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Missouri State Auditor

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MENTAL HEALTH

Protecting Clients from Abuse and Neglect

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YELLOW SHEET

State mental health clients not fully protected from abuse and neglect due to problems with incident investigations and abusive workers still employed

This audit reviewed how well the Department of Mental Health tracks, investigates and handles incidents and investigations of individuals committing abuse or neglect against its 140,000 clients. All such allegations, including client deaths are tracked in the department's Incident and Investigation Tracking System, which reported 5,689 incidents from July 2003 through August 2004. This audit also followed up on recommendations from a 2001 audit and found systemic problems with abuse investigations.

Only 2 of 8 previous audit recommendations implemented	As of June 2005, only 2 of 8 recommendations from the previous 2001 audit report had been implemented. The 2001 audit found regulations did not fully protect clients from physical aggression and injuries. Follow up audit work showed: providers did not submit all incident reports to the department for the tracking system, not all regional centers tracked incident reports, and the department did not track client on client abuse. As a result, the department and regional centers could not identify abuse trends and patterns. In addition, department officials did not act on 2004 department internal reviews, which made suggestions to correct problems in the existing system. (See pages 4 and 9)
Continuing to employ known felons led to more abuse	Auditors found criminal background check procedures were not always followed, which led to further abuse. In one case, a state-run facility did not immediately fire an employee when a background check showed multiple felonies. During the 12 days between knowing the background check results and the employee's termination, the employee sexually abused a client. (See page 19)
Employees who previously abused clients were still working	Auditors found 38 individuals listed on state employee disqualification lists - which list abusive/neglectful employees - still working with mental health clients between April 2003 and April 2005. Auditors found these individuals by doing an automated match between employee disqualification lists and state employment records, a match never done before by the department. In addition, auditors found the process to put a disqualified employee on the list too slow. In one case, a regional center did not place a disqualified employee on the list until 2 years after the alleged abuse occurred. In the meantime, another provider hired the employee, who then neglected and verbally abused another client. (See page 20)
Abusive provider still allowed to run facility until audit	Department officials had continued to contract with a provider owned by persons who had been on the disqualification list since March 1999. During that time, 11 substantiated cases of neglect occurred at this home, including one client's death. Although department officials knew the owners were on the list, they did not initially think they had the authority to revoke the provider's certification. After auditors shared concerns about this provider, the department removed all clients from the home and did not renew the provider's contract. (See page 22)

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Abuse investigations lack independence and consistency

Auditors found investigators employed at the mental health facilities - rather than independent investigators from outside the facility - conducted 89 percent of the abuse and neglect investigations. Investigations were also inconsistent with each facility having its own investigative process and investigation outcomes differing depending on the facility. Since the audit, department officials have completely revamped the investigative process, including requiring outside, independent investigators. (See page 17)

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Honorable Matt Blunt, Governor
and
Mental Health Commission
and
Dorn Schuffman, Director
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The Department of Mental Health (DMH) serves approximately 140,000 Missourians annually through services at state-operated facilities and contracts with private organizations and individuals. The department's Incident and Investigation Tracking System keeps track of all individuals committing acts of abuse and neglect against clients receiving services from the department. In addition, all allegations of abuse, neglect, misuse of funds/property, and all deaths are required to be entered into this system. From July 2003 through August 2004, the system reported 5,689 incidents. Because of the importance of protecting clients from abuse and neglect, we focused review objectives on whether (1) DMH implemented recommendations from our 2001 report, (2) DMH took corrective action on internal department recommendations relating to its abuse/neglect system, (3) problems continue to exist in the department's incident reporting system, (4) investigations have been conducted independently and consistently, and (5) clients have been protected from disqualified employees.

We found the department has not implemented all recommendations in our previous report. Problems have continued with DMH's incident reporting system and the department has not taken corrective action addressing abuse/neglect system problems identified in department internal management reports. In addition, the department has not ensured complaint investigations have been conducted independently and consistently and clients have been protected from disqualified employees.

We conducted our work in accordance with Government Auditing Standards issued by the Comptroller General of the United States. This report was prepared under the direction of Kirk Boyer. Key contributors to this report included John Luetkemeyer, Anissa Falconer, and Preston Hammond.

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Abbreviations

BHC	Bellefontaine Habilitation Center
CSR	Code of State Regulations
DMH	Department of Mental Health
MRDD	Division of Mental Retardation and Developmental Disabilities
RSMo	Missouri Revised Statutes
SAO	State Auditor's Office

Introduction

The Department of Mental Health (DMH) is comprised of three program divisions that serve approximately 140,000 Missourians annually. Those divisions include (1) Mental Retardation and Developmental Disabilities (MRDD), (2) Comprehensive Psychiatric Services, and (3) Alcohol and Drug Abuse. The department provides services through state-operated facilities and contracts with private organizations and individuals. The state-operated psychiatric facilities include inpatient psychiatric services for adults and children, as well as the Missouri Sexual Offender Treatment Center. In addition, 6 habilitation centers and 11 regional centers serve individuals with developmental disabilities. Other services are purchased from a variety of privately operated programs statewide through approximately 4,000 contracts managed annually by the department.

The department located the Central Office Investigations Unit (investigations unit) within the Office of Quality Management until April 2005. DMH then moved it under the department's General Counsel. The department created the investigations unit in 1989 to investigate the most serious incidents of abuse, neglect, and misuse of funds or property occurring throughout the state. The majority of investigations are not conducted by the central office unit, but are conducted locally by facility and regional center staff. Specific criteria have been established to identify which incidents shall be investigated locally and which shall be investigated by the investigations unit.

Complaints or incident reports are primarily received in facilities, regional centers, or by the department's Office of Consumer Affairs. Administrators in the three divisions analyze these reports and then decide whether an investigation should occur.

The investigations unit is responsible for department operating regulations and Code of State Regulations (CSR) regarding investigations and incidents. The unit is also responsible for the Disqualification Registry, including the processing of paperwork, tracking appeals, and quality assurance regarding the individuals to be placed on the registry.[1] The department's Office of Human Resources handles registry inquiries and background screenings.

State law[2] disqualifies any facility or day program operated, funded, or licensed by DMH from employing any person who has committed abuse, neglect, or misuse of funds/property acts that are Disqualification Registry qualifying offenses. The department developed the Incident and

[1] The statute that authorizes DMH to perform investigations is Section 630.167, RSMo.
[2] Section 630.170.1, RSMo.

Investigation Tracking System (tracking system) in 1997 to keep track of those individuals that had committed acts of abuse and neglect against individuals receiving DMH services. All allegations of abuse, neglect, misuse of funds/property, and all deaths are to be entered in the tracking system.[3] The tracking system is also a collection of data for report generation to improve services.

The department recorded 5,689 incidents in its tracking system from July 2003 through August 2004, and initiated investigations on 2,281 or (40 percent) of those incidents. Various types of incidents are not required to be investigated. During this time period, 63 percent of the incidents reported related to the MRDD division, 32 percent related to the Division of Comprehensive Psychiatric Services, and 5 percent related to the Division of Alcohol and Drug Abuse.

According to state law,[4] DMH clients are entitled to humane care and treatment, to be treated with dignity as a human being, and to be free from verbal and physical abuse.

Previous SAO Work

Our previous report[5] evaluated the effectiveness of the MRDD division's oversight of its 11 regional centers and the effectiveness of the regional centers' oversight and inspections of contractors operating residential facilities and day habilitation programs. Our report disclosed the division had not established regulations to adequately protect clients with developmental disabilities from physical aggression and injuries. In addition, the MRDD division lacked programs and reporting systems to ensure all clients received the same level of safety and quality of care.

Table 1.1 depicts the status of our prior recommendations, as of June 2005. Of the 8 recommendations, only 2 were implemented. Five recommendations were not implemented and 1 was partially implemented.

[3] The tracking system procedures manual requires all incidents where there is an allegation or reasonable cause to suspect abuse, neglect or misuse of funds/property be reported in the tracking system.

[4] Section 630.115, RSMo.

[5] Audit of Management and Oversight of Contractors Responsible for Care of People with Developmental Disabilities (Report no. 2001-20, March 15, 2001).

Table 1.1: Status of Prior Recommendations

Prior recommendations	Status
1. Amend 9 CSR 45-5 and 9 CSR 40-5.030 to require contractors to submit Incident and Injury Reports to their respective regional centers immediately when serious injuries are involved and within 24 hours for other injuries and incidents.	Not implemented
2. Amend 9 CSR 45-3.050 to apply to clients living in contractor operated facilities.	Not implemented
3. Amend 9 CSR 45-5.010 to state errors in administering or in self-administration of medications shall be reported immediately to the regional center or placement office.	Not implemented
4. Develop an effective quality assurance program and ensure it is uniformly implemented by all regional centers.	Implemented
5. Establish a divisional policy that requires regional centers to systematically analyze contractors' incident reports to identify patterns of aggression, injuries, and medication errors and other incidents that can affect clients safety and well being.	Not implemented
6. In concert with contractors and regional centers, develop a standard incident report form (which could be scanned) to record and report information that needs to be included in incident reports.	Implemented in October 2004
7. Require each regional center to install an automated database to record and analyze contractors' incident reports. The division should require centers without a database to adapt an existing database currently used by other centers until the division can develop a standard database.	Partially implemented
8. Encourage contractors to electronically submit their incident reports.	Not implemented

Source: SAO

As of June 2005, MRDD division officials reported improvements are in place, are planned, or are in process to address most of the weaknesses reported. However, follow-up review efforts disclosed the division has not begun implementing at least 3 of the recommendations including (1) established a system-wide data collection system to identify and monitor clients living in contractor operated facilities who display aggressive behavior, (2) required regional centers to systematically analyze contractor incident reports, and (3) encouraged contractors to submit incident reports electronically. In addition, the division is still in the process of implementing recommendations requiring contractors to submit reports immediately when serious injuries are involved, requiring errors in administering medication be reported to regional centers, and requiring all regional centers to begin using a standard database for incident reports. The division has established a quality assurance program and has developed a

standard incident report form. (See chapter 2 for information related to incident reporting.)

Serious Allegations of Abuse and Neglect Lead to Reviews

In August 2004, the media published reports of serious allegations of abuse and neglect at Bellefontaine Habilitation Center (BHC). These allegations included the severe beating of one client, and a second client's death resulting from abuse. As a result of these allegations, which ultimately were not substantiated, several organizations began investigations or reviews of BHC including:

- DMH
- Department of Health and Senior Services
- Bellefontaine Police Department
- Missouri Protection and Advocacy Services, Incorporated

These reviews included the following findings:

- Lack of clarity regarding authority and responsibilities.
- Instances of injuries and allegations of mistreatment had not been thoroughly investigated.
- Staff accused of abuse had been reassigned to other units, rather than placed on paid leave.
- Training on the use of physical restraint and abuse reporting was not current.
- Parents and guardians not notified in timely manner of significant incidents.
- Families had not been fully informed about the use of the grievance process.
- Incidents had not been adequately documented.

Actions taken by DMH included appointing a new superintendent, reviewing all investigations conducted in the past year, adding staffing, contracting with an outside vendor for assistance in correcting problems, adding an ombudsman to assist families in the grievance process, and improving the quality assurance process.

Scope and Methodology

To determine the status of recommendations made in our prior report, we reviewed documents provided by DMH officials pertaining to follow-up efforts.

To determine whether incidents meeting criteria had been recorded in the tracking system, we obtained 10 databases maintained by 17 DMH facilities or 11 regional centers showing all incidents occurring between July 1, 2003 and August 31, 2004. We compared these databases to the tracking system. We also contacted five police departments located near five judgmentally selected DMH contracted providers and requested all related police reports.

We then determined whether the providers had notified the regional center of incidents involving clients.

We reviewed 40 randomly selected incident reports to determine whether incident reports included necessary information and whether regional center staff had reviewed the reports. We reviewed the reports for incident dates, times, provider names, type of incidents, and for documentation showing whether regional center staff had reviewed the reports.

To determine whether all regional centers track incident reports, we visited DMH regional centers in Albany, St. Louis, Columbia, and Springfield. We discussed the status of recommendations in our prior report[6] with MRDD division personnel and reviewed procedures the regional centers used to track incident reports.

To determine whether clients were adequately protected from abuse by other clients, we queried data in the tracking system, identified clients with more than 20 aggressive incidents, and department officials notified us of actions taken regarding these clients.

To determine what, if any, corrective action had been taken in response to DMH internal reports, we obtained copies of these reports prepared by the investigations program director. We then discussed problems identified in these reports with DMH officials.

To determine whether problems related to incident reporting had been corrected, we visited DMH facilities in Fulton, Marshall, St. Louis, and Albany. At each of these locations, we talked with officials about investigation procedures and reviewed 15 investigation files randomly selected from all incidents occurring between July 2003 and August 2004. We also reviewed 50 randomly selected incidents local facilities investigated to determine if the department's investigation unit should have conducted the investigation rather than the local facility. Finally, we reviewed all 225 notifications received by the DMH client complaint-line the department classified as abuse and neglect to determine whether the notifications had been recorded in the department's tracking system.

To determine whether DMH officials are using, and tracking systems are providing, pertinent, and relevant information to properly manage and monitor client safety, we reviewed reports prepared by the DMH

[6] Audit of Management and Oversight of Contractors Responsible for Care of People with Developmental Disabilities (Report no. 2001-20, March 15, 2001).

investigations program director. We also reviewed the Governor's 2005 State of the State address, Department of Health and Senior Services certification surveys, DMH prepared cost analysis, and media publications to obtain a broad understanding of the issues currently facing BHC. Finally, we visited BHC and interviewed officials to determine improvements made and challenges the center continues to face.

To determine whether investigations were conducted consistently and independently, we talked to department and facility officials to ensure we gained an understanding of the investigation process. We also queried data in the tracking system to ascertain the frequency of local investigations. We talked to representatives from Missouri Protection and Advocacy Services, which protects the rights of persons with disabilities through legally based advocacy, to determine what concerns they had regarding DMH's investigation process. We also reviewed materials prepared by the National Association of Protection and Advocacy Systems to learn more about the group's legal rights. Finally, we researched "best practices" on the Internet, and based on this information, we obtained additional information from the investigative unit in Massachusetts, regarding processes used to investigate abuse and follow-up with law enforcement.

To determine if any DMH contracted providers employed persons disqualified from working with clients, we reviewed employment information for all persons included on DMH's Employee Disqualification Listing and the Department of Health and Senior Services Employee Disqualification Listing. We also queried tracking system data to identify cases where background checks were not completed. Finally, we used tracking system information to determine the average delay between substantiated determination and the date a perpetrator was added to the registry.

In order to gain assurance as to the accuracy of incident and investigation data in the tracking system, we performed data validation procedures. We accounted for all consecutive numbers that should have been included in our sample period. However, we found numerous examples of incidents not entered in the tracking system. As a result, information in the tracking system was not sufficiently reliable for purposes of this report. Therefore, we developed recommendations to help ensure the system reflects a complete record of all incidents, and department policies are followed.

We requested comments on a draft of our report from the Director of the Department of Mental Health, and those comments are reprinted in Appendix I. We conducted our work between August 2004 and June 2005.

Problems Continue to Exist in Incident Reporting and DMH's Abuse and Neglect System

DMH has not implemented prior recommendations to (1) require providers to submit all incident reports to regional centers, (2) require all regional centers to track incident reports, and (3) establish a policy to require regional centers to analyze incident reports to identify patterns of client aggression. Although DMH implemented a recommendation to develop a standard incident report form, this action was not timely. Improvements are also needed in DMH's abuse and neglect system because department officials have not taken corrective action on DMH internal review recommendations.

Previous Incident Reporting Problems at Providers Continue

We previously recommended improvements be made in the submission and tracking of incident reports. However, follow-up efforts disclosed problems previously reported have not been corrected. These problems include providers not always submitting incident reports, incident reports not always including all necessary information, and regional centers not always tracking incident reports and patterns of client aggression.

These problems have continued through the end of our audit period—over four additional years. Therefore, the department has less assurance that clients receive humane care and treatment, are treated with dignity, and are free from verbal and physical abuse as required by state law.[7] This situation continued to occur because DMH management had not implemented most of our recommendations. Monitoring to ensure the findings of audits and other reviews are promptly resolved is a key element of internal control.

Providers not submitting all incident reports

Our review of police reports related to 5 contract providers disclosed police responded to these homes 41 times over a 16-month period.[8] Of those, 26 incidents were significant events involving clients, such as abuse by caregivers, assaults on other clients, runaways, and disturbances. However, we found 2 providers in the Kansas City area had not reported 10 of the 26 incidents (38 percent) to the regional center. Unreported incidents included a client considered a threat to herself and others, runaway clients, and multiple disturbances.

Contracts between DMH and providers require providers to notify regional centers of any medical emergencies, deaths, unexplained absences, and allegations of abuse or neglect. However, providers are not required to submit all incident reports to regional centers, as recommended in our prior audit report. For example, one of the police calls a provider did not report to the regional center involved a client who had threatened to stab other clients

[7] Section 630.115, RSMo.

[8] Police reports from August 2003 through November 2004.

with scissors. The client also caused a friction burn on her arm. In March 2005, the department proposed a state regulation[9] to require submission of additional incident reports, including those in our test, to the regional centers.

Incident reports have not always included necessary information

Review efforts at four regional centers[10] disclosed 12 of 40 (30 percent) incident reports did not include all necessary information. Missing data included incident dates, incident times, provider names, type of incidents, and documentation showing regional center staff had reviewed the reports. Additionally, the SAO audited the Kansas City Regional Center in 2004[11] and found that 9 of 10 (90 percent) incident reports reviewed were not complete.

Our 2001 report found department officials did not dictate the information required in incident reports, and allowed contractors to use different types of incident reports, making entry in a database difficult. We recommended the department require the use of a standard incident form that included all necessary information and allowed for easier data entry. During our review, we found some providers tested a standardized form and, in October 2004, providers began using this form. However, until that time, providers used various incident report formats. Department officials have proposed a state regulation[12] that would require all contractors to use the standard incident report form.

Division officials provided us with an overview of the process creating the standardized form. Although division officials began creating this form in March 2001, they did not submit the form to department officials for approval until March 2004. A policy requiring the use of this form has not been established as of June 2005. Reasons for the delay included lengthy testing periods and time spent trying to create a report applicable for all three divisions, according to division officials.

Not all regional centers tracked incident reports

We previously reported that five of six regional centers reviewed did not have an effective system to archive incident reports. Our work disclosed two of four regional centers visited had inadequate tracking systems for incident and injury reports, as of August 2004. For example, the Albany Regional Center filed all incidents in large boxes according to the client's last initial.

[9] Proposed 9 CSR 10-5.206.

[10] We reviewed ten incident reports at each of four centers.

[11] Department of Mental Health Kansas City Regional Center (Report no. 2004-100, December 30, 2004).

[12] Proposed 9 CSR 10-5.206.

The St. Louis Regional Center had five filing systems located in five buildings and officials told us they could not easily determine if any incidents had been reported from April 2003 through late 2004 for over 1,000 clients. In addition, our December 2004 audit found the Kansas City Regional Center had not established a system to track incident reports.

Our 2001 report recommended division officials require regional center staff maintain a database of all incident reports and analyze these reports to identify trends and patterns. In the four years since our prior recommendation, DMH has required regional center staff to record some incidents in the department tracking system. However, the division has not required regional centers to track or analyze all incidents.

Client on client abuse not tracked

DMH has not required regional centers to report client on client abuse in its tracking system. However, some regional centers voluntarily submit this information. Our analysis of tracking system data for 14 months—July 2003 through August 2004—found the following examples of clients with aggressive incidents:

- Client A committed physical acts of aggression against other clients 60 times during a 13-month period.
- Client B committed physical acts of aggression against other clients 48 times over a 6-month period.
- Client C had a total of 52 incidents during a 14-month period, including 16 acts of aggression against fellow clients and staff, and 11 elopements.

In each of the above cases, the regional center staff took actions, including implementing behavior plans, changing roommates, and admitting a client into long-term habilitation center placement. However, DMH has not established regulations requiring regional center staff to classify these clients as displaying aggressive tendencies, and requiring increased levels of supervision.

Corrective Action Not Taken on Abuse/Neglect Problems Reported in 2004

DMH's investigations program director issued reports in March and April 2004 detailing problems existing in the abuse/neglect system, and made recommendations to correct some reported problems. However, DMH officials did not take corrective action or prepare a corrective action plan.

The reports primarily reviewed investigations and data in the tracking system for fiscal year 2000 through fiscal year 2003. Problems reported included:

- Allegations of abuse and neglect had not always been entered in the tracking system.

- Investigations meeting the criteria for a central office investigation had sometimes been conducted by facilities.
- Timeliness requirements often had not been met for: entering incidents in the tracking system, completing investigation reports, entering determinations in the tracking system, submitting paperwork to central office, and entering plans of action in the tracking system.
- Required notifications had not always been given to local law enforcement, the Department of Social Services Child Abuse and Neglect Hotline, parents and guardians, and complainants.
- Physical exams and photographs had not always been included in investigation files when required.

DMH officials did not prepare a plan to correct problems discussed in the reports, or implement recommendations made. Officials told us the planned new version of the tracking system program would correct some problems reported. The new version of the tracking system is currently scheduled to be implemented in the fall of 2005, approximately three years after the planned implementation date of December 2002. The new version is included in the Consumer Information Management, Outcomes and Reporting System.

Some problems reported by DMH still exist

Our review of incident activity for July 2003 through August 2004 disclosed some problems reported on by DMH in 2004 still existed. We found abuse/neglect complaints had not always been entered in the department's tracking system, or handled in a timely manner. In addition, appropriate parties had not always been notified of investigations and required information has not always been included in investigation files. We found facilities referred most required cases to the central office investigations unit.

Abuse/neglect complaints not always entered in tracking system

Our review of 225 client complaint-line calls made in fiscal year 2004 disclosed 101 related to alleged abuse or neglect. Of the 101, we determined 18 (18 percent) had not been entered in the tracking system. According to officials, the allegations had not been entered in the tracking system because some had been made by delusional patients and others lacked specific information or corroborating evidence. In addition, discussions with DMH officials and review efforts disclosed almost half the allegations at Fulton State Hospital, and an unknown number at BHC, had not been entered in the tracking system because these facilities conducted "preliminary investigations" before determining what information would be entered in the tracking system. According to the head of Fulton State Hospital, the hospital had a very open system and encouraged clients to file complaints. This system results in the hospital receiving many complaints including complaints that were not factual, complaints that were incoherent or

delusional, or grievances concerning treatment issues. As a result, preliminary investigations were done to make the best use of limited investigation resources.

DMH operates a hotline allowing anyone to lodge complaints, including allegations of abuse or neglect. The tracking system procedures manual requires facilities and regional centers to report all allegations of abuse and neglect in the tracking system. DMH guidance has not given facilities the authority to conduct preliminary investigations or exclude allegations from the tracking system, due to situations surrounding the complaint.

Some complaints not investigated or processed within timeframes

Our review of the timeliness of 60 randomly selected investigations at 4 facilities[13] disclosed 10 had not met DMH's 30-work-day criteria for timeliness. For example, 7 took between 35 and 50 work days to investigate and we found 3 investigations (5 percent) took 60 work days, or twice as long as allowed by DMH.

In other audit tests, we found lengthy investigations occurred at the Albany, St. Louis, Kansas City, and Joplin regional centers. For example, the Kansas City Regional Center did not initiate an investigation for four and a half months after officials became aware of the situation. In another instance, the St. Louis Regional Center had not completed an investigation seven months after being made aware of possible physical abuse. According to DMH officials inadequate resources led to untimely investigations.

We also found the St. Louis Regional Center had not complied with DMH regulations regarding timeliness for processing complaints. Five of nine tracking system cases had not been entered within one day, and all nine had no determination made within ten days as required by DMH regulation.[14] In addition, two of the nine case determination forms had not been forwarded to the investigations unit until after we requested the forms. In both cases, the final investigation reports had been delivered to the regional center's Director five months earlier. Regional Center officials stated that these significant delays occurred because unfilled positions led to a large backlog of cases to review.

DMH regulations[15] established required time frames for conducting investigations. From the time a facility is notified of possible abuse or neglect, the investigation is to be completed within 30 working days.

[13] Investigations occurred between July 2003 and August 2004.

[14] DMH Operating Regulation Number 2.210.

[15] DMH Department Operating Regulation Numbers 2.205 and 2.210.

Department officials stated regular management reports showing investigations not completed or processed timely had not been prepared during our audit period. In June 2005, officials told us they had begun to prepare these reports on a regular basis.

Applicable parties not always notified of investigations

Our review of 60 investigations disclosed officials did not document notification of some appropriate parties in 45 (75 percent) of the investigations. DMH regulations[16] require parents or guardians be notified when allegations of abuse or neglect are received, and when the investigation is concluded. An acknowledgment must also be sent to the person who made the complaint, and in certain circumstances, local law enforcement and other state agencies must be notified.

According to department officials, the department notified parents in some cases, but failed to document it in the file. In other cases, officials did not notify parents and complainants due to oversight. One official was almost certain a patient was delusional, and therefore did not notify law enforcement. Another official only notified law enforcement when she believed criminal charges would result. DMH guidance[17] requires staff to notify parents and complainants in writing. Additionally, this guidance requires law enforcement be notified in certain instances, regardless of the patients' mental state or the likelihood that criminal charges will be filed.

Required information not always included in investigation files

Our review of the 60 investigations disclosed 22 involved allegations of sexual abuse or physical abuse with injuries. We found in 3 of the 22 investigation case files (14 percent) did not contain documentation of a physical exam or photographs. DMH regulations[18] require clients be given a physical exam and physical injuries be documented with color photographs, regardless of the age of the injuries, when alleged sexual abuse or physical abuse with injuries occurs.

In one case, officials stated a physical exam did not occur because the injuries were old and healing by the time the facility was notified of the alleged abuse. In a second case, officials did not document injuries with photographs due to oversight.

Central office investigations were not requested for some qualifying incidents

Our review of 50 randomly selected local investigations, conducted between July 2003 and August 2004, disclosed 2 investigations (4 percent) should have been turned over to central office for investigation.

[16] DMH Department Operating Regulation Numbers 2.205 and 2.210.

[17] See footnote 16.

[18] See footnote 16.

DMH's tracking system procedures manual requires ten types of investigations to be conducted by central office investigators, rather than local investigators. Examples include suspected sexual abuse of clients by staff and suspected suicides.

Division officials stated they did not refer one case of sexual abuse to the investigations unit because the client denied the incident occurred, the client refused to cooperate, and the only witness report indicated it was a consensual act. In the second case, a facility investigation did not find reasonable cause to believe sexual abuse occurred. DMH guidance requires facility management to refer all sexual abuse cases to the investigations unit, regardless of the patient's willingness to participate in the act. Additionally, guidance did not allow facility management to conduct a local investigation prior to turning the case over to the investigation unit.

Preparation and analysis of management reports might have detected BHC problems sooner

The department did not prepare management reports for trend analysis until August 2004, after media reports regarding a client death at BHC, according to division officials. Our review of information included in these reports for January through July 2004 data disclosed BHC had almost 70 percent more investigations per client than the average for habilitation centers.

In response to problems identified, BHC obtained additional staffing to provide the necessary level of care for resident clients. However, DMH and facility management expressed concerns because some staff left for other jobs and it has been more difficult to hire quality staff persons due to the planned closure of the center.

Conclusions

Our work disclosed DMH has not corrected problems associated with incident reporting. We found providers have not been required to, and did not submit, all incident reports to regional centers. The department also has not required all necessary information to be included on incident reports. Unless providers are required to submit necessary information and all incident reports, any analyses done by regional centers will be incomplete. The department also has not required regional centers to design effective systems to track and/or analyze all incident reports. Therefore, the department has no assurance that regional centers will be able to identify trends and patterns. Although some regional centers voluntarily submitted information, DMH has not required regional centers to report client on client abuse in its tracking system. While the regional centers took corrective action in the instances we identified, DMH has not established regulations requiring regional center staff to classify these clients as having aggressive tendencies, and requiring increased levels of supervision.

The department also has not taken corrective action or prepared a corrective action plan to address abuse/neglect system problems disclosed in DMH's 2004 internal reviews. Department officials have not designed effective controls to ensure that facilities are following regulations requiring all allegations of abuse and neglect be entered into the tracking system, investigations are completed within required timeframes, appropriate parties are notified of investigations, appropriate information is included in the investigation files, and required investigations are completed by the investigations unit. DMH management cannot get a true picture of all abuse/neglect allegations if some allegations are not reported in the tracking system and cannot make valid comparisons between facilities/regional centers. Timely conclusions to investigations are important to protect clients from abusive staff, and to allow accused staff to return to work if allegations are false.

Recommendations

We recommend the Director of the Department of Mental Health:

2.1 Develop corrective action plans to address problems identified by external and internal reports.

2.2 Establish effective internal controls and periodic monitoring efforts to ensure that regulations involving incident investigation and reporting are followed.

2.3 Continuously monitor staff to client and investigations per client ratios at BHC to ensure that client care does not suffer during the closing process.

Agency Comments

See Appendix I for agency comments.

Improvements Needed in Investigations of Abuse and Neglect

Improvements are needed in investigations of abuse and neglect because DMH has not ensured (1) investigations have been conducted independently, and (2) investigation methods and determinations have been consistent. As a result, clients may be at increased risk.

Investigations Lack Independence and Consistency

Tracking system data supplied by department officials included 2,281 investigations. Our review of this data disclosed investigators employed at the facility where the complaint originated conducted 2,019, or 89 percent, of these abuse and neglect investigations. Local investigators reported investigation results to the head of the facility and often worked in other positions and with other employees at the facility.

The Department of Health and Senior Services' conflict of interest policy is designed to promote objectivity in the inspection and complaint investigation process regarding nursing homes. The policy does not allow employees to participate in inspections and complaint investigations at facilities where they have been employed until two years have lapsed from their previous employment. In addition, a May 2001 U.S. Department of Health and Human Services, Office of Inspector General report entitled "Reporting Abuses of Persons with Disabilities" addressed abuse reporting/investigating practices in seven states. The report found states with the most structured systems included an organizational structure which provided for an independent agency to handle incidents and/or oversee investigations performed by others.

Investigation methods and determinations lack consistency

Investigation methods and forms have not been consistently applied among facilities. For example, Fulton State Hospital used polygraph testing as an effective investigative tool, while other facilities visited either used polygraph testing only occasionally, or not at all. In addition, each facility independently developed forms to track the investigation process and to report investigation results.

In an April 2004 report, the DMH investigations program director found determinations had not been made consistently throughout the state. Lack of standard criteria led to differences in the number of charges substantiated, as well as in the types of actions considered abuse or neglect. An incident involving the neglect of four clients might be considered one count of neglect by some determiners, but four counts of neglect by other determiners. Errors in dispensing medication might be considered neglect by some determiners, but not by others. In discussing these issues with us, department officials agreed consistency would improve the investigation process.

Department making changes to investigation process

In June 2005, as we were concluding our work, department officials told us they were changing the investigation process. Changes include the elimination of local investigators; all investigators will now be under the authority of the central office investigations director. As a result of these changes, department officials told us they hope to achieve more consistency in forms, methods, and determinations.

Conclusions

DMH's use of facility investigators to conduct investigations at local facilities has not been in the best interest of the department. Having to possibly investigate fellow employees and/or question facility management decisions subjects the investigator to potential conflicts of interest. We believe investigators should be independent of the facility being investigated and findings should be reported to DMH's investigations unit.

DMH has not ensured consistency in investigations because it has not established policies/guidance that require investigators to use consistent methods in investigations, standardized investigation forms, and make consistent determinations. A standardized process would provide more structure to critical decision points when investigating incidents, increase the consistency and validity of conclusions, and improve the effectiveness of the investigation unit.

Recommendation

We recommend the Director of the Department of Mental Health:

3.1 Establish an independent investigation unit and require the use of standardized forms and methods to handle complaint investigations.

Agency Comments

See Appendix I for agency comments.

Clients Not Adequately Protected From Disqualified Employees

DMH has not ensured clients have been adequately protected from individuals having histories of abuse or neglect. This situation has occurred because (1) facility and contractor administrators have not always conducted criminal background screenings for new employees, or terminated employees with disqualifying information; (2) DMH has not had procedures to identify disqualified individuals working for providers; and (3) delays often occurred in placing individuals on DMH's disqualification listing. In addition, the department allowed a facility owned and operated by disqualified individuals to continue to operate. As a result, clients have been at risk of being abused or neglected.

Lack of Background Checks and Termination of Disqualified Employees Resulted in Abuse

DMH policies require background screenings to be completed for all new employees. These policies require facilities and providers to deny employment to disqualified individuals. However, facility and contractor administrators did not always comply with DMH procedures regarding criminal background screenings for new employees.

The following examples illustrate how the failure of administrators to conduct background checks or to immediately terminate employees with disqualifying information in background checks resulted in client abuse:

- One state-run facility did not take immediate action to terminate an employee when a background check disclosed the employee committed multiple disqualifying felonies, including arson, aggravated assault, and unlawful use of a weapon. During the 12 days between the time the facility learned of the felonies and termination of the employee, DMH determined this employee sexually abused a client.

  According to department officials, the employee's termination did not occur timely because the facility's human resources director was on vacation.

- A contract provider did not immediately terminate an employee when learning of disqualifying crimes on his background check. Crimes included robbery, unlawful use of a weapon, and drug trafficking. Additionally, after termination, the employee continued to have contact with clients. The employee is alleged to have sexually abused a client before and after his termination.

  According to documents provided by department officials, the provider believed there was no problem with his employment because the employee came from another provider.

- Another contract provider did not conduct a background check for one employee and did not provide required training. DMH determined this employee later sexually abused a client.

Department officials provided us with copies of letters sent out to all providers in March 2005 to remind and inform contractors of requirements regarding background screenings.

Disqualified Persons Employed by Contractors

State law[19] disqualifies certain persons who have abused or neglected individuals in the past and persons who have committed specific crimes. However, we identified 38 individuals on the DMH or Department of Health and Senior Services disqualification list that worked with clients between April 2003 through April 2005. DMH officials had not been aware of these individuals until we brought this matter to their attention.

In one instance an employee had been disqualified due to physically and verbally abusing a client. St. Louis Regional Center officials did not report the substantiated charges to central office until 10 months after the original abuse occurred. At that time, the regional center did not submit all of the necessary documentation, resulting in a second delay of more than one year. Therefore, department officials did not add the perpetrator to the disqualification listing until almost two years after the original abuse occurred, despite the fact that the perpetrator did not appeal any of the charges. During these two years, a second contracted provider hired the perpetrator, who then committed verbal abuse and neglect against another client.

After we discussed these employees with department officials, they contacted each employer to ensure the provider had terminated each employee. Additionally, after March 2005, department officials began conducting quarterly matches with employment data to determine if disqualified individuals are working with clients.

Information provided to us by the department indicated that some providers conducted a proper background check, but the employee had not yet been added to the disqualification listing, while other providers misinterpreted the results of the background screenings. For example, some providers reviewed one disqualification listing and thought they had received clearance to hire an employee, when in fact another listing needed to be reviewed.

[19] Section 630.170.1, RSMo.

Delays occurred in adding individuals to the disqualified listing

We found significant delays often occurred in placing individuals on DMH's disqualification listing. This problem occurred, in part, because of the delay between the time investigators completed reports and the time facility managers made determinations on cases. DMH policies allow the process to take approximately 50 days. However, St. Louis Regional Center exceeded 50 days in this process for more than half of its investigations between July 2003 and August 2004. The regional center took over a year to make some of these determinations. In addition, we found an average of 9 months between DMH determining an individual committed an abuse and placing the individual on the disqualification registry.

Time delays sometimes had been compounded by facility delays submitting paperwork to the investigations unit. We found all 6 registry qualifying offenses at the St. Louis Regional Center[20] ranged from 7 months to over a year to be added to the registry after determinations had been made. For example, in one case regional center administrators did not submit paperwork to the investigations unit for over a year after an employee was found to have neglected clients. We found further delays once the necessary paperwork reached the investigations unit. For example, delays often occurred when employees waited to "batch" several cases at once, instead of handling each case individually.

We also found DMH policy did not require monthly management reports identifying cases not progressing in a timely manner. However, in discussing this matter with us DMH officials stated policies related to adding individuals to the disqualification listing were revised in April 2005 and officials initiated management reports in June 2005.

Although the DMH has policies in place requiring all state and provider employees who have contact with clients to have background checks prior to employment, these checks cannot identify individuals who have committed disqualifying offenses but have not been added to the disqualification listing.

Department making changes to enhance process

After we discussed these issues with department officials, they established new procedures for adding persons to the disqualification listing. These changes allow persons to be added to the listing in a timely manner, according to the officials.

[20] During July 2003 through August 2004.

Problem Provider's Certification Not Revoked

DMH has continued to contract with a provider owned and operated by persons on DMH's disqualification listing since March 1999. During that time, there have been 11 substantiated cases of neglect at this home, including one leading to the death of a client.

From May 2003 to April 2005, DMH had been aware the owners and other persons on DMH's disqualification listing had contact with clients in the home. Persons having contact with clients in the home had been initially disqualified for (1) choking, kicking, and slapping clients; (2) pushing a client's face to the floor; (3) striking a client with a broom; (4) verbal abuse, including cussing at clients and threatening to kill clients; (5) failure to provide prompt medical attention and to follow proper medical procedures; (6) failure to provide proper support for clients, leading to the death of one client; and (7) failure to report the mistreatment of clients.

According to documents received from department officials, the owner of this provider admitted that he had contact with clients 24 times during May 2003. Department officials told us they did not initially believe they had the authority to revoke a provider's certification because its owner was on the disqualification listing, but they now believe they do have this authority.

After we notified DMH of our concerns about this provider, the department removed all clients from the home and did not renew the provider's contract.

Conclusions

DMH has not ensured clients have been adequately protected from abuse or neglect by individual caregivers. Facility and contractor administrators have not always conducted criminal background screenings for new employees, or taken action to immediately terminate employees with disqualifying information in background checks. As a result, some clients have been unnecessarily abused by these individuals. We believe, DMH should emphasize the need to immediately terminate employees with disqualifying information and penalize providers for not doing so.

DMH also had not established adequate controls to ensure contracted providers do not employ disqualified persons. We found individuals included on disqualification listings, as well as persons who had disqualifying offenses on background screenings, employed by providers. We believe the department should continue conducting recently established reviews of employment data to ensure contracted providers do not employ disqualified persons.

We also believe clients have been put at risk because of unnecessary delays in placing individuals on the disqualified listing. This problem occurred because of (1) delays between the time investigators completed reports and

the time facility managers made determination on cases, (2) facility delays submitting paperwork to the investigations unit, and (3) investigation unit delays while employees waited to "batch" several cases at one time.

We also found DMH officials have allowed one provider to remain open, despite documented cases of contact with clients by persons on the disqualification listing. Officials chose not to take action even though the owner, who was on the disqualified listing, admitted to having contact with clients. As a result, clients were unnecessarily placed at risk from individuals with histories of abuse and neglect.

Recommendations

We recommend the Director of the Department of Mental Health:

4.1 Conduct automated matches to identify instances where individuals listed on the DMH and Department of Health and Senior Services disqualification listings, or individuals with criminal backgrounds are inappropriately working for DMH providers.

4.2 Ensure contractor staff are trained to conduct background screenings properly, aggressively sanction providers who knowingly allow disqualified persons to have contact with clients, and decertify providers with repeat violations.

4.3 Streamline the process of placing individuals on the disqualification listing who have been found to have abused or neglected clients, and generate monthly management reports to monitor incident investigations that are not progressing in a timely manner.

Agency Comments

See Appendix I for agency comments.

Agency Comments

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August 24, 2005

John Luetkemeyer
State Auditor's Office
P.O. Box 869
Jefferson City, MO 65102

Dear Mr. Luetkemeyer,

We have received the revised draft report titled, "Mental Health: Protecting Clients from Abuse and Neglect." We appreciate the opportunity we had on August 8th to discuss the contents of the report with you and are pleased with the changes made to the report at our request. Please find enclosed the Department of Mental Health's written responses and our plans to implement the recommendations.

If you have any questions, please contact Janet Gordon at 573/751-8067.

Sincerely,

Dorn Schuffman
Director

DS:cw
Enclosure
cc: Janet Gordon
DMH Executive Team

The Department of Mental Health does not deny employment or services because of race, sex, creed, marital status, religion, national origin, disability or age of applicants or employees.

Appendix I
Agency Comments

Recommendation 2.1: Develop corrective action plans to address problems identified by external and internal reports.

DMH Response:

We concur. We have already implemented corrective actions to address the recommendations from the prior audit[1] cited on page 5 above, and have developed plans of correction to address each of the findings of the internal report cited on page 11 above.

At the time of the prior audit, there was no rule requiring contactors to submit Incident and Injury Reports in a timely manner, and Incident and Injury Reports did not explicitly require reporting medication errors or incidents between consumers that did not involve abuse or neglect as defined by statute. The prior audit recommended amending existing rules to require the timely submission of Incident and Injury Reports by all contractors, and that the Incidents and Injury Reports require reporting medication errors and all incidents between consumers that could help to identify patterns of aggressive behavior.

The Department concurred with these recommendations, and, as noted on page 10 above, before revising the administrative rules regarding the reporting of incidents and injuries, the Department initially tried to develop a revised Incident and Injury Report form that could be used by all three of its divisions. However, differences in the needs and vulnerabilities of the consumers served by the three divisions, eventually resulted in the development of one form for use by the Division of Mental Retardation and Developmental Disabilities, and one form for use by both the Division of Alcohol and Drug Abuse and the Division of Comprehensive Psychiatric Services. Both sets of forms include the additional information recommended by the prior audit regarding medications errors and incidents between consumers. The forms were field tested before being finalized. DMH facilities and contractors began using the new forms in the fall of 2004. A proposed rule requiring all contractors to submit the revised Incident and Injury Reports in a timely manner was filed in December, 2004. Following the period of public review and comment, a revised rule was filed in March, 2005. Following the required rule making timeframes, the final rule will be effective October 31, 2005.

The prior audit also recommended that MR/DD regional centers install an automated database to record and analyze contactor's incident reports, and that contractors be able to submit incident reports electronically. Implementation of these recommendations awaits full implementation of the Department's new web-based management information system (CIMOR) which will be able to fully accommodate the additional data now included in the Incident and Injury Reports, as well as electronic submission of the reports by contractors. However, in the interim, data from the revised Incident and Injury forms is being entered into an automated Community Event Form data base created by the Division of Mental Retardation and Developmental Disabilities to track incidents and injuries in community programs.

[1] Audit of Management and Oversight of Contractors Responsible for Care of People with Developmental Disabilities (Report no. 2001-20)

1

The internal report regarding the incident and injury reporting system (iiTS), noted on page 11 above, was developed by mid-level managers as part of their routine quality assurance activities. The report both identified processes that were working well, and recommended changes in the iiTS system. Although the report was shared with an immediate supervisor, it was not forwarded to the DMH Executive Team for review and action. (It should be noted that responsibility for abuse and neglect investigations, the incident and injury reporting system, and the consumer complaint line have been administratively reorganized under the DMH General Counsel.) Some of the recommendations of the internal report have already been implemented and will be institutionalized when the rule published in March becomes effective October 31st. Plans of correction have been developed for the remaining recommendations in the internal report.

Recommendation 2.2: Establish effective internal controls and periodic monitoring efforts to ensure that regulations involving incident investigation and reporting are followed.

DMH Response:

We concur. Several additional internal controls have been developed to ensure that regulations involving incident investigation and reporting are followed. These new procedures will be fully implemented with the activation of the newly centralized DMH investigations unit on September 16th, 2005. (See the response to Recommendation 3.1 below.)

All parties responsible for inputting data into the incident and investigation tracking system (iiTS) were retrained to assure timely entering of data using the standardized forms and consistent with revised procedures.

New procedures provide for a distinction between incidents that may involve abuse or neglect and therefore require an investigation, and those that do not appear to involve abuse and neglect. The new procedures require facility heads to conduct a preliminary review of incidents that do not appear to involve abuse or neglect to determine whether there is reasonable cause to believe the incident involves abuse or neglect. When the head of the facility does not find reasonable cause to believe the incident involves abuse or neglect, the head of the facility is required to enter the incident information into iiTS as an "inquiry". Monthly reports of all "inquiries" entered into iiTS for each facility are required to be reviewed by the office of the general counsel and the relevant division for compliance with the regulation defining "inquiry".

New procedures require investigators to:

> note in their reports whether notice was provided to parents, guardians, complainants, required state agencies or law enforcement as required by law, and to obtain copies of the notice for the file; and to notify the head of the facility, during the investigation, if required notifications have not been made in a timely manner;
>
> ensure that physical exams have been conducted in all cases of sexual abuse and physical abuse as required by regulations by noting same in the report and incorporating into the file documents that establish same; and

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ensure that photographs of all injuries are incorporated into the investigation file as required by regulations.

New investigator training materials stress the timeliness of investigations. It has always been the practice to provide a timely preliminary report and to request additional time due to matters out of the control of the investigator (i.e. awaiting autopsy results, polygraph results, records from outside agencies, etc.) in all investigations that are not completed in the timeframe under regulations. New procedures require weekly meetings between the general counsel or designee and the investigation unit director to review all incomplete and pending cases which review includes the timeliness of the investigations. New procedures also require that monthly reports for timeliness of determiners' substantiated determinations are reviewed with the divisions by the office of the general counsel.

New procedures require that all investigations are reviewed for completeness by the regional supervisor before being issued to the determiner, and in critical cases, determined upon assignment, that they are reviewed by the unit program director or general counsel/designee.

With the creation of the centralized investigation unit, all incidents involving a reasonable suspicion of abuse or neglect are required to be reported and investigated by the central investigation unit so that there is no longer any need for criteria central versus local investigations.

New procedures require the development and review of reports to ensure the timely entry of incidents, final determinations, and completion of history fields into the incident and investigations tracking system (iiTS); timely completion of investigators' final reports and interim reports; timely submission to the Office of the General Counsel of the Final Determination Forms; timely decisions on appeals to the Department's Hearings Officer; and the timely addition of offenders' names to the employee disqualification registry. In addition, as noted below, on a quarterly basis, persons on the employee disqualification registry will be matched to Division of Employment Security records to identify persons illicitly working for an agency funded, certified, or licensed by the Department.

Finally, the Department will institute periodic monitoring reviews at provider, state-operated facility, and Central Office levels to ensure regulations involving incident investigation and reporting are followed, as well as to determine if process changes have achieved the desired results.

Recommendation 2.3: Continuously monitor staff to client and investigations per client ratios at BHC to ensure that client care does not suffer during the closing process.

DMH Response:
We concur. The Division of MRDD has developed a scorecard for each MRDD facility that includes the recommended performance measures. Data from the scorecard will be compared with iiTS information regarding investigations as well as consumer complaints. This information will be gathered and reviewed on a monthly basis. The Division will be monitoring the "action plans" that are written in response to the investigation by the facility, to ensure thoroughness and timeliness.

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Recommendation 3.1: Establish an independent investigation unit and require the use of standardized forms and methods to handle complaint investigations.

DMH Response:
We concur. Effective April of 2005 the investigation unit was reorganized under the office of the general counsel with the direction to centralize the unit department-wide. The transition from a decentralized system in which the majority of investigations were conducted by staff under the direct supervision of the Department's six habilitation centers, eleven psychiatric facilities, and eleven regional centers to a centralized system under the supervision of the Department's general counsel required reallocating resources, including reclassifying, transferring and/or hiring, and training personnel; revising regulations, policies, and procedures, and establishing or relocating offices. The centralized unit under the general council will be fully operational on September 16, 2005.

In addition, as noted above, standardized forms have been developed for the reporting of all incidents. These forms are currently being used, and the final rule requiring all contractors to use the standard forms will be effective on October 31, 2005.

Recommendation 4.1: Develop automated matches to identify instances where individuals listed on the DMH and Department of Health and Senior Services disqualification listings, or individuals with criminal backgrounds are inappropriately working for DMH providers.

DMH Response:
We concur. Since the beginning of 2005, the DMH audit section has matched Division of Employment Security (DES) data with persons on the DMH disqualification list on a quarterly basis. Providers who are found to employ disqualified persons are notified to take appropriate action. The department is in the process of entering into a memorandum of understanding (MOU) with DHSS to share disqualification lists. Issues involving information systems security and process are pending resolution. The department audit section will then match quarterly the DHSS list with the DES data and DMH provider data to identify persons disqualified from employment. Matches shall be addressed with the provider. As part of their review, certification and licensure currently ensure that background checks are completed on all new hires by the agency being reviewed. Policy is being developed to require that certification and licensure staff incorporate as part of their survey a process of obtaining the names of current employees, social security numbers, dates of birth and addresses with each provider and provide the names and other relevant information to the audit section to run against appropriate criminal misconduct data bases.

Recommendation 4.2: Ensure contractor staff are trained to conduct background screenings properly, aggressively sanction providers who knowingly allow disqualified person to have contact with clients, and decertify providers with repeat violations.

DMH Response:
We concur. At the time of initial certification or licensure of an agency, providers are trained in how to properly conduct background screening. In March, 2005, a letter was

sent to all contractors reminding them of their statutory and regulatory obligations to conduct background screenings, and advising them of the processes for doing so. Current regulations allow DMH to decertify an agency whenever consumers are at risk. Employers who knowingly employ individuals on a disqualification list or who have a criminal background, or who allow such individuals to have contact with consumers, will have their certification and/or license revoked.

Recommendation 4.3: Streamline the process of placing individuals on the disqualification listing who have been found to have abused or neglected clients, and generate monthly management reports to monitor incident investigations that are not progressing in a timely manner.

DMH Response:
We concur. In April, 2005 the disqualification list process was reorganized under the office of the general counsel and a timely centralized process initiated for the receipt of all determiners' substantiated determinations to be inputted into the automated history file. The practice of "batching" determinations and waiting 180 days was abandoned, and in lieu thereof any provider employee who fails to appeal within 15 days of final determination is placed immediately on the disqualification list and any state employee who does not appeal to the PAB in 35 days is placed on the list. In order to assure due process, the department will continue to await a final decision from the internal or external hearing tribunal for those who have timely appealed before placement on the disqualification list. The office of the general counsel reviews this process with the registry coordinator on a monthly basis. The office of the general counsel reviews with the investigation unit director on a weekly basis all incomplete pending investigations listed in management reports and included in this review is the timeliness of the investigations. Training of the new investigations unit stresses the need for thorough and timely reports.

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