authority for reaching the final conclusions and determining outcomes based on that conclusion.
- l. Determine who is responsible for making decisions about what follow-up actions will be taken, monitoring the implementation, and assessing the impact of those corrective actions. This involves coordinating post-investigation reports, assigning responsibility for any follow-up corrective action (including interventions involving the individual receiving services and employee discipline), and any required training based upon what is learned during the investigation.

3. WRITING THE INVESTIGATORY QUESTION

The investigatory question serves two purposes for the investigation: 1) provide a general guide to the parameters of the investigation and 2) assist the CI in avoiding tunnel vision. The allegation, not the question, is what gets confirmed or unconfirmed in the final determination. The investigatory question is simply an investigative guidance tool.

While there may be circumstances where there is the need for multiple investigatory questions, most investigations require only one properly written investigatory question. When a CI believes there is a need for multiple investigatory questions, they should review the incident allegations to make sure that they are not actually attempting to investigate multiple incidents which require separate investigations.

The investigatory question should be generic as to the actions being investigated. If possible, it is:

- Anchored to time
- Linked to the alleged victim
- Linked to the general location of the incident

Investigatory questions should NOT include the name of the target(s), the specifics of the allegation, reported motive, or the specifics of place.

Incorrect question: Did Chris poke Mary's arm with a fork at the table in the kitchen because he was frustrated that she would not leave the table on March 1, 2015?

Correct question: What happened to Mary at XYZ home on March 1, 2015?

The correct question anchors the investigation to the alleged victim, as well as the specific date of the incident and general location without creating the tunnel vision. Tunnel vision is a natural human tendency that leads CIs to focus on specific theories and then select and filter evidence only through those preconceived theories. This includes ignoring or suppressing evidence that doesn't fit with the preconceived ideas. For example in the incorrect question, the CI may only select and filter evidence on what did or did not occur in the kitchen and ignore or suppress evidence that may indicate that the event happened in a bedroom instead.

MODULE 4: IDENTIFYING AND COLLECTING PHYSICAL AND DEMONSTRATIVE EVIDENCE

1. PHYSICAL EVIDENCE

Physical evidence is defined as things themselves (e.g. an injury, weapon, a piece of furniture, etc.) or the absence of things, as well as the spatial relationship among things that have the potential to describe or explain an incident under investigation.

As previously stated, all physical evidence should be identified, collected, and/or preserved as quickly as possible during an investigation.

When initiating investigations, a preliminary assessment about potential physical evidence should be made as soon as the incident is reported. If potential physical evidence exists, as appropriate, the following procedures should be implemented:

a. Injuries

Whether or not an individual has sustained injury is very relevant in the ODP incident management system. If an injury exists, the investigator will need to try to determine how the injury was sustained and whether or not it is related to the incident under investigation. For example:

- The type of injury sustained could help determine how an incident occurred.
- The pattern and size of an injury can be critical to assessing how the injury occurred. The opinion of a medical professional can be helpful in this assessment.
- The presence (or sometime more importantly, the absence) of an injury could help determine whether an incident occurred as described.

b. Medical Intervention

Once an incident has been identified, individuals who are injured should receive medical attention immediately from a physician or other healthcare professional. Even those without apparent injury should be assessed immediately in order to rule out potential injury and to document the condition of the individual at a specific point in time.

Physicians, other healthcare professionals, or other people (e.g. direct support staff) authorized to provide initial medical assessment and interventions (e.g. providing first aid) in response to an incident should complete a report documenting the assessment and treatment provided. The report should include the nature and estimated age of the injury, and, if appropriate, a note about the possible cause of the incident.

If an individual needs treatment in a hospital or emergency room, the staff should follow their agency policy and procedures.

Because of the special responsibilities ODP-funded organizations have regarding incident

reporting and documentation, it is generally recommended that representatives meet with the local hospital and/or emergency room personnel to explain the type of reports and information that would be beneficial to the incident management and investigative process. This helps to alleviate potential problems in the future.

c. Investigator's Role Related to Injuries

The investigator should attempt to see the injury (either before or after treatment), make notes about their observations, and when possible, take photographs. Even if no immediate injury is identified, it is recommended this procedure be followed. If the injury is on a private area of the body or if, for any reason, showing it to the CI could be traumatic to the victim, the CI can rely on the evaluation of a physician and other medical records to describe the injury.

When conducting witness interviews, it is also appropriate to focus questions on observations made by the witness regarding the victim's physical condition prior to, during, and post-incident, prior to any medical interventions and/or physical examination.

Another technique that may provide useful evidence in an investigation is observing the physical characteristics of individuals allegedly involved in an incident. For example, are the fingers and/or hand of the person identified as the alleged target of the investigation similar in size and/or shape to the bruises found on the victim's arm?

d. The Physical Environment

The environment where incidents occur, including the location, physical lay-out, properties (e.g. temperature, visibility, noise, weather conditions, etc.), and spatial relationship among things (e.g. furniture, other items in the environment, even people) may provide crucial evidence in an investigation. As soon as an incident has been reported and the scene is identified, steps should be taken to immediately secure the scene to the best degree possible.

By properly securing incident locations, objects and substances are protected from changes associated with activities that might have occurred post-incident had others been free to enter and use the location. Failing to secure the scene not only compromises the quality of the evidence available, it may ultimately compromise the conclusions and outcomes drawn from the investigation.

e. Securing the Scene

Identifying the exact location where an incident occurred is a critical step in answering the investigatory question. A scene is secured when the integrity of the items within it are not moved, handled or disturbed in any way by any person at any time following the occurrence of an incident.

When initiating steps to preserve, identify, and collect objects and substances for possible future use in hearings, evidentiary rules require that a clear "**chain of custody**" be created and maintained. The chain of custody begins as soon as the environment where the incident occurred is secured. The investigator is responsible for showing exactly where the evidence has been from the moment it was collected, until the time it might be used during a hearing. If the chain of custody is broken, the certainty of the evidence is undermined and questions can be raised about its validity.

Many of the protocols used to identify, collect, and preserve physical evidence are similar regardless of whether it is a criminal, civil, and/or administrative investigation being conducted. Even when a criminal investigation occurs (and takes precedence over any other investigation involving the same incident), the service provider or entity responsible for the location where an incident allegedly occurred is generally in the best position to initiate steps to secure the scene until law enforcement arrives.

In order to secure the environment or scene where an incident occurred, the following steps should be followed to the best degree possible:

- i. Station a person at the entrance of a room in order to prevent others from entering.
- ii. If a room has more than one entrance and there are insufficient people to station at each entrance as in "a" above, then the person assigned should remain in view of the other entrances to the room when possible.
- iii. If there are multiple entrances with only one individual available to station at an entrance and the other entrances are not clearly visible, those entrances could be locked. There are regulatory violations, though, to locking doors and prohibiting egress to the outside in a licensed facility.
- iv. Anyone needing to enter the room once it has been secured should do so only if necessary; care should be taken to avoid disrupting the condition of the room. The person responsible for securing the room should take notes of anyone entering the room, the reason for entering, the time they entered and left the room, and what they did while in the room.
- v. When an incident occurs in a public place, e.g. a hallway, securing the scene becomes more challenging. It may not be possible to cordon off (rope off) a room from use as was described above. In the example of a hallway, what may need to suffice is having the immediate vicinity cleared by moving people or activities from one side of the hallway to the other. In this case, a person should stay at the incident scene until the investigator arrives, take detailed notes about the scene being altered in any way, and communicate this information to the investigator upon their arrival.
- vi. If traffic cannot be rerouted, someone should remain at the incident site until the investigator arrives.

2. COLLECTING PHYSICAL AND DEMONSTRATIVE EVIDENCE

In an investigation, physical evidence is preserved by creating *demonstrative evidence*, e.g.

photographs, videotapes, diagrams, x-rays, etc. The following protocols outline the steps used by an investigator to identify and collect physical and demonstrative evidence in an investigation:

- a. Upon arriving at the scene of an incident, the investigator's role is to assume control of the scene and its evidence. The investigator should first speak with the person stationed at the scene to understand the exact procedures used to secure the environment prior to the investigator's arrival. The investigator should also ask that individual for any notes and/or logs they maintained, and as necessary, conduct a formal interview and prepare a statement.
- b. Before entering the room or environment where the incident occurred, the investigator should make initial observations about the layout and make decisions about how to enter and walk around the room so as to not disturb any of the evidence. If there are objects or substances on the floor, the investigator must move cautiously to avoid tracking substances around the room.

Creating Demonstrative Evidence: Photographs

The next steps involve taking photographs and/or video of the physical evidence. Preserving the condition of physical evidence by creating demonstrative evidence through photographs is an important aspect of the investigation process. While the use of digital equipment to create evidence has raised evidentiary concerns in the past because of the user's ability to easily alter the evidence, advances in technology and investigation protocols currently make them a viable option. One advantage to the use of a digital camera is that it negates the possible breach of confidentiality associated with sending film to an external lab for development. When using digital equipment, investigators should make use of the date and time stamp feature and should make sure the date and time is correctly set before taking any photographs.

Note: While most of the procedures outlined below reference photographing of injuries, follow the same procedures when creating photographs of the environment where an incident allegedly occurred, or when documenting the *absence of physical evidence* (e.g. an injury that otherwise should be present if testimony is accurate but is not).

When photographing the alleged victim, it is important to always ask their permission to take pictures of their body and their residence. If they refuse to allow you to photograph, the CI should consult their supervisor. If evidence is available in an individual's genital region or requires the individual to partially undress for the picture to be taken, the CI is strongly urged to use documentation of an examination by a certified medical professional instead of taking photographs. If the documentation is not sufficient, the medical professional who conducted the examination should be interviewed. If photographs were taken by someone other than the CI, i.e. a medical photographer or law enforcement officer, these pictures can be used as evidence for the investigation.

1. The first step in photographing the individual is to take photos that show the entire body of the individual. Typically, this can be done with a full body photograph with the individual facing toward you. Depending on the nature of the allegations, you should also consider taking full body photographs of the left and right side profile of the individual as well as a photo of them turned away from you.
2. After taking full body photo(s), begin taking **mid-distance** photos of the injured area. The mid-distance photo is approximately 50% closer to the individual versus the overall "bookend" photos

identified in #1 above. The mid-distance photo(s) continues to identify obvious physical landmarks while still showing the injured area in the center of the picture. When there are multiple injuries that do not show up in the full body shot taken for #1, take pictures that will allow you to create an overlapping series of photographs showing the sequence of injuries to the individual.

3. After taking the mid-distance photo(s) take **close-up** photos of the injured area(s) next using the following steps:
 - a. Photograph the injured area from the front (or straight on) with a measuring device. Do not place anything that is not sanitized on the skin or close to an open wound (i.e. a coin).
 - b. Take a follow-up close-up photograph without the measuring device.
4. Once close-up photos are finished, take **extreme close-up** photo(s) so the injury fills the entire viewfinder.
 - a. Photograph the injured area from the front (or straight on).
 - b. If injuries are too large for a single extreme close-up photo, then take overlapping photos to capture the entire injury for the extreme close-up photos.
5. Using the initial incident report for reference, the investigator should take photos of any location and/or objects identified in the report. For example, if the report indicated the individual tripped and fell on a piece of rug that wasn't tacked down properly, the investigator should observe the flooring material at the location and take photos regardless of whether it has wall-to-wall carpeting, a throw rug, or a wood floor with no rugs over it. When photographing the environment where the incident occurred, the first photographs would be taken from the entrance of the room looking in. After taking a series of progressively closer photographs culminating with the object identified in the report, the investigator should then walk to a different entrance or the opposite side of the room and take a series of photos beginning from that vantage point.
6. As photos are taken, the investigator should keep a photo log identifying each photo, adding notes including the date, time, and any other relevant information.
7. Any substance or object that is removed from the environment by the investigator should always have photos taken prior to its removal. Until this step is completed, nothing should be removed from a secured location.

Maintaining and Securing Digital Photographs for the Investigation

The vast majority of cameras used to take evidence photos today use digital technology. Because of the shift from film to digital technology, the rules used to create and maintain the "chain of custody" for photographs have changed. It is important to work with Information Technology (IT) staff in organizations to identify and create standard operating policy and procedures to properly manage all evidence created and maintained digitally or electronically for investigation purposes. Modify information outlined below (like naming folders and files) based on advice from the IT professionals.

Adhere to the following protocols when maintaining digital photos as demonstrative evidence:

- a. Digital photos or videos should be copied immediately to a CD-R disc (or its equivalent) as CD-R format does not allow the information on the disc to be modified.
 - b. Identifying information should be included on the disc, just as you would do if writing on a Polaroid or the back of a 35mm photo. Information to be documented includes:
 - The name of photographer

- Date, time and place it was taken
 - Subject of the photo
 - Case name and number
 - A unique number assigned to each piece of evidence in the order collected. This number is used to identify the object or substance in evidence logs, on diagrams, etc.
1. After taking the digital pictures, but *before* transferring pictures to a secure disk, rename each photo. The file name might include using the case number, organization name, date, and sequential picture order (e.g. 001, 002, etc.). The file extension, e.g. “.jpg”, etc. remains the same. An example of the above is “12345ODP030112 001.jpg; 12345ODP030112 002.jpg, etc.” The image should always be saved in the same format in which it was originally taken. Saving the photo in a different format from the original can change details (including color) in a way that would make it inconsistent with the original.
 2. Create a primary folder for the investigation on the “secure disk” that is used to transfer and maintain all related evidence files, including photos from the memory card or device. Use a basic file name such as the one created above for this folder by using the case number, organization name, and date (e.g. “12345ODP030112”).
 3. Create a sub-folder where the digital photos are transferred and stored related to the individual. Include the following in the folder name: case number, individual’s name, organization, and date (e.g. “12345SmithODP030112”). If there are photos taken of multiple individuals, other physical evidence, or environments, create separate sub-folders for each series taken.
 4. After creating the primary folder and sub-folders on the secure disk, transfer the photos from the memory card or device to the appropriate sub-folder on the secure disk.
 5. Crosscheck that all photos copied correctly between the memory card and the secure disk by doing a picture count of the files and a visual comparison.
 6. After transferring photos to the secure disk, delete photos from the memory card or device.
 7. All pictures should be developed utilizing an in-house color printer
 8. The disc and/or photos should be secured following the same protocols used to create the chain-of-custody.

Creating Demonstrative Evidence: Diagrams

- a. After completing the taking of photos, a diagram of the environment where the incident occurred should be created. Diagrams are helpful in demonstrating spatial relationships and movement, and are an important tool to be used when interviewing witnesses.
- b. Diagrams do not need to be to scale, yet at the same time the diagram that’s created should be clear. To improve accuracy, measure distance (e.g. the length of a wall or the distance between two pieces of furniture) with a measuring tape and note the information on the diagram.
- c. When measuring moveable objects included on the diagram, the measurement should be taken from at least two permanent features of the environment (a door jam, window frame, etc.) to the same spot on the object.
- d. Diagrams need to be signed and dated by the person who created the diagram (CI or witness). Each diagram needs to be listed as a piece of demonstrative evidence in the final report.

There will be times when recreating a scene is valuable for purposes of more accurately diagramming or

photographing the spatial relationships between persons involved in the incident. The investigator may use stand-ins for this purpose. Stand-ins can be people involved in the investigation (i.e. target or direct witnesses) or can be other staff available to assist. The investigator should not use the victim to stand in for this purpose due to risk of further traumatizing that individual.

Collecting Physical Evidence

- a. After the investigator has taken photographs and created diagrams, the objects and substances that might be relevant to an investigation should be clearly marked. Tags can be secured to large objects; labels can be attached to smaller objects. Regardless of whether tags or labels are used, the following information should be included:
 - A description of the object
 - The date, time, and place it was collected
 - The name of the investigator collecting it
 - Case name and identification number of the case
 - A unique number assigned to each piece of evidence in the order collected. This number is used to identify the object or substance in evidence logs, on diagrams, etc.
- b. For small objects, plastic baggies will generally suffice. After the object is placed in the baggie, the opening would be sealed with masking tape. The tape should be placed in such a way that it would be torn if the object was removed. This is a technique used to help detect any tampering of the evidence. Identifying information would be written in pen on the masking tape.
- c. Objects containing organic material (e.g. clothing with body fluids or blood) are never placed in plastic. Instead, the objects would be placed in a clean paper bag, sealing the bag with tape and marking the bag as described in “r” and “s” above. This is generally due to the fact that moisture can collect within the plastic bag, altering the composition of organic substances.
- d. If liquids need to be collected, the investigator would use a sterile urine specimen cup or something similar to pour a sample of the liquid into. If the liquid substance is on the floor or other surface making it difficult to pour, a sterile gauze pad could be used to soak up a sample of the liquid. Either way, after placing the liquid sample in the sterile cup, close the cap tightly, place the cup in a plastic baggie, sealing and marking the evidence as described in “r” and “s” above.
- e. As each piece of evidence is collected, the evidence should be documented on the physical evidence log maintained by the investigator (See Appendix II for log sheet).
- f. The physical evidence collected is then placed in a secure location, e.g. locker, file cabinet, closet, etc. which should be locked at all times. The number of people having access to this location should also be minimized, with preferably only the investigator having the key.
- g. Evidence secured in this manner should only be removed from the evidence locker for official purposes. Evidence log sheets should be used with notations made to the log whenever a piece of physical evidence is taken from this storage area. The notation should identify who removed the evidence, the date and time the evidence was removed, the reason it was removed, and the date and time evidence was returned. Whenever evidence is removed, the individual taking custody of the evidence is responsible for accounting for the material at all times.

MODULE 5: IDENTIFYING AND COLLECTING TESTIMONIAL EVIDENCE

1. SETTING THE STAGE: A MODEL OF COMMUNICATION

Interviewing witnesses including alleged victims, individuals, targets, staff, physicians, family members, etc., at its simplest level, is the process of two people communicating and sharing information with one another. In order to develop strong interviewing skills, it is important to understand the basis of how people communicate, which is based on the following four-stage model:

1. Investigator sends relevant information to witness.
2. Witness must process and understand information.
3. Witness must send-back relevant information to investigator.
4. Investigator must process and understand information.

This process is cyclical and continues until either 1) the interview is successfully completed, or 2) a negative dynamic emerges during the course of the interview that impedes or breaks down the interview.

2. WITNESS INTERVIEWS: THE PROCESS OF PROVIDING TESTIMONY

The ability of a witness to provide testimony on the topic of an investigation is based on three functions:

1. Witness' capacity to make observations.
2. Witness' ability to create memories of their experiences or observations.
3. Witness' ability to communicate the memories of their experiences/observations.

Regarding the witness' capacity to make observations, it is important to remember that the ability to observe (as well as to experience events) is based on our senses: sight, hearing, taste, touch, and smell. A witness can have one or more senses impaired (e.g. be blind, but still have the ability to hear, taste, touch/feel, and smell) and be seen as a competent witness for the purpose of an investigation. The challenge for the investigator in these situations is to ask questions that focus on the sense(s) used by the witness in their experience or observation of the event.

Witnesses must also have the capacity to create memories of their experiences or observations; this is a basic rule associated with collecting testimonial evidence from witnesses.

The investigator is responsible for assuring the witness is allowed opportunity to effectively communicate memories of their experiences/observations during the investigation. In order to do this, investigators may need to provide accommodations to meet the communication needs of the witness by providing sign or spoken language interpreters, use of communication boards, etc. The witness is thereby given the opportunity to communicate in the most effective manner possible. Not only will this help improve the overall quality of their testimony, it also minimizes the risk that testimony is seen as tainted or compromised. In order to best provide these accommodations, it is necessary to research their communication needs prior to the interview.

In addition to the accommodations, the investigator must research prior to and assess during the interview other communication preferences of the witness. For example:

- The alleged victim may have certain times of the day that they are better able to communicate than others.
- The individual may have non-verbal gestures that have specific meanings.
- All witnesses will use a certain set of vocabulary. Definitions and meaning of words are not necessarily consistent and can vary based on local colloquialisms, cultural diversity, educational level, professional lingo, etc.

3. SETTING THE STAGE: CULTURAL AWARENESS

Every person communicates differently based on their personal communication history and their cultural communication patterns. In the course of communication, cultural differences can arise in definitions of words, body language, amount of detail in answers, views of authority, and perspectives on caregiving. All of these differences can result in the inaccurate recording and analysis of testimony.

A CI needs to be aware of communication differences that may be occurring due to cultural differences. When the CI believes that there is a cultural difference in the communication patterns during an interview, the CI should practice cultural inquisitiveness and ask the subject of the interview about their unique patterns of communication. For example if the CI notices that the person is not maintaining the eye contact that is typically expected, the CI should not assume that the person is lying. The CI should ask the person a question like “I notice you are not looking at me when you answer my questions. Is there a reason for that?”

It is also appropriate for the CI to ask questions that address potential cultural differences as part of their investigation. For example, the CI can say “Please tell me your definition of ‘bad care’.” or “The term that you used is generally considered offensive. What was your intention by using the term?”

It is very important that the CI avoid overgeneralizing cultural differences and assuming cultural communication “rules” apply to everyone from that particular culture. Many people teach that individuals from an Asian culture do not utilize the same level of eye contact that is used in the United States, especially to someone in “authority.” This idea is highly dependent on what part of Asia an individual is from, i.e. Hong Kong, rural China, Vietnam, etc. It is also very dependent on the acculturation level of the subject of the interview, i.e. first generation vs. third generation.

In other words, cultural patterns of communication are very individualized. Just because someone appears to have a certain cultural background, the CI should not assume how they will communicate. As noted, the CI needs to be able to identify when there may be cultural differences in the interview and then address them through questions that help to clarify whether cultural differences are affecting the interview. This can be done in the initial interview, but will often occur in the follow-up interview after the CI has had a chance to review the evidence from the initial interviews.

4. TYPES OF INVESTIGATION INTERVIEWS

As defined in Module 1, testimony is defined as information a witness shares with the investigator,

according to his or her capacity to observe a specific environment over a period of time. The capacity to experience events and to make observations derives from the senses: what the witness saw, heard, tasted, felt, or smelled.

In any investigation, there are generally three types of interviews that are used to collect testimony from potential witnesses. The three types to be explored in this module are:

- Initial Incident interviews conducted with identified witnesses to the incident
- Background interviews
- Follow-up interviews

5. BASIC RULES FOR STRUCTURING THE INTERVIEW PROCESS

The purpose of the incident interview is to *allow a witness to communicate memories of their experiences or the observations they had the capacity to make, relating to a specific environment over an identified period of time.*

Creating testimonial evidence that is thorough and can withstand possible evidentiary challenges is a critical skill any investigator must develop.

Even before meeting with a witness to conduct the interview, there are a number of “rules” or guidelines investigators should follow to prepare for the interview, including:

- a. Conduct interviews individually with witnesses, not in groups. The general rule is witness interviews are conducted on a 1:1 basis, although exceptions to this rule will emerge that are addressed in other sections of this manual. Not only can group dynamics or peer pressure discourage or even suppress responses. More importantly, the investigator runs the risk that witness testimony will be seen as tainted.
- b. Collect information regarding the communication needs of the witnesses. Provide proper accommodation of communication needs, e.g. professional interpreters, and communication devices such as picture books and other technology used to facilitate communication.
- c. Does the witness (individual[s] receiving services and/or employee[s]) require a third-party to be present? If so, make arrangements to accommodate needs. Some examples of third-party representation may include:
 - A person the individual receiving services is familiar with (e.g. staff person, family member, etc.). Care must also be taken to assure this person is not a potential witness for the investigation.
 - A union representative for employees with the right to representation.
- d. Where applicable, consider union issues and the protocols (typically outlined in the collective bargaining agreement) that must be followed.
- e. Environment: Conduct interview in private place if at all possible.
- f. Arrange for water and/or coffee to be available. Tissues may also come in handy.
- g. Prepare diagrams and introduce into each witness interview to help document movement, spatial relationships, etc. being described.
- h. If you are planning to interview several witnesses in one day, schedule sufficient time to complete each interview.

- i. Maintain the appearance of objectivity and neutrality. It is important to convey to all witnesses that the organization takes the allegation seriously. Be factual, minimize small talk and do not attempt to play the role of "one of the guys." It may only call into question the credibility of the investigation as well as your credibility as an investigator.
- j. Do not promise confidentiality, but try to maintain it; you can tell the witness that you will attempt to only share information with management or others who have a need to know. But if a lawsuit or grievance is filed, you generally will not be able to keep that promise because you will be compelled to disclose information.
- k. Generally, do not tell the witness being interviewed what was said by other witnesses. Exceptions to this rule might involve follow-up interviews where there is a need to reconcile conflicting testimonial evidence, or when interviewing the alleged target.
- l. Do not discuss your own opinions or conclusions.
- m. Do not make promises to witnesses, such as offering a bargain or favor in exchange for testimony, e.g. change of shift, or immunity; avoid at all costs any oral agreements.
- n. Focus on using nonverbal communication in assisting your interview process. For example, the SOLER method is an effective nonverbal communication structure to use in interviewing:
 - S-Sit squarely
 - O-Open posture
 - L-Lean forward
 - E-Eye contact
 - R-Relax
- o. Use disability etiquette when interviewing individuals who receive services
 - Assume nothing. If you have a question about what to do, how to do it, what language or terminology to use, what assistance to offer, ask the individual with the disability.
 - Do not overgeneralize. Just because an individual has a particular form of disability, does not mean they share the exact same needs as someone else with that disability.
 - Use a normal tone voice. Avoid altering your volume unless asked to do so.
 - Never lean on or touch an individual's assistive device (i.e. wheelchair, walker, etc.).
 - Even when the individual has a support companion or interpreter, talk directly to the individual.
 - Offer assistance but do not insist on assisting.
 - When speaking with someone who uses a wheelchair, sit down or kneel in order to maintain eye level contact with them.
 - When someone may be lip-reading, look directly at the person, speak normally, avoid talking with your hands, and grant permission for them to let you know if they can't understand you.
 - When speaking with individuals with an intellectual disability, use simple and straight forward but NOT childish language.
 - When someone has difficulty communicating, be very patient, give undivided attention, ask shorter questions that require shorter answers, offer alternative communication methods, and ask for clarification when you don't understand. Do not finish their sentences or assume you know what they meant.

When investigators spend time up front addressing potential issues like those identified above, the opportunity has been created for a smoother interview process to unfold.

6. THE INITIAL WITNESS INTERVIEW

Initial interviews are generally conducted with people identified as potential witnesses who were at (or around) the scene of where an incident allegedly occurred. Testimony provided by witnesses during the initial Interview may be considered direct or circumstantial depending on the question(s) of the investigation needing to be answered and the witness' relationship to the incident. The investigator's goal during the initial Interview is to help the witness elicit relevant, detailed information regarding their memory of their experience or observations made relevant to the incident under investigation.

Structuring the Initial Witness Interview

The following provides a framework by which to structure the Initial Incident Interview:

a. Introduce yourself and generally describe the purpose of your interview.

When initially meeting with the witness, the investigator needs to introduce him or herself and the investigative role, even though they may already personally know the witness. The investigator should also provide a brief description of the purpose of the interview; this is done to establish a clear understanding, especially from the witness' perspective, about the seriousness of the process they're about to undertake and to minimize potential misrepresentation of the interaction and roles between investigator and witness.

One way to present this introduction is as follows:

"Good afternoon, Jane. My name is Max Jones. You may know me in my role as Program Manager for Day Programs at Agency XYZ, but today I'm here in a different role. I've been asked to investigate an incident that occurred earlier today in our Residential Program at one of our apartments. The incident involved John Smith, one of our residents, who sustained an injury. I understand you may have some information that may help me better understand this incident."

b. The witness speaks.

After the introduction and a brief description of why you need to speak with the witness, ask a general question, otherwise known as the "venting question":

"What can you tell me about this incident?"

The purpose of asking the venting question is to provide the investigator an opportunity to:

1. Assess the level of knowledge the witness may have about the incident.
2. Decide where to begin the interview process.
3. Allow the witness the opportunity to become comfortable with the process.

c. Begin to structure and organize the interview.

After listening to the witness' response to the venting question, the investigator's goal is to

begin guiding the witness through the interview to help them organize the memories being communicated and generate detail. To do this effectively, the investigator needs to focus on using **open-ended questions starting with who, what, when, where, or how**. This technique not only generates more complete information, but it also allows the witness to answer questions with more than a “yes” or “no” answer.

By asking open-ended questions, the investigator also minimizes the risk of asking **leading questions** which imply answers the investigator is willing to get. (example: “How angry did that make you feel?”)

Other types of questions to avoid using include:

- Compound questions, e.g. combining multiple issues into one question (examples: “What time did you arrive and who was present when you go there?” “Did you read and understand the manual?”)
- Accusatory questions, e.g. questions containing accusations or referencing incriminating facts (example: “Why did you hit her?”)
- Loaded questions, e.g. questions that do not have a “right” answer and that generally ask a witness to choose between two evils (example: “Are you still engaging in criminal behavior?”)
- Supposition questions, e.g. questions that ask someone to guess about someone else’s motives (example: “Why do you think Jim hit Bob?”)

d. Elicit relevant chronological detail from the witness

"Tommy fell." (Signed) Karen Smith, Aide

Karen is a woman of few words, apparently. As witness statements go, the above two-word gem has the advantage of brevity. Yet it does not tell us nearly enough about the circumstances of the incident it so succinctly describes. Our job as investigators is to **help the witness tell us every relevant fact she experienced or observed so that a complete and detailed account of all the facts and circumstances known to her is preserved in a record.**

"Well I was planning to leave early because I had to pick up my son from day care and if you aren't there by 6 they charge you by the minute so I was looking for my keys or else I would not have been there when I heard a noise and I saw Allan give Tommy a big shove right by that ugly couch I wish they would get rid of."

(Signed) Pete Drake, Psychologist

Pete, on the other hand, is a fountain of information, only some of which has anything to do with the cut on Tommy's head. Our job as investigators is to **help the witness focus on relevant information.**

"I was holding a pillow to Tommy's head to stop the bleeding — see, Tommy had thrown the pillow at Allan. When I came into the room Tommy was on the floor. The pillow

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throwing was earlier. Then I helped pick everything off the floor. I mean after the pillow fight. Then I came back in the room when I heard the commotion."

(Signed) Eve Cook, Nurse

Eve may have many of the relevant facts, but they are in such a jumble that they are of little use to anyone who wants to know how Tommy came to be injured. Another of our jobs as investigators is to **help the witness tell the story of what he or she experienced or observed in chronological order.**

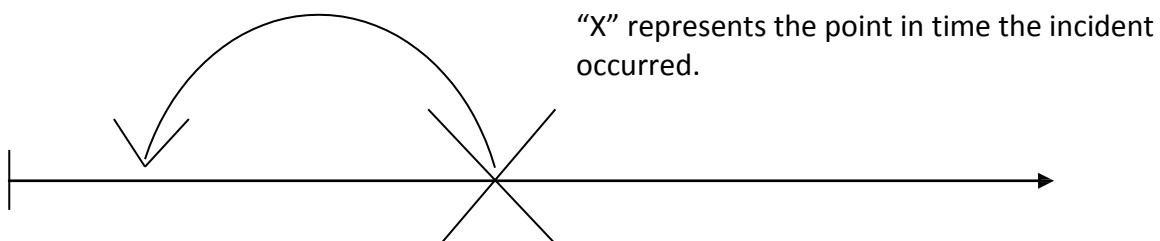
Witnesses often do not think in detail; they may be focused on irrelevancies; they may tell the story in any sequence that comes to mind. One of the primary goals of an investigator when interviewing witnesses is to **ensure you have conducted the most detailed, comprehensive interview possible of a witness.**

In order to do that effectively, the structure of the interview becomes important in helping to organize and elicit that detail. Once the venting question has been asked of a witness, and an answer has been received, an opportunity is created to help a witness:

1. Remember more detail
2. Focus on what is relevant
3. Organize his or her memories chronologically

Develop the Facts

To do this successfully, the interview should be structured using chronological "building blocks" (or slices) of time. Begin by determining the time and place **prior to the incident** where you believe the **witness' testimony becomes relevant** to the investigation.



Since the functional aspects of testimony are based on the witness's experiences or observations stemming from their senses (e.g. the ability to see, hear, taste, touch/feel and/or smell), the questions asked of the witness for each "block" should initially contain the following:

1. What did you see?
2. Who did you see?
3. What did you hear?

Based on the witness' response to these questions, it is important to **ask follow-up questions as**

they become relevant; do not wait. In essence, the witness' answer determines the next question. Types of follow-up questions to be considered relevant to each block of time may include:

1. What time was this?
2. Where did this happen?
3. Who else was there?
4. What is your relationship with that person?
5. Who else may know relevant information?
6. What occurred?
7. How did it happen?
8. Who did (or said) what? In what order?

Do not leave the chronological block until all of the details necessary to recreate the incident are established.

Other interviewing techniques to consider include:

1. Give the witness time to think before responding; do not rush them.
2. Do not interrupt and cut off the witness when they're providing an answer.
3. Use silence – people are generally uncomfortable with silence, and it may encourage a witness to provide you with additional information. This can be a useful technique if the investigator feels a witness is avoiding a question, or is being vague.
4. Restate what the witness has said by periodically summarizing and reviewing. This is useful to determine whether you've heard the witness correctly and assure the witness they're being understood.
5. Remember to introduce and use diagrams of the environments witnesses describe during the interview. This helps to clarify issues such as spatial relations and movement being discussed.
6. Before concluding the interview, give the witness the opportunity to disclose anything else she or he wants the investigator to know. Inform them of the goal of conducting a thorough, complete investigation that tells the most accurate story. Ask each witness whether she or he knows of additional evidence or relevant situations that were not discussed during the interview.

Interviewing Family Members

As part of an investigation, it may necessary to interview family members of the individual either as witnesses with direct evidence, witnesses with circumstantial evidence, or for background information. The interviewing techniques described above can be utilized for family members as well other witnesses.

While many family members will be eager to participate in your investigation, family members, unlike staff, do not have to agree to being interviewed or cooperate during the interview. Investigators should use effective interviewing techniques, such as building rapport and trust, in

order to mitigate the family's concerns about participating in an investigation.

If a family member is willing to speak with you but not willing to complete a witness statement, you cannot force them to do it. At that point, you should, at the first opportunity, provide a summary of the interview in your case documentation.

7. OTHER TYPES OF INTERVIEWS USED IN INVESTIGATIONS

a. The Background Interview

Background Interviews are used to generate evidence considered relevant, but not specifically originating from the incident itself. Background Interviews can be conducted with witnesses identified as being present at the scene when the incident occurred, or with other individuals who weren't present when the incident occurred, but have the potential of providing relevant "background" information. Examples of issues addressed during a Background Interview include:

1. Review and/or discussion about policies and procedures used by the organization in relation to issues of actual "practice" that emerged related to the incident, e.g. implementation of a person's behavior support plan versus what was actually written in the plan. The psychologist who developed the plan might be interviewed to discuss how and/or why the plan was developed, what training was provided to staff regarding the plan and its implementation, and what observations the psychologist made of staff and the individual since the plan was implemented, even though the psychologist was not present when the incident under investigation occurred.
2. Collecting information about medical issues that the investigator uses to support or dispute other evidence in the investigation, e.g. standards of care or "best practice" considerations.
3. Collecting information about relevant performance issues involving the alleged target(s) or other employees.
4. Collecting and assessing information about relationships among individuals considered principal to the incident (e.g. alleged victim(s), target(s), or other key witnesses).

The structure of a background interview generally consists of focused questions. As a result, care must be taken so the questions don't become leading. Otherwise, the evidence generated from this type of interview may be viewed as biased or prejudicial. Use of this evidence should be carefully weighed in relation to other key pieces of direct and circumstantial evidence identified in the investigation.

b. The Follow-up Interview

Follow-up Interviews are generally conducted with identified witnesses and used primarily to reconcile conflicting evidence, ask about new evidence emerging in the investigation, or ask questions the investigator failed to ask during earlier interviews with a witness. Examples of issues addressed during a Follow-up Interview include:

1. Asking witnesses to clarify any visual or hearing impairments they may have that affects their ability to see and/or hear, especially when their testimony is inconsistent with other evidence collected.
2. Generating additional detail related to a witness' testimony because the investigator failed to do this during earlier interviews.
3. Asking specific questions related to newly identified and/or conflicting evidence emerging in the investigation in an attempt to better reconcile these conflicts.

The structure of a follow-up interview generally consists of focused questions. As a result, care must be taken so the questions don't become leading. Otherwise, the evidence generated from this type of interview may be viewed as biased or prejudicial. Use of this evidence should be carefully weighed in relation to other key pieces of direct and circumstantial evidence identified in the investigation.

8. PERSONAL SAFETY

While safety issues can occur in a number of areas, the most significant risk posed to CIs is during the interview process. The following guidelines are meant to help you begin thinking about safety during interviews.

1. The first and most important guideline is "When in doubt, get out." Whenever you sense that an interview could get dangerous, you should end the interview immediately.
2. Never assume someone doesn't have the ability to be a risk to your personal safety.
3. Subjects of your interviews will get frustrated and angry at times but the CI does not need to tolerate prolonged screaming, yelling or personal attacks.
4. Position yourself to provide a line of escape if you need to exit the interview.
5. When traveling to a site to do an interview, park where your car can have a clear pathway to escape.
6. Have an emergency # preset on your phone that requires only one button to initiate.
7. When traveling outside your agency, report to a supervisor where you are going and establish a check-in system with a supervisor.
8. Do interviews where privacy of the conversation can be assured but support and assistance are nearby.
9. When someone threatens you with physical violence, stop the interview immediately. The highest predictor of imminent violence is the verbal threat of physical violence.
10. Consider your cyber-security. Think about what identifying information exists in the public space and consider ways to reduce that risk (i.e. privacy settings on social media sites).
11. Be mindful of the clothing you wear. For example, high heels can encumber a quick getaway; Neck ties can be used to choke.
12. When going into the community, be aware of safety risks such as weapons, pets, etc. Do not conduct investigations when weapons are present and in easy access of people in the house.

MODULE 6: IDENTIFYING AND COLLECTING DOCUMENTARY EVIDENCE – PREPARING WITNESS STATEMENTS

As defined previously, documentary evidence is defined as evidence that is in written form, whether on paper or electronic. This category includes written statements – the way in which the investigator attempts to preserve testimonial evidence created during an investigation interview. The business records of an organization, including the records of individuals receiving services, personnel records, policies and procedures, training records, time and attendance records, financial documents, meeting minutes, records of the governing board, etc. are also examples of documentary evidence.

1. PREPARING WRITTEN STATEMENTS

The function of preparing witness statements is to **preserve intact the witness' communication of their memory of experiences they had or observations they made**. The primary purpose of preparing written statements is to:

- a. Refresh the memory of the witness at a later time.
- b. Impeach the accuracy of contradictory later testimony by the same witness.

There are two different ways of preparing witness statements: narrative and deposition-style formats.

The preferred method of taking a statement is the **narrative format**. In the narrative format, the witness him or herself does the actual writing of the document. The witness would write in the first-person format and produce his or her "story" of what is recollected of the event.

A **deposition-style format** is writing and showing the question asked and the answer given, one question at a time. The deposition-style format is utilized on a limited basis and is used when the witness requires this level of prompting to provide a detailed statement.

Regardless of what format is used, it is important when preparing written statements reflecting the investigation interview with a witness that their statements are produced verbatim; and there is **no altering or editing of the actual language used by the witness**. As examples, the CI may **NOT** insert employee numbers in the statement, change wording or spelling, or take out the full names used by the witness.

Statements can be taken in one of two ways:

a. Narrative Format

1. The investigator should use the witness statement format provided in this manual.
2. Investigator would review the witness' testimony with him or her, asking similar questions as they did during the first level of the interview. In essence, the investigator recreates the chronological sequencing of the witness' movement through time.

3. As a question is re-asked, the witness would restate their answer and write their answer on the witness statement form, using complete sentences when possible. Example:

"I arrived for work at about 8:30 a.m. today, July 7th. I knew that it was 8:30 a.m. because I punched in at the time clock and saw it was 8:30."

4. The investigator would continue in this manner (investigator asks the question, witness restates their answer, witness writes down their answer) until the investigator is satisfied sufficient detail has been created and the interview can be concluded.
5. Prior to concluding the interview completely, the investigator asks the witness to re-read their entire statement, preferably out loud. The investigator should also direct them to consider any other changes they'd like to make before signing the statement.
6. The investigator should review the statement for any parts that appear illegible and ask the witness to rewrite if necessary.
7. The witness should always initial and date any changes made to the statement to show it was the witness who actually made the changes and no one else.
8. At the completion of this process, the witness should sign and date the statement, along with the investigator and any other 3rd party that may have been present during the interview process. If a 3rd party is present, a note should also be added to the statement referencing the role and function played by that 3rd party. Ensure that all other identifying details (e.g. time and place of interview, etc.) is filled in on the witness statement form.

b. Deposition-style Format

Statements would be produced in a manner similar to "a" above and should be used if the investigator is going to control the writing and documentation process. As each question is restated, the investigator should write the question verbatim. As the answer is then given, the investigator would write the answer verbatim. This process would continue until the statement has been reproduced to the piece of paper. Example:

Q: *"What were you doing about 8:30 a.m. today, July 7th?"*
A: *"I had just arrived for work at that time."*
Q: *"How did you know that it was 8:30 a.m.?"*
A: *"I had just punched in at the time clock and saw it was 8:30."*

This type of format would be used when the witness is unable to write the statement themselves and the investigator controls creating documentation of the witness' testimony. The CI must document in the final report the reason for utilizing this method and any evidence that supports this decision.

2. OTHER RULES TO APPLY WHEN PREPARING WRITTEN STATEMENTS

- a. The investigator must be present when the written statement is created. This is to ensure the validity of the conditions of how the document itself was prepared. The investigator later may be called upon to testify at a deposition or evidentiary hearing as to the conditions under which the statement was produced.
- b. Written statements should not be taken unless witnesses have first been interviewed.
- c. Statements should never be edited for incorrect grammar, spelling, syntax, etc.
- d. Handwritten statements, are the preferred method of collection of witness statements.
- e. The statement, if typed, should be typed immediately. If the typing of statements needs to occur, always maintain the original document with the typed version. The witness must reread and sign off on the typed and hand-written statements. The person who typed the statement must be noted on the witness statement. The typist must also sign the statement.
- f. Generally, interviews should not be tape-recorded or videotaped, although there are exceptions to that rule. People are uncomfortable and tend to be less forthcoming when being taped, impacting the overall quality of the interview.
- g. If the interview is recorded (for whatever reason), the following steps should be followed:
 - i. Check state laws for any restrictions or procedural requirements.
 - ii. The tape recorder or video camera should always be placed in plain view.
 - iii. Obtain any required consents from the witness prior to starting the recording.
 - iv. When the recording begins, state the date, time, and place of the interview, names of the individuals present, and have the witness confirm on tape his or her knowledge of, and consent to, the recording.
 - v. Once the interview is concluded, identify and mark the tape as a piece of evidence. Follow protocols relevant to creating and maintaining the "chain of custody" for evidence as previously outlined in this manual.
 - vi. As appropriate, the communication preserved on the tape should be transcribed as soon as possible after the interview is completed. The witness should then review the transcription for accuracy, and sign-off on the written statement. This document would be entered as a written statement in the investigation files.

MODULE 7: DOCUMENTARY EVIDENCE – IDENTIFYING AND COLLECTING RELEVANT BUSINESS RECORDS OF THE ORGANIZATION

1. Overview

One of the biggest challenges when conducting incident investigations is identifying documentary evidence typically available in human service and healthcare organizations that is truly *relevant*.

When conducting investigations, the CI must collect all documentary evidence that may be relevant to the incident. While it is usually not necessary to collect all progress notes ever written on an individual, the CI should always err, during the investigation, on the side of collecting too much rather than too little. During the Reconciliation of Evidence stage, the CI will determine what is relevant and what is not.

All investigators need to have a good understanding of the mechanics involved in organizational process. Policies, procedures, forms used in the organization, ways people communicate and share information all produce potential pieces of evidence that may “make or break” a case.

2. Types of Business Records Produced by Organizations

To help improve this knowledge, following are lists identifying the types of documentary evidence often produced by human service and healthcare organizations. The lists are broken into the core management process areas of an organization: Program (records of individuals receiving services and program operations), Personnel, Fiscal, and Administrative.

1. MEDICAL AND PROGRAM RECORDS OF INDIVIDUALS RECEIVING SERVICES

Medical and program records maintained by service providers generally include the following types of information:

1. Intake Forms
 - a. *Face Sheets*
 - b. *Identifying Information*
 - c. *Conditions of Admission, Consents*
2. Assessments & Evaluations
 - a. *Psychiatric*
 - b. *History & Physical*
 - c. *Pharmacology*
 - d. *Social Service*
 - e. *Nutrition*
 - f. *Nursing*
 - g. *Education*
 - h. *Occupational Therapy (OT), Physical Therapy (PT), Speech, Psychology, Behavior Support*
3. Consultations
4. Physician Orders
5. Medication Administration Records (MARs)
6. Plan of Care (POC) or Individual Support Plan (ISP)

- a. *Support Needs*
 - b. *History*
 - c. *Outcomes*
 - d. *Services and Supports*
7. Support Team Reviews and Meetings
8. Physician Notes
9. Interdisciplinary Notes
 - a. *Nursing Notes*
 - b. *Non-licensed Staff Notes*
 - c. *Ancillary Staff Notes – Social Work, Recreational Therapy (RT), Nutrition, etc.*
10. Human Rights Committee (HRC) Approved Restrictive Procedure Plans and Related Forms
11. Restrictive Procedure Review Committee (RPR) including Behavior Support Plans (BSPs) and Related Forms
12. Labs & Radiology
13. Charts and Graphs
 - a. *Vital signs*
 - b. *Height & weight*
 - c. *Sleep*
 - d. *Dietary Intake including Liquids, Solids, etc.*
 - e. *Toileting and Bathing*
14. Legal Documents
 - a. *Informed Consent*
 - b. *Guardianship and Conservator Papers*
 - c. *Involuntary Commitment*
15. Discharge Summaries
16. Death Documentation
17. Old Medical Records

II. PERSONNEL RECORDS

Another potential source of relevant evidence for an investigation is the personnel files of employees involved in the incident. The most relevant evidence in these files include:

1. Job Application(s)
2. Training Records (i.e. training on medical procedures, medication administration, behavior plans, CPR/First aide, safety policies, incident management, etc.)
3. Time and Attendance Records
4. Signed Personnel Policies and Procedures

Although employee disciplinary/commendation histories are also part of personnel records, the CI must exercise caution in the use of these records, as a person's past actions do not necessarily reflect their role, if any, in the incident under investigation. Reliance on these records could create bias either for or against a person.

III. FISCAL RECORDS

With increased concerns regarding incidents such as financial exploitation, the fiscal records of the organization can become increasingly more significant as evidence. Fiscal records typically maintained

by service providers include the following:

1. Accounts Payable and Receivable
2. Cash Accounts
3. Finances of Individuals Receiving Services
 - a. *Personal accounts*
 - b. *Pay records*
 - c. *3rd party rep, Guardians, or Conservators*
4. Balance Sheets (monthly, year-to-date)
5. Agency Budgets (approved, monthly, year-to-date)
6. Bank Statements
7. Agency Audits and Management Letters
8. Fiscal Policies and Procedures

IV. OTHER ADMINISTRATIVE RECORDS

Other records maintained by organizations that could become relevant evidence in an investigation include:

1. Email communications
2. Meeting Minutes
3. Incident Report forms
4. Investigation Files
5. Telephone logs and/or records
6. Visitor logs and/or records
7. Shift Reports
8. Strategic Plans
9. Quality Improvement Plans and related documents
10. Policies and Procedures
11. Training Curricula
12. Self-Assessment completed by providers prior to Licensing inspections
13. Licensing Inspection Summary or Licensing Surveys for ICF/IDs (including relevant correspondence and documentation)
14. Any other miscellaneous records produced by an organization

V. INVESTIGATIVE RECORDS

All notes that are taken by the CI during the course of the investigation are considered documentary evidence. These notes should be signed and dated at the time of the notation. It is recommended that agency establish an Investigative Notes Form for use by the CI. The CI's notes should be listed as documentary evidence in the final report.

MODULE 8: IDENTIFYING AND COLLECTING DIGITAL EVIDENCE

Digital evidence provides an increasingly valuable source of evidence to the CI. Digital evidence includes social media posts, blog entries, electronic communications such as text and instant messages and emails, digital photos stored on a smart phone or tablet, etc. Currently there are over one-billion users of social networking worldwide. Social media and networking became the primary form of electronic communication, surpassing email, in 2009. Best practice standards and case law are still being developed on the collection and use of digital evidence. CIs should consider evidence gathered from email, text messaging and social media sites to be part of conducting a thorough investigation. In collecting evidence, it is important that the evidence collected is relevant and authenticated.

- a.* Electronic communication is typically defined as text messaging or email communication.
- b.* Social media has an evolving definition. Several types of social media exist such as Social Networks (Facebook, LinkedIn), Media Sharing (Youtube, Instagram, Snapchat), Activity Training (FourSquare), Blogs and Microblogs (Twitter), Social News (Digg and Reddit), Discussion Forums, and Review Sites (TripAdvisor, Yelp).
- c.* Agencies should have strong "Acceptable Use Policies" that include wording that explicitly states that a user's activity on computer information systems may be used for the purposes of administrative action. Such language then permits investigators to collect pieces of evidence such as email communications, web browsing history, text messaging, etc. from any agency-owned device.
- d.* Agency policies should also consider directly prohibiting communication about agency business and/or individuals receiving services via personal communication or social media sites. This should be done by carefully considering applicable privacy laws and freedom of speech protections.
- e.* Under such policies, the CI can actively seek out evidence as defined by agency policy. In the absence of such policy, the CI may still receive electronic communication or social media evidence offered to them by the individual, target, or any other person who brings such evidence to the CI. It is important that regardless of how the evidence is discovered, that proper collection techniques be followed.
- f.* For text messaging, the CI should ask the person holding the evidence on their phone to take progressive screen shots of their text conversation chain from the start of the discussion of the incident through the current date. This must be done progressively in order to show the entirety of the messaging. Each screenshot should then be forwarded via email to the CI.
- g.* For social media sites, the CI should sit down at an agency computer with the person stating they are aware of evidence. The CI should have the witness log into their account. The CI should have the person identify any relevant entries on their wall and through messaging that potentially apply to the incident. The witness should then be instructed to take a screen shot (including the taskbar with the date and time showing) of the page containing relevant content. Each screenshot should then be forwarded via email to the CI.
- h.* On sites that allow comments, the field should be expanded to include all comments. In cases where the comments expand beyond a single screen view, multiple screen captures with overlap should be taken.
- i.* It is generally considered allowable and ethical for the evidence collection of publically

available data. While most social media networks allow the user to determine their own privacy setting, users often choose to make a lot of information available to the public. The CI should utilize the same evidence capturing techniques as described above for information they find in the public domain.

- j.* It is not advised to attempt to gain access to non-public information through the CI attempting to gain direct access to that information during the course of the investigation, i.e. sending a “friend request” during the course of the investigation. Additionally, CIs should not use the method of pretexting in the gathering of evidence. Pretexting is when the investigator misrepresents his/her identity for the purpose of obtaining information, i.e. using a false identity to send a “friend request”.
- k.* Evidence obtained through electronic communication or social media must be authenticated. Authentication is essentially how we identify that the evidence is what it claims to be. There are several methods that can be used to achieve authentication. The original author of a communication or posting can authenticate that a communication, post, or comment was indeed made by them. If there was a witness who directly observed another individual send or submit the communication, that witness may also be able to authenticate the evidence. Lastly, a witness may testify to how they discovered the evidence and why they believe the evidence was can be attributed to the alleged author. This is the least weighty of methods of authentication as it cannot be established that someone else did not send the messages, “hack” the alleged author’s social media site, set up a fictitious account, or access an account that was left unattended by the owner.
- l.* The CI should maintain a thorough record of all actions taken by them or others with regard to the acquisition, transfer, printing, authentication, etc. of digital evidence.

MODULE 9: RECONCILING EVIDENCE

No two witnesses tell exactly the same story. Inevitably one witness will say there was oatmeal in the bowl, and another will swear it was Cream of Wheat. Contradictions in testimony and other evidence need to be resolved or "reconciled." This means we must choose which version of a fact at issue is more likely than not to be true, although there may be times when neither version is "true." What the CI learned through reconciliation of evidence is captured in Section IV of the Certified Investigation Report, the Certified Investigator's Initial Analysis of Evidence. The following guidelines will help you sift out the more reliable pieces of testimony and other evidence from the less reliable in situations where discrepancies exist.

Rules Used to Reconcile (or Weigh) the Evidence

1. Is the witness' story consistent over time? Generally, a witness whose story is consistent over time will be viewed as more credible than a witness who alters or changes significant facts of his or her story over time.
2. Establishing independent corroboration of a principal's version of the event enhances that principal's credibility. (A principal is someone who is a key to the incident, e.g. the alleged victim(s), target(s), etc.)
3. Is the physical evidence available in the investigation consistent or inconsistent with testimony given by witnesses? Where physical evidence is consistent with witness testimony, more value or weight is given to that version of the event.
4. Based upon the witness' location with respect to the incident itself (physical proximity and obstacles in the environment), how will his or her capacity to make observations (see, hear, taste, touch, smell) be affected?
5. What are the witness' capacities to see and hear? Are there impairments to either the sense of seeing or hearing? If so, was use of the impaired sense critical to the observation made by the witness? If the impairment to the critical sense was corrected at the time of the observation, such as through use of eye glasses or a hearing aid, the reliability of the observation may not have been compromised.
6. What was the witness' level of focus and attention during the course of the incident?
7. What is the witness' relationship to other people involved in the incident (was the witness biased or objective)?

MODULE 10: PREPARING THE CERTIFIED INVESTIGATION REPORT

The Certified Investigation Report (CIR) is an important tool used to organize and present investigation protocols related to identifying, collecting, preserving, and analyzing evidence. Using a written report is the most effective way to organize the CI's conclusions and allow for a determination of appropriate corrective actions. It provides the reader a roadmap leading to the *findings of fact*, and documents decisions made regarding corrective actions to be implemented related to the findings.

Good documentation takes time. It is critical that the CI have uninterrupted time to complete the necessary documentation. An investigation cannot be considered of high quality without proper and thorough documentation that provides a road map for the reviewer explaining why the CI did what they did during the investigation.

Quality documentation serves four main purposes:

1. Quality assurance – assures that the investigation was done to the highest of quality standards
2. Compliance – assures that the investigation meets the minimum standards of investigations
3. Justification – provides reasoning behind what actions were taken, in what order and why
4. Memory – supports the CI's memory about what actions were taken, what witnesses said, what other evidence was observed, etc.

The CIR is maintained in the investigation file along with the other evidence collected related to the incident. A portion of the information in the CIR is also included as part of the final section of the incident report.

Structuring the Certified Investigation Report

(Note: please refer to Appendix II for the complete Certified Investigation Report format, along with Appendix III for a sample written Certified Investigation Report)

A thorough, organized Certified Investigation Report includes the following, documented by the CI:

1. A description of the alleged incident
2. A description of the investigation protocols used to identify, collect, preserve and analyze the physical, demonstrative, testimonial, and documentary evidence
3. A summary of the evidence collected
4. Analysis of the evidence, including determinations as to credibility when conflicts in evidence arise
5. Findings of fact based on the totality of credible evidence - the reconciliation of the evidence utilizing the "*preponderance of evidence*" standard for civil or administrative investigations

A thorough, organized Certified Investigation Report includes the following, documented by the organization's management:

1. Documentation of the administrative review and findings of the investigation, including:
 - a. Determination of final outcomes
 - b. Recommendations for corrective action (affecting not only the individual(s) receiving services, but also impacting personnel, policy and procedures, and/or any other administrative, program or fiscal issues of the organization) as a result of those decisions

2. Implementation of those recommendations

The Certified Investigation Report should:

1. Be chronological in order
2. Utilize a logical and ordered structure
3. Be thorough in discussing the evidence gathered
4. Include a reason for why there was a diversion when things were done outside the norms provided in the manual
5. Cite the diagrams and pictures used to demonstratively capture those relationships when discussing spatial relationships
6. Use first person language
7. Use the exact words of a person when quoting them
8. Be organized so that the evidence is easy to review (Lists and bullet points are useful to keep track of the presentation of the evidence)

The Certified Investigation Report should NOT contain:

1. Generalized conclusions that cannot be backed up
2. Needless facts (By documenting these, the impression is created that the investigation was not carefully conducted, and may result in needless disclosure of facts unrelated to the investigation)
3. Non-fact-based statements
4. Evidence that is confusing, irrelevant, immaterial, or prejudicial (Identify evidence that's relevant to the investigation. Including irrelevant evidence can suggest the investigation is skewed and not objective)
5. Generic descriptors, such as they, he, she, etc.
6. Labeling and using diagnostic language (The CI in their role as an investigator is not qualified to make diagnoses. So calling someone "bipolar" or an "alcoholic" is not something that the investigator can diagnose. Diagnoses can be listed but only when there is documentation to support those diagnoses)
7. Unanswered questions (If something is not known, the documentation should acknowledge it)
8. Acronyms or abbreviations unless on a standardized and agency approved list
9. Sanitizing the language used by a witness (If a witness uses profane words, derogatory expressions, homophobic, racist, or sexist comments, or wording that is not grammatically correct, the CI should quote them as they said it. It is not the role of the CI to correct language that they believe to be professionally or personally inappropriate.)

Once the Certified Investigation Report has been written, the investigation is ready for the Administrative Review, and a decision or recommendation can be made regarding final conclusions and outcomes. **Management of an organization is responsible for validating the investigation, and for determining the final conclusions, outcomes, and recommendations for corrective action.** If the final conclusions and recommendations for corrective action are to be made in conjunction with others, the management should meet with those individuals and make these decisions jointly.

APPENDIX I: GLOSSARY

Beyond a Reasonable Doubt: The burden of proof needing to be satisfied in criminal proceedings in order to determine a defendant guilty. Generally defined to mean no "reasonable doubt" can exist in the mind of a reasonable person that the defendant is guilty. Doubt can still exist, but only to the extent that it does not affect a reasonable person's belief that the defendant is guilty.

Chain of Custody: The investigation protocols used to assure the integrity of evidence over time in an investigation. The chain of custody begins as soon as the environment where the incident occurred is secured. The investigator is responsible for showing exactly where the evidence has been from the moment it was collected until the time it might be used during a hearing. If the chain of custody is broken, the certainty of the evidence is undermined and questions can be raised about its validity.

Circumstantial Evidence: Evidence which is not directly from an eyewitness or participant and requires some reasoning to prove the fact in question.

Collusion: A secret agreement between two or more parties for a fraudulent, illegal, or deceitful purpose. (*The American Heritage Dictionary of the English Language, Fourth Edition*)

Demonstrative Evidence: Evidence that represent a piece of physical evidence. The way in which physical evidence identified in an investigation is preserved. Demonstrative evidence includes photographs, diagrams, x-rays, CAT scans, etc.).

Direct evidence: Evidence in the form of testimony from a witness who was present for the incident and experienced the fact in question through sight, hearing, touch, taste, or smell.

Documentary Evidence: Anything written down, on paper or electronically. This category includes written statements – the way in which the investigator attempts to preserve testimonial evidence – created during an investigatory interview. The business records of an organization, including service recipient and personnel records, policies and procedures, training records, time and attendance records, financial documents, meeting minutes, records of the governing board, etc. are all examples of documentary evidence as well.

Facts: Pieces of information (evidence) available to the investigator.

Inconclusive: Not conclusive; not leading to a definite decision or result, e.g. *inconclusive evidence*.

Incident: An event with **potential to adversely impact an individual's health, safety, or rights**.

Incident Management: The response to an event, intended to ensure the adequate, appropriate, and effective protection of the health, safety, and rights of the individual

Investigation: The process of identifying, collecting, and assessing facts (evidence) in a systematic manner. The purpose of an investigation is to objectively describe and explain what did (or did not) occur at a given place and time.

Irrelevant Evidence: Facts that do not have the potential to describe or explain an incident under investigation.

Objectivity: The ability to describe or perceive something based on facts without influence by personal emotions, experiences, bias, or opinion.

Physical Evidence: Objects or things such as an injury, weapon, fluids, etc., as well as the **absence of things** that otherwise would be available based on the testimony of witnesses. Spatial relationships are another aspect of physical evidence available for assessment in an investigation (location of people in a room, the placement of furniture, distance of witnesses to the incident itself occurring).

Preponderance of the Evidence: The standard of evidence generally applied to civil or administrative proceedings requiring that conclusions of fact be based on the **weight of the evidence**. Other definitions characterize the preponderance test as the fact finder being convinced that the conclusion of fact chosen is **“more likely than not,”** or that 51% or more of the evidence supports one conclusion of fact over another.

Relevant Evidence: Facts that **potentially** describe or explain an event or incident under investigation.

Rules of Evidence: Laws governing the admissibility of proof at a hearing. They include the codified rules of the jurisdiction (e.g. a State's Administrative Procedures Act) as well as constitutionally mandated requirements.

Standard of Proof: The level of evidence necessary for a party to prevail in a given case. Standards of evidence applied include **“preponderance,”** and **“beyond a reasonable doubt.”**

Testimonial Evidence: Information a witness shares with the investigator in verbal form or the equivalent (sign language, gestures, behaviors, etc.), according to his or her experiences or capacity to observe a specific environment over a period of time. Experiences and the capacity to make observations derive from the senses: what the witness saw, heard, tasted, touched/felt, or smelled.

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CERTIFIED INVESTIGATION PHYSICAL EVIDENCE LOG SHEET

CASE NAME: _____ CASE NUMBER: _____

Physical Evidence Identified	Collected?	Date/Time Collected	Chain of Custody Notes
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			

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CERTIFIED INVESTIGATION DEMONSTRATIVE EVIDENCE LOG SHEET

CASE NAME: _____ CASE NUMBER: _____

Description of Demonstrative Evidence	Date/Time Collected	Chain of Custody Notes
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		

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CERTIFIED INVESTIGATION TESTIMONIAL EVIDENCE LOG SHEET

CASE NAME: _____ CASE NUMBER: _____

Witness Name	Title/Relationship	Date of Interview	Time of Interview	Written Statement (Y/N?)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				

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CERTIFIED INVESTIGATION DOCUMENTARY EVIDENCE LOG SHEET

CASE NAME: _____ CASE NUMBER: _____

Description of Documentary Evidence	Date/Time Collected	Chain of Custody Notes
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		

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CERTIFIED INVESTIGATION DIGITAL EVIDENCE LOG SHEET

CASE NAME: _____ CASE NUMBER: _____

Description of Digital Evidence	Date/Time Collected	Authentication and Chain of Custody Notes
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		

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Sample Witness Statement Form

Case Name _____ Case Number _____
Witness Name _____ Phone _____
Title (relationship) _____ Phone _____
Work Location _____ Home Address _____
Date of Interview _____ Time _____ Location of Interview: _____
Reason for Interview _____ Investigator _____

Witness Signature _____ Date _____

Interviewer Signature _____ Date _____

Page 1 of _____

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Sample Witness Statement Form (continuation page)

Case Name _____ Case Number _____
Witness Name _____ Date of Interview _____
Location of Interview _____ Time _____

Witness Signature _____ Date _____

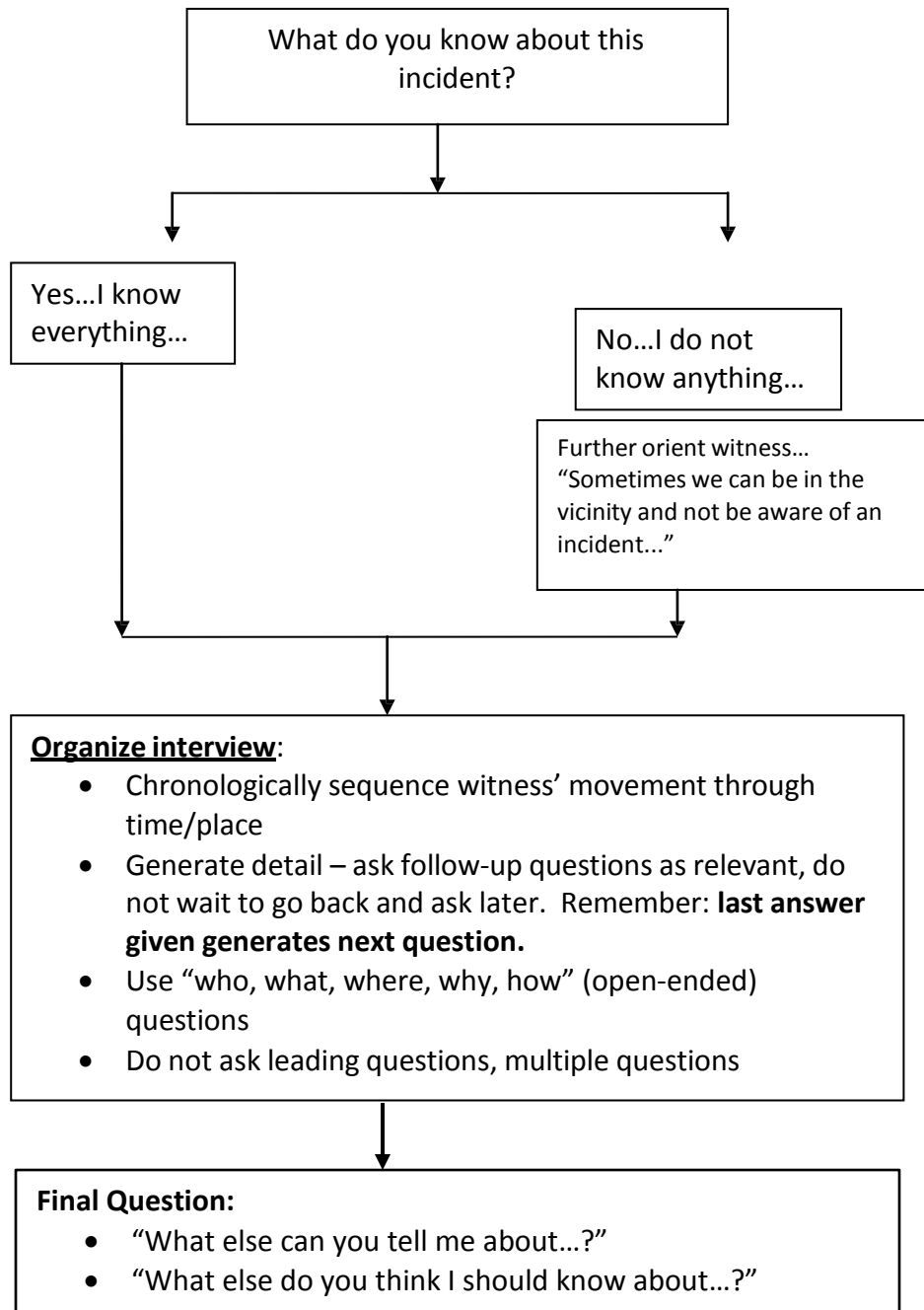
Interviewer Signature _____ Date _____

Continuation Page ____ of ____

STRUCTURING THE INITIAL WITNESS INTERVIEW

Structure the initial witness interview as follows:

- I. **Introduction**
- II. **Reason for interview**
- III. **Opening (or venting) question:**



RULES USED TO RECONCILE (WEIGH) EVIDENCE



CHECKLIST – PREPARING THE INVESTIGATION

After being assigned the task of conducting a certified investigation, the CI can use the following checklist to begin organizing the investigation:

TASK	COMPLETED (Yes or No)	NOTES
1. Establish timelines for the process		
2. Determine the investigatory question(s)		
3. Identify required tasks (e.g. identify and collect physical and demonstrative evidence, interview witnesses, etc.) needing to be completed. Remain flexible.		
4. Did modification of the processes identified in #3 above occur because of other issues emerging in the investigation?		
5. Identify and classify potential witnesses: <ul style="list-style-type: none"> a. Alleged Victim(s). b. Witnesses with direct evidence. c. Witnesses with circumstantial evidence. d. Alleged Target(s). 		
6. Plan the chronology and schedule witness interviews. Accommodate needs for interpreters or other 3 rd party representation.		
7. Was there a need to modify the investigation plan due to: <ul style="list-style-type: none"> a. Timing concerns (e.g. delays leading to destruction of evidence or loss of key witnesses). b. New leads being identified c. The need to fill gaps and oversights in the plan. d. Evidence of other incidents or misconduct requiring an expanded or separate investigation, or the need to report an incident not previously reported. 		
8. Determine if any special communication and/or public relations needs exist involving the incident under investigation. If so, develop plan on handling special communications and communicate that information to all parties needing to know.		

CHECKLIST – PRESERVING EVIDENCE – GENERAL STEPS

The following checklist can be used to assure initial steps are taken to begin preserving evidence after an incident requiring a certified investigation is reported:

TASK	COMPLETED (Yes or No)	NOTES
1. Was the scene secured after the incident was reported? (If yes, explain how it was secured; if no, explain why not).		
2. Were initial photos of injuries (or potential injuries) taken properly? a. Were photos taken over a period of several days showing the condition of the site allegedly injured over time?		
3. Did any individual involved need medical treatment? a. If yes, was it provided promptly? b. Date and time treatment provided: _____		
4. Were victim(s) provided any protections? If yes, identify in the "notes" column.		
5. Was there an alleged target(s) identified? If yes, indicate what was done to remove them from contact with individuals receiving services, including date and time this action occurred.		
6. Were witnesses separated after the incident? Explain.		

CHECKLIST – PHYSICAL EVIDENCE

The following checklist can be used to assure initial steps are taken to begin preserving physical evidence after an incident requiring a certified investigation is reported:

TASK	COMPLETED (Yes or No)	NOTES
1. Was a person stationed at the entrance of the room or environment where the incident occurred in order to prevent others from entering?		
2. If a room has more than one entrance and there are insufficient people to station at each entrance as in "1" above, did the person assigned remain in view of the other entrances to the room when possible. a. Were the other entrances locked if only 1 individual was available to station at an entrance and the other entrances are not clearly visible?		
3. Did anyone enter the room once after it was secured? Was the condition of the room disrupted because of this? Did the monitor take notes of anyone entering the room, the reason for entering, the time they entered and left the room, and what they did while in the room?		
4. Upon arriving at the scene, did the CI speak with the person stationed at the scene to assess information regarding procedures used to secure the scene prior to the CI's arrival? a. Were logs maintained, and if so, did the CI collect them? b. If necessary, did the CI conduct a formal interview and prepare a statement with the monitor?		
5. Regardless of whether the scene was secured, did the CI assess the location where the incident occurred for physical evidence?		

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TASK	COMPLETED (Yes or No)	NOTES
<p>6. Were diagrams prepared showing the environment where the incident occurred?</p> <p>a. As appropriate, were distances measured and clearly marked on the diagram?</p> <p>b. Was other identifying information clearly marked?</p>		
<p>7. Were sufficient photos taken to create demonstrative evidence?</p> <p>a. Photos of injuries and/or absence of injuries.</p> <p>b. Photos of the environment where the incident allegedly occurred.</p> <p>c. Photos of individual objects referenced in the incident report.</p>		
<p>8. Were photos and/or videos marked with proper identifying information?</p> <p>a. The name of photographer.</p> <p>b. Date, time and place it was taken.</p> <p>c. Subject of the photo.</p> <p>d. Case name and number.</p> <p>e. A unique number assigned to each piece of evidence in the order collected. This number is used to identify the object or substance in evidence logs, on diagrams, etc.</p>		
<p>9. Was a Photo and/or Video Evidence Log created?</p>		
<p>10. Were images saved in the same format they were originally taken in?</p>		
<p>11. Were digital photos and/or videos copied to CD-R format?</p>		
<p>12. Were any substance or object removed from the environment photographed, and identified and placed on diagrams?</p>		
<p>13. Were all objects and substances removed from the environment clearly marked with the following information:</p> <p>a. A description of the object.</p> <p>b. The date, time, and place it was collected.</p> <p>c. The name of the CI collecting it.</p> <p>d. Case name and identification number of the case.</p>		

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TASK	COMPLETED (Yes or No)	NOTES
e. A unique number assigned to each piece of evidence in the order collected. This number is used to identify the object or substance in evidence logs, on diagrams, etc.		
14. Were all objects or substances collected included on the Physical Evidence Log?		
15. Was the evidence maintained over time in a secure, controlled location?		
16. Was a "chain of custody" log maintained showing: a. Who removed the evidence? b. Date and time the evidence was removed. c. Reason it was removed. d. Date and time the evidence was returned.		

CERTIFIED INVESTIGATION REPORT GUIDE **(Sections I – IV)**

I. INTRODUCTORY STATEMENTS

(Note: this section of the report is used to introduce basic information associated with how the incident was identified and reported, a brief description of the initial allegation, and to document initial decisions made regarding the need to conduct an investigation including assignment of the investigator.)

The following information should be documented in this section:

1. If known, the date and time incident allegedly occurred.
2. The date and time incident was reported to agency personnel.
3. The name(s) of the person(s) reporting the incident and their role or relationship to the principals involved in the incident.
4. The date and time the investigator was assigned the case (note any possible conflicts of interest identified when assigning the investigation).
5. A description of the allegation (or reason for the investigation) and information provided **to the CI** at the time of assignment.

II. INVESTIGATION PROTOCOLS

(Note: the following section is used to document the investigative protocols utilized to identify, collect, preserve, and analyze evidence available to the investigation. When possible, simply use lists to present the information rather than longer, narrative formats of writing.)

A. General Introduction

The following information should be documented in this section:

1. The date(s) and time(s) investigator visited the site of the incident.
2. The person(s), (by name and title), the investigator spoke with at the site, *e.g.* reporter of the incident and site supervisors or management of the organization where the incident occurred, etc. (the purpose of these discussions is to assess initial responses to preserving evidence, as well as issues and needs of the investigation).

B. Collecting Physical, Demonstrative, and Digital Evidence

The following information should be documented in this section:

1. Identify how the incident scene was secured (if it wasn't secured explain why).
2. Identify and list physical evidence **identified** and logged.
3. Identify and list each piece of physical evidence **collected**.
4. Identify and chronologically list (by date, time, and name of person taking photo) any photographs or video taken.
5. Identify and list (by date and time) all diagrams, maps, floor plans, x-rays, etc. available to the investigation, *e.g.*,
6. Identify and list (by date and time) all digital evidence identified and collected.
7. Identify how the physical, demonstrative, and digital evidence was preserved after collection in order to maintain the **chain of custody**.

C. Collecting Testimonial Evidence

The following information should be documented in this section:

1. Briefly describe how potential witnesses were identified.
2. Chronologically list all witnesses interviewed. Include title, date, and time of each interview.
3. Identify the person(s), if any, as the alleged target(s) of the investigation.
4. Note the date and time alleged target(s) was removed from contact with individuals and placed on administrative leave or reassignment to other duties. If administrative leave or reassignment did not occur, note why.
5. If the right to representation exists by law, regulation, or labor contract, describe how the alleged target(s) or other witnesses were afforded this right.

D. Collecting Documentary Evidence

The following information should be documented in this section:

1. List written statements taken from individuals interviewed during the investigation. If identical to II.C.2. above, simply reference here; if not, create a chronological list noting name, date, and time statement was prepared for all documents considered "witness statements."
2. Identify and list all other documents collected in the case (business records of the organization, etc.).
3. Identify how business records collected as evidence were secured prior to, and after, collection.

III. EVIDENCE SUMMARY

(Note: this section is used to document the primary question[s] needing to be answered as a result of the investigation and to classify the direct and circumstantial evidence available to answer that question[s]).

The following information should be documented in this section:

1. **Identify and list the investigatory question(s) needing to be answered by the investigation** (if multiple questions must be answered, *list each one separately*).
2. **Describe/discuss all relevant evidence** (evidence available to answer each investigatory question).

IV. CERTIFIED INVESTIGATOR'S ANALYSIS OF EVIDENCE PRESENTED IN SECTION III

*(Note: this section is used to document the analysis of evidence presented in the **Section III: Evidence Summary** above.)*

1. For each investigatory question identified in **Evidence Summary** above, prepare a narrative analysis of the initial reconciliation of evidence and the reasons for the conclusions being drawn.

Analysis of the evidence and reasons for the conclusions of evidence presented:

Certified Investigation Report

Case: Tim Smith
CI: Jack Brewster

Case #: 007
Date of Report: March 1, 2017

I. Introduction

1. Indicate the date and time the incident allegedly occurred, if known.

The incident allegedly occurred on February 21, 2017 around 7:35 a.m. at the 2nd Street home.

2. Indicate time the incident was reported to facility personnel.

Incident was reported to Janis Bonnet, Incident Management Point Person, on February 21, 2017 at approximately 9:30 a.m. Marc Charton, Residential Director, had contacted Ms. Bonnet to alert her of an alleged critical incident discussed by Tim Smith, service recipient, after a bump was observed on his head by Denise Williams, Day Program Supervisor.

3. List name(s) of the person(s) reporting the incident.

Marc Charton, Director of Residential Services.

4. Indicate date and time the investigator was assigned the case.

Jack Brewster, agency Certified Investigator, was assigned the case on February 21, 2017 at 3:30 p.m. by Janis Bonnet.

5. State the nature of the allegation (or reason for the investigation), and information provided to the investigator at the time of assignment.

Tim Smith, an adult individual receiving services living at the 2nd Street home, was allegedly slapped in the head by an employee, Zack Myers.

II. Investigative Methodology

A. General Information

1. List the date(s) and time(s) the investigator visited the site of the incident.

The incident was initially discovered and reported by Day Program staff. The alleged site of the incident was the 2nd Street Residence. I visited the 2nd Street residence on February 22, 2017 at 9:00 a.m.

2. List the person(s) with whom the CI spoke with at that site to assess initial responses to preserving evidence as well as issues and needs of the investigation.

I spoke with Marc Charton, initial reporter of the incident and Director of Residential Services.

B. Collecting Physical, Demonstrative, and Digital Evidence

1. Describe how the incident scene was secured (if it wasn't secured explain why).

Scene of alleged incident was not secured. Alleged incident occurred about 7:35 a.m. on February 21, 2017 at Tim Smith's residence. Mr. Smith reported the incident to Day Program staff (different location) about 2 hours later; staff had already cleaned-up the kitchen prior to leaving to take individuals to their work/day program sites.

2. List each piece of physical evidence identified and logged.

- a. Bump to Tim Smith's head.
- b. General environment where incident allegedly occurred (spatial relationships correlated to witness testimony)
- c. Absence of any blood in the kitchen area

3. List each piece of physical evidence collected.

No physical evidence was specifically collected for this investigation; photographs of injury and the environment are noted below under #4 - photographs taken; diagrams created listed under #5.

4. Chronologically list (by date, time, description and name of person taking photo) any photographs or videos taken.

- a. Series of photographs taken of Tim Smith's injury to his head (#1-5) taken on February 22, 2017, 9:10 am.
- b. Series of photographs taken at the 2nd Street residence showing the environment and layout of the house (#6-15) taken on February 22, 2017, 9:15 am.

5. List (by date and time) all other diagrams, maps, floor plans, x-rays, etc. available to the investigation.

- a. Diagram added to by Joe Jones, Residential Counselor, of the 2nd Street residence, 2/22/17, 11:30 a.m.
- b. Diagram added to by Zack Myers, Residential Counselor, 2/23/17, 12:15 p.m.
- c. Diagrams were not added to by the two other direct witnesses; due to the severity of their communication and cognitive disabilities (as described in their ISPs), they were unable to identify spatial relationships when presented with the blank diagrams.

6. Identify and list (by date and time) all digital evidence available to the investigation.

No digital evidence was identified or collected for this investigation.

7. Describe how the physical, demonstrative, and digital evidence was kept after collection in order to maintain the chain of custody.

- a. There was no specific physical or digital evidence collected for this investigation
- b. Photographs were taken of the bump on Mr. Smith's head and of the 2nd Street residence. All photographs taken are maintained on a CD-R which is kept in my locked filing cabinet. Photographs are also printed and kept in my case file in the locked filing cabinet.
- c. Diagrams are signed and dated by the person who added to the diagram and kept in my case file.

C. Collecting Testimonial Evidence

1. Briefly describe how potential witnesses were identified.

Initial call from Marc Charton alerted me to contact and meet with Felicia Valdez, Program Manager for 2nd Street. She presented me with an incident report filed by Zack Myers concerning the above referenced alleged incident along with separate incident reports involving Tim Smith from other staff members for that week. Felicia Valdez indicated that Joe Jones was on duty at 2nd Street residence providing a 1:1 with another individual, Sam Slade, at the time of the alleged incident.

In discussing the alleged incident with Zack Myers, Zack indicated that Bill Tedesco, Behavior Specialist, was alerted to the alleged incident when Zack dropped Tim off at the MLK Avenue Adult Day Program site. The initial observation of the bump on Tim's head was made by Denise Williams, Day Program Supervisor, and treated by Otesia Barr, physician. I formally interviewed Zack Myers, Joe Jones, Tim Smith, Bill Tedesco, Denise Williams, and Otesia Barr.

Due to the scene not being properly secured, Jane Mark who was the kitchen staff responsible for cleaning that day was interviewed.

I interviewed Sam Slade and Chris Malerno, individuals who reside in the home. Due to severe cognitive and communication disabilities (as described in his ISP), Chris Malerno was unable to provide any testimony. Sam Slade was unable to communicate orally but through the use of a letter board was able to provide testimony.

2. Chronologically list all witnesses interviewed. Include title, date and time of each interview.

Jane Mark* – Kitchen Staff – 2/22/17 9:30 a.m.
Tim Smith – Alleged Victim – 2/22/17 10:00 a.m.
Joe Jones – Res. Counselor – 2/22/17 11:30 a.m.
Sam Slade – Individual at Home – 2/22/17 12:45 p.m.
Chris Malerno – Individual at Home – 2/22/17 1:45 p.m.
Felicia Valdez – Program Manager – 2/22/17 2:30 p.m.
Bill Tedesco – Behavioral Specialist – 2/22/17 3:30 p.m.
Otesia Barr – Medical Director – 2/23/17 8:15 a.m.
Denise Williams – Day Program Sup. – 2/23/17 10:00 a.m.
Zack Myers – Res. Counselor – 2/23/17 12:15 p.m.

*While the alleged victim is normally interviewed first, Jane Mark was interviewed first as this was her break and waiting might impede her ability to prepare lunch for the participants in the program.

3. Name the person(s), if any, as the target(s) of the investigation.

Zack Myers, Residential Counselor, is identified as the alleged target.

4. If the right to representation exists by law, regulation or labor contract, describe how the alleged target(s) or other witnesses were afforded this right.

No right to representation exists for the witnesses from this agency and none of the witnesses requested the right to representation.

D. Collecting Documentary Evidence

1. List written statements taken from individuals interviewed during the investigation. If

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identical to II.C.2. above, simply reference that here. If not create a chronological list noting name, date, and time statement was prepared for all documents considered "witness statements."

Witness statements were prepared for all witnesses identified in II.C.2. above except for Chris Malerno, who did not provide any testimony.

2. List all other documents collected in the case (business records of the organization, etc.).

- a. Doc. #1 - Status sheet completed by Otesia Barr
- b. Doc. #2 - Status sheet completed by Denise Williams
- c. Doc. #3 - Behavior Report form completed by Zack Myers
- d. Doc. #4 through #8 - Behavior Report forms completed by various Residential Program staff
- e. Doc. #9 - 12 - Behavior Report forms completed by Day Program staff.
- f. Doc. #13-18 – Staff timesheets
- g. Doc. #19 – Behavior Plan for Tim Smith
- h. Doc. #20 – ISP for Tim Smith
- i. Doc. #21-24 – Staff Training Records
- j. Doc. #25 – CI notes from interview with Chris Malerno

3. Describe how business records collected as evidence were secured prior to, and after, collection.

Business records were not secured prior to collection. Documentary evidence collected for the investigation is kept in the investigation file in a locked filing cabinet in administrative records room of the organization. There is limited, controlled access to this room and files.

III. Evidence Summary

1. List the investigatory question(s) needing to be answered by the investigation (if multiple questions must be answered, list each one separately).

What happened to Tim Smith on February 21, 2017 at the 2nd Street Home?

2. Describe/discuss all relevant evidence (evidence available to answer each investigatory question).

- a. The only other identified witnesses to the morning breakfast incident other than Zack Myers and Tim Smith were Joe Jones, Sam Slade and Chris Malerno.

- b. Mr. Jones and Mr. Slade testify that they did not see Zack Myers slapping Tim Smith in the head. Due to severe cognitive and communication disabilities, Chris Malerno was unable to provide any testimony.
- c. Joe Jones testifies that Zack Myers handling of the incident was consistent with Mr. Smith's Behavior Support Plan.
- d. Tim Smith did not indicate to the investigator that Zack Myers slapped him on the head.
- e. A bump on Tim Smith's head was observed by Denise Williams and Otesia Barr on February 21, 2017. Mr. Smith appeared calm and relaxed during the investigator's interview with him. He smiled, laughed, and nodded when staff names were mentioned, including Zack Myers. His ISP notes that these are indications of him liking something or someone.
- f. Tim Smith showed no signs of fear or of being intimidated by Zack Myers. Mr. Smith also indicated he likes his home.
- g. Zack Myers and Tim Smith were involved in a behavioral incident at breakfast on the morning that the bump was discovered. The incident involved Mr. Smith attempting to throw his plate at another individual after indicating that he didn't want to take his medication. As noted, the employee witness does not corroborate any unusual physical response from Zack Myers.
- h. Jane Mark cleaned up the kitchen after breakfast on February 21. She testified that there was nothing out of the ordinary in the appearance or condition of the kitchen before she cleaned it.
- i. Denise Williams testifies that she immediately recognized that Tim Smith was upset that morning by looking at the frown on his face and observing him trying to run away from Zack Myers as Mr. Myers was escorting him down the hall. Once Denise Williams addressed Mr. Smith, Mr. Smith began to cry and eventually alerted her to the bump on his head, indicating by making slapping motions toward his head and pointing to where Mr. Myers had been standing that Mr. Myers had slapped him, causing the bump on his head. The Status Sheet completed by Ms. Williams is consistent with her testimony.
- j. The Status Sheet completed by Otesia Barr reports that Mr. Smith appeared upset (frowning and crying) upon arrival at the day program. Upon inspection of his head, she found that he had a bump on his head that was approximately one inch in diameter. Photographs of the bump that I took were consistent with this assessment.
- k. Ten (10) behavioral reports were filed that week surrounding Tim Smith. These reports from both Residential Services and Adult Day Program accounted for a variety of physical and aggressive interactions between Mr. Smith, other service recipients, a kitten and staff. Several of the reports mention that Mr. Smith reported feeling anxious about an upcoming family wedding that he would be attending. None of the reports, though, directly correlated to the bump on Tim Smith's head.
- l. Review of Mr. Smith's Behavior Support Plan and interview with Behavior Specialist Bill Tedesco both reveal that Mr. Smith often becomes anxious or excited when he knows of upcoming events that he is looking forward to, such as visits to his family members. When anxious, he sometimes attempts to throw things. The Behavior Plan

outlines steps to help Mr. Smith calm down in these situations, including talking to him calmly about the aspects of his daily routine that are in his immediate future.

- m. Training records show that Mr. Myers and Mr. Jones were both trained on Mr. Smith's Behavior Plan by Bill Tedesco. The most recent training took place on January 4, 2017. Mr. Tedesco confirmed the date of the training and the people who attended.
- n. Residential and Day Program staff provided testimony to the effect that Mr. Smith had stated on numerous occasions during the week of February 21 that he was anxious about the upcoming family wedding.
- o. Mr. Smith's ISP describes him as an individual who enjoys being physically active.
- p. Staff timesheets show that the only two Direct Support Professionals on site the morning of the alleged incident were Mr. Myers and Mr. Jones. Time sheets also verified that kitchen staff Jane Mark was also on site.

IV. Certified Investigator's Initial Analysis of Evidence

For each investigatory question identified in the Evidence Summary above, prepare a narrative analysis of the initial reconciliation of evidence and the reasons for the conclusions being drawn.

Analysis of the evidence and reasons for the conclusions of evidence presented:

What happened to Tim Smith on February 21, 2017 at the 2nd Street Home?

It was evident through my interviews and review of documentary evidence that numerous behavioral incidents involving Tim Smith had occurred during the week. Many of the reports indicated that Mr. Smith had been excited about attending a family party during the February 25th weekend. This excitement apparently led to heightened anxiety during the course of the week as the wedding drew nearer. Importantly, the employee witness, Joe Jones, corroborates with Zack Myers that Mr. Myers reacted responsibly and reliably when Mr. Smith was about to throw his breakfast plate at another individual. Mr. Myers also indicated that he was in full control of the incident and believed that he handled it professionally and appropriately in accordance with Mr. Smith's Behavior Support Plan and organizational policies. Mr. Myers immediately filed a behavior report form that morning and submitted it to Bill Tedesco for his review and documentation.

No specific type of physical contact that may have caused the bump on Mr. Smith's head could be identified by any witness. When meeting with Tim Smith, he indicated positive responses to Zack Myers and breakfast medications. Mr. Smith is a physically active individual who had numerous behavioral incidents leading up to the discovery of the bump on his head.

V. Administrative Review, Findings, Recommendations, and Implementation

1. Was the incident reported in a timely manner? Yes No (Circle One)

If No, please explain here. (AND enter your corrective action plan in Implementation section below.)

NA

2. What actions were taken immediately to protect the health and safety of the individual?

List actions here. If none were taken, please explain here. (AND enter your corrective action plan in implementation section below.)

The individual was immediately taken for examination of the bump on his head by agency physician.

2a. Was victim assistance offered when appropriate? Yes No NA (Circle One)

If yes, what assistance was offered? If no, please explain here. (AND enter your corrective action plan in Implementation section below.)

The individual was offered counseling services to discuss the event.

3. If the incident involved a target, was the alleged target(s) removed from potential contact with all individuals receiving services until the incident investigation is completed?

Yes No NA (Circle One)

If yes, enter date and time personnel action occurred: 2/21/17 at 10AM

If no, explain here. (AND enter your corrective action plan in Implementation section below.)
NA

4. Were there injuries to the individual? Yes No (Circle One)

Enter date and time injury discovered: 2/21/17 9:30A

4a. If yes, was prompt medical attention provided? Yes No NA (Circle One)

**If no, a neglect incident may have to be filed and corrective action in response to the delay in treatment needs to be present in the report.*

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If no, please explain. (And enter your corrective action plain in Implementation section below.)
NA

4b. Is follow up medical treatment recommended? Yes No (Circle One)

If yes, date and time of scheduled follow up appointment(s):

Follow up appointment 3/15/17 at 11:00AM with agency physician

5. Did the investigation start in a timely manner? Yes No (Circle One)

If no, please explain. (AND enter your corrective action plan in Implementation section below.)
NA

6. Was the family notified of the incident within 24 hours? Yes No (Circle One)

If no, please explain. (AND enter your corrective action plan in Implementation section below.)
NA

6a. When appropriate were notification requirements relating to *the Adult Protective Services Act, Older Adult Protective Services Act* and *Child Protective Services Law* met?

Yes No (Circle One)

If no, please explain. (AND enter your corrective action plan in Implementation section below.)
NA

7. Did the evidence collected and presented in the report by the investigator support their analysis?

Yes No (Circle One)

Please explain why you believe the evidence collected and presented did or did not support the investigator's analysis.

The Administrative Review Team thoroughly examined the physical, testimonial, demonstrative and documentary evidence. The Team found that the Certified Investigator, Jack Brewster, was thorough in his identification and collection of evidence and used appropriate protocols for evidence collection. His examination/analysis of the facts was found to be objective and thorough. His report provided adequate information to guide the reviewers in understanding and reconciling the evidence.

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8. Did the evidence support a determination that abuse or neglect occurred?

Yes **No** (Circle One)

If yes, explain. (AND enter your corrective action plan in Implementation section below.)
NA

9. Were there violations of agency or facility policy involved in this incident?

Yes **No** (Circle One)

If yes, explain. (AND enter your corrective action plan in Implementation section below.)
NA

10. Review Status: To Be Continued **Closed** (Circle One)

If to be continued, due date: NA

11. Administrative Findings: Confirmed **Not Confirmed** Inconclusive (Circle One)

Please explain the basis/reasons for your Administrative Finding (confirmed, not confirmed, inconclusive).

Tim Smith was involved in numerous behavioral incidents leading to the discovery of the bump on his head. A review of the incidents reported prior to discovering the bump provided an explanation and shows consistency in Zack Myers' testimony of what had occurred in the morning at the 2nd Street residence. It's possible that one of these previous incidents might have caused the bump on Mr. Smith's head. Joe Jones did not witness nor hear of a slap to Mr. Smith's head. Mr. Jones claims to have witnessed an appropriate response by Mr. Myers to Mr. Smith's attempting to throw a breakfast plate at another individual. He noted that Zack Myers was in control of the behavioral incident and easily guided Mr. Smith to the living room to be seated and calm down. Mr. Jones also noted that prior to departing from 2nd Street; Mr. Myers and Mr. Smith were calmly seated in the living room area while Mr. Myers completed a Behavior Report form.

Mr. Smith's initial statements may have been the result of his upcoming attendance at a family party; the numerous behavioral incidents around this time period appear to reflect his increased anxiety. When interviewed by the investigator, Mr. Smith showed no signs of distress over what had allegedly occurred between himself and Mr. Myers. He also indicated a favorable response to his home and staff, including Mr. Myers.

Based on the evidence reviewed, the allegations that Zack Myers slapped Tim Smith and caused Mr. Smith to injure his head are not confirmed.

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Implementation

12. Were there any issues or concerns identified in the investigation that would lead to changes in individual(s) care, modifications to the individual support plan personnel, or other administrative and systemic practices?

If no, explain.
NA

If yes, use the template below to create an action plan. Include information on what activities are to be completed, who is responsible for completing them, a target date for completion, and the date the action is completed (if known at time of completion of report).

Action	Functional Area (e.g. Fiscal, Program Services, Personnel, etc.)	Person(s) and Position(s) Responsible	Target Date	Status
1. Instruction to Zack Myers about resuming professional services for the individual.	Personnel	Janis Bonnet, Director of Human Services	March 2, 2015	Pending
2. A thorough review of individual's medications and behavioral support plan to more effectively address anxiety levels.	Program Services	Marc Charton, Residential Director and Dr. Otesia Brown	February 28, 2015	Completed and medication change recommended to family
3. Staffing should be assessed for possible increased staffing to best assure smoother morning functions.	Program Services	Marc Charton, Residential Director	March 2, 2015	Pending

Reviewer Name and Title

Signature

Charles Weigles – Executive Director	<i>Charles Weigles</i>

West's Pennsylvania Administrative Code
Title 55. Human Services
Part I. Department of Human Services
Subpart E. Home and Community-Based Services
Chapter 52. Long-Term Living Home and Community-Based Services
Subchapter B. Provider Qualifications and Participation

55 Pa. Code § 52.17

§ 52.17. Critical incident and risk management.

Currentness

- (a) The requirements in this chapter are in addition to the reporting requirements under Chapter 2380 or 2390 (relating to adult training facilities; and vocational facilities), 6 Pa. Code Chapter 11 (relating to older adult daily living centers) and 28 Pa. Code Chapters 601 and 611 (relating to home health care agencies; and home care agencies and home care registries).
- (b) A provider shall report a critical incident involving a participant to the Department or the SCE, or both, on a form prescribed by the Department.
- (c) A provider shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of critical incidents.
- (d) A provider shall meet the risk management requirements as specified in the approved applicable waivers, including approved waiver amendments.
- (e) If the Department requires additional follow-up information to a critical incident, then the provider shall submit additional information as requested to the Department.
- (f) A provider shall reduce the number of preventable incidents. The methods used by the provider to reduce the number of preventable incidents shall be documented on the provider's QMP.

Credits

Adopted May 19, 2012.

Current through Pennsylvania Bulletin, Vol. 49, Num. 34, dated August 24, 2019

55 Pa. Code § 52.17, 55 PA ADC § 52.17