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Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities

U.S. Department of Health and Human Services

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MAINE DID NOT COMPLY WITH FEDERAL AND STATE REQUIREMENTS FOR CRITICAL INCIDENTS INVOLVING MEDICAID BENEFICIARIES WITH DEVELOPMENTAL DISABILITIES

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Inspector General

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Office of Inspector General

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Report in Brief
Date: August 2017
Report No. A-01-16-00001

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities

Why OIG Did This Review

We are performing reviews in several States in response to a congressional request concerning the number of deaths and cases of abuse of residents with developmental disabilities of community-based providers.

Federal waivers permit States to furnish an array of home and community-based services to Medicaid beneficiaries with developmental disabilities so that they may live in community settings and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) requires States to implement an incident reporting system to protect the health and welfare of the Medicaid beneficiaries receiving waiver services.

Our objective was to determine whether Maine complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings from January 2013 through June 2015.

How OIG Did This Review

We reviewed medical records for selected beneficiaries residing in community-based settings who had hospital emergency room visits and were diagnosed with conditions that we determined to be indicative of high risk for suspected abuse or neglect. We also reviewed critical incident reports contained in Maine's reporting system.

What OIG Found

Maine did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities. Specifically, Maine did not ensure that community-based providers reported all critical incidents to the State; ensure that community-based providers conducted administrative reviews of all critical incidents involving serious injuries, dangerous situations, or suicidal acts and submitted their findings within 30 days; appropriately report all restraint usage and rights violations to Disability Rights Maine; review and analyze data on all critical incidents; investigate and report immediately to the appropriate district attorney's office or law enforcement all critical incidents involving suspected abuse, neglect, or exploitation; and ensure that all beneficiary deaths were appropriately reported, analyzed, investigated, and reported to law enforcement or the Office of the Chief Medical Examiner.

Maine did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents for a variety of reasons. Accordingly, Maine did not fulfill many of the participant safeguard assurances it provided to CMS in its Medicaid waiver. Therefore, Maine failed to demonstrate that it has a system to ensure the health, welfare, and safety of the 2,640 Medicaid beneficiaries with developmental disabilities covered by the Medicaid waiver.

What OIG Recommends and Maine's Comments

We recommend that Maine fully implement its regulations regarding the reporting and monitoring of critical incidents to fulfill the participant safeguard assurances it provided in its Medicaid waiver and help protect Medicaid beneficiaries from harm.

Maine agreed or partially agreed with all seven of our recommendations and with four of our findings, but it did not agree with two of our findings. Specifically, Maine disagreed that it did not ensure that community-based providers reported all critical incidents and that it did not investigate or report critical incidents to the appropriate authorities. We maintain that the evidence supports all our findings.

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INTRODUCTION

WHY WE DID THIS REVIEW

We have performed reviews in several States[1] in response to a congressional request concerning the number of deaths and cases of abuse of residents with developmental disabilities in group homes. This request was made in response to media coverage throughout the country of deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors.

In Maine, individuals with developmental disabilities may reside in community-based settings such as group homes, shared living arrangements, and private family homes (collectively known as "community-based providers").

OBJECTIVE

Our objective was to determine whether the Maine Department of Health and Human Services (State agency) complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings from January 2013 through June 2015 (audit period).

BACKGROUND

Developmental Disabilities Assistance and Bill of Rights Act of 2000

As defined by the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (the Disabilities Act),[2] "developmental disability" means a severe, chronic disability of an individual. The disability of the individual is attributable to a mental or physical impairment, or a combination of both; must be evident before the age of 22; and is likely to continue indefinitely. The disability results in substantial limitations in three or more major life areas, including self-care, receptive and expressive language, learning, mobility, self-determination, capacity for independent living, and economic self-sufficiency.

Federal and State Governments have an obligation to ensure that public funds are provided to residential, institutional, and community providers that serve individuals with developmental disabilities. Further, these providers must meet minimum standards to ensure the care they provide does not involve abuse, neglect, sexual exploitation, and violations of legal and human rights (the Disabilities Act § 109(a)(3)).

[1] See Appendix A for related work.

[2] P.L. No. 106-402 (Oct. 30, 2000).

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 an array of home and community-based services that assists Medicaid beneficiaries to live in the community and avoid institutionalization. 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 the waiver's target population.

The Office of Aging and Disability Services within the State agency administers Maine's HCBS waiver program. The HCBS waiver program in Maine provided 2,640 individuals with needed comprehensive support services during our audit period.

States must provide certain assurances to the Centers for Medicare & Medicaid Services (CMS) to receive approval for the HCBS waiver, including that necessary safeguards have been undertaken to protect the health and welfare of the beneficiaries receiving services (42 CFR § 441.302). This waiver assurance requires the State to provide specific information regarding its plan or process related to participant safeguards, which includes whether the State operates a critical event or incident reporting system (HCBS waiver, Appendix G-1). In its waiver, the State agency stated that it has a critical event or incident reporting system that relies on its own regulations. The State agency established certain policies and procedures, which require coordination with other State and local agencies and Disability Rights Maine (DRM), a private, nonprofit organization.[3]

Critical Incident Reporting for Community-Based Providers

The HCBS waiver and State agency regulations define a reportable event (critical incident) as any event that has or may have an adverse impact on the safety, welfare, rights, or dignity of adults with developmental disabilities or autism. The HCBS waiver and State agency regulations further state that community-based providers must immediately report critical incidents, such as abuse, neglect, exploitation, rights violations, or death, to the State agency. Other critical incidents that must be reported to the State agency within 1 business day include restraint usage and medication errors. Community-based providers must enter a written report of the critical incident into the State agency's Enterprise Information System (EIS) (*Department of Health and Human Service Adult Developmental Services Reportable Events, Instruction for*

[3] DRM is Maine's Protection and Advocacy (P&A) agency. The first P&A program was created by the Developmental Disabilities Assistance and Bill of Rights Act of 1975 (DD Act). The DD Act requires P&A agencies to pursue legal, administrative, and other appropriate remedies to protect and advocate for the rights of individuals with developmental disabilities under all applicable Federal and State laws. The DD Act provided for the governor of each State to designate an entity as the P&A agency and to assure that the P&A agency was, and would remain, independent of any service provider. Most entities designated as P&A agencies are private nonprofit organizations created specifically to conduct P&A programs.

Completing the Reportable Event Form, page 10). Table 1 contains the types and number of critical incidents recorded in EIS during the audit period.

Table 1: Number and Type of Critical Incidents Reported in the Enterprise Information System

Type	Number
Medication Issues	13,039
Physical or Verbal Abuse	6,317
Restraint Usage	5,863
Dangerous Situations	4,842
Serious Injuries	3,300
Rights Violations	1,045
Neglect	885
Suicidal Acts or Attempts or Threats	536
Sexual Abuse or Sexual Exploitation	329
Nonsexual Exploitation	327
Deaths	133
Total	**36,616**

Community-based providers must also conduct administrative reviews of all critical incidents excluding allegations of abuse, neglect, exploitation, and rights violations.[4] These reviews must attempt to identify the cause of a critical incident and recommend preventive or corrective action as necessary. The reviews' findings must be reported to the State agency within 30 days of the critical incident.

HOW WE CONDUCTED THIS REVIEW

We extracted 2,264 emergency room claims for 2,243 emergency room visits[5] from the Maine Medicaid Management Information System (MMIS) that the State agency paid on behalf of 705 Medicaid beneficiaries with developmental disabilities with a minimum age of 18 residing in community-based settings from January 2013 through June 2015. We determined that all of the 2,243 emergency room visits met the State agency's definition of a "critical incident." We then compared these 2,243 emergency room visits to EIS to determine if these emergency room visits were reported as critical incidents to the State agency.

To determine whether mandated reporters reported these critical incidents to the State agency, we also reviewed 104 emergency room records for 82 of the 705 beneficiaries who were diagnosed with at least 1 of 50 conditions that we determined to be indicative of high risk

[4] Allegations of abuse, neglect, or exploitation are required to be investigated by the State agency. Allegations of rights violations may be investigated directly by DRM or in conjunction with the State agency.

[5] Some emergency room visits had more than one Medicaid claim.

for suspected abuse or neglect.[6] We also reviewed critical incident reports that were submitted to the State agency through EIS to determine if the State agency followed Federal and State requirements regarding critical incident reporting and monitoring.

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

Appendix B contains details of our audit scope and methodology. Appendix C contains details on the Federal waiver and State requirements relevant to our findings. Appendix D contains a description of the 50 diagnosis codes we reviewed and details of the injury types of the 82 beneficiaries who were treated at a hospital emergency room.

FINDINGS

The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings. Specifically, the State agency did not:

- ensure that community-based providers reported all critical incidents to the State agency;
- ensure that community-based providers conducted administrative reviews of all critical incidents involving serious injuries, dangerous situations, or suicidal acts and submitted their findings within 30 days;
- report appropriately all restraint usage and rights violations to DRM;
- review and analyze data on all critical incidents;
- investigate and report immediately to the appropriate district attorney's office or to law enforcement all critical incidents involving suspected abuse, neglect, or exploitation; and

[6] These conditions were indicative of high risk because they are associated with diagnosis codes that indicate an increased risk of abuse or neglect, such as codes for head injuries, bodily injuries, certain medical services, and safety issues. We used diagnosis codes identified in a 2012 report by the Connecticut Office of Protection and Advocacy (OPA) that reviewed the deaths of individuals with developmental disabilities in that State. Although the OPA report analyzed only deaths in Connecticut, the diagnosis codes used provide reliable indications of high-risk conditions that could have resulted from abuse or neglect. We relied on these diagnosis codes as indicators because OPA has experience investigating allegations of abuse or neglect—it is responsible in Connecticut for the protection and advocacy of individuals with developmental disabilities between the ages of 18 and 59. This report is available at http://www.ct.gov/opapd/lib/opapd/documents/adobe/reports/full_report_-_10_years_of_reviews_and_investigations_2012.pdf. Last accessed July 24, 2017.

- ensure that community-based providers reported all beneficiary deaths to the State agency appropriately and that the State agency analyzed, investigated, and reported the deaths to law enforcement or Maine's Office of Chief Medical Examiner (OCME).

In performing our audit, we noted another issue that while outside the scope of our review is worthy of the State agency's attention. This issue involves the failure of hospital-based mandated reporters to report to the State agency all critical incidents with reasonable suspicion of abuse or neglect.

The State agency did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents for a variety of reasons that are described later in the report. Therefore, the State agency did not fulfill participant safeguard assurances it provided to CMS in the HCBS waiver. The State agency failed to demonstrate that it has an adequate system to ensure the health, welfare, and safety of the 2,640 Medicaid beneficiaries with developmental disabilities covered by the Medicaid waiver in accordance with 42 CFR § 441.302(a).

COMMUNITY-BASED PROVIDERS DID NOT REPORT ALL CRITICAL INCIDENTS TO THE STATE AGENCY

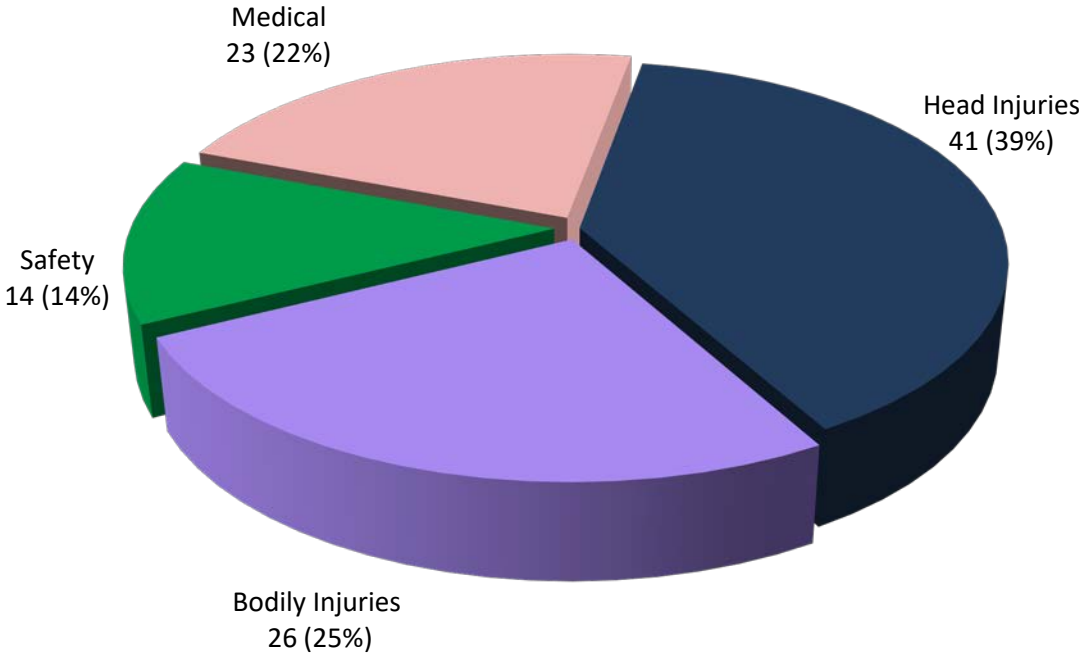
Community-based providers in Maine are required to report to the State agency critical incidents involving Medicaid beneficiaries with developmental disabilities. Critical incidents that must be reported immediately to the State agency include abuse, neglect, serious illness or injury, and death. Maine broadly defines "serious illness or injury" to include any change in medical conditions caused by accident or illness that requires hospitalization (HCBS waiver, Appendix G-1(b)). The State agency's reportable events training for community-based providers further clarifies that any change in medical conditions that requires hospitalizations, including initial emergency room visits, must be reported (*State Agency Office of Aging and Disability Services Reportable Events Training*, page 13). Therefore, all of the 2,243 emergency room visits made by 705 Medicaid beneficiaries with developmental disabilities during our audit period met the State agency's definition of a "critical incident." Furthermore, a person with knowledge of an incident related to client care must immediately report the details of that incident in accordance with State agency requirements (Maine Revised Statutes, Title 34-B, chapter 5, subchapter 4, § 5604-A (1)).

Community-based providers did not report to the State agency all critical incidents involving beneficiaries with developmental disabilities. Specifically, we determined by matching Medicaid claims data with EIS entries that community-based providers reported 1,474 (66 percent) of the 2,243 critical incidents involving emergency room treatment. However, community-based providers did not report to the State agency the remaining 769 (34 percent) critical incidents.

We selected 104 high-risk critical incidents from the 769 unreported incidents and determined that mandated reporters at community-based providers did not report any of these incidents to

the State agency.[7] The Figure contains details of the 104 high-risk critical incidents that we reviewed separately by diagnosis code category.[8]

Figure: Diagnoses Associated With the 104 Critical Incidents



Community-based providers gave us various reasons, such as staff turnover and clerical errors, for why they did not always report critical incidents to the State agency. State agency officials did not provide an explanation of why the State agency did not ensure that community-based providers reported all critical incidents to the State agency. The State agency and DRM were not always able to pursue legal, administrative, and other appropriate remedies to protect and advocate for the rights of individuals with developmental disabilities under all applicable Federal and State laws because not all critical incidents were reported to them.

[7] We also determined that the 104 high-risk critical incidents were not reported to the State agency by other mandated reporters, such as family members.

[8] State agency officials reviewed all 104 undetected high-risk critical incidents and confirmed that the community-based providers should have reported the 104 emergency room visits as critical incidents. The State agency officials informed us that they are in the process of developing a plan of correction for this issue.

A Representative 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 a history of 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 beneficiary's medical records noted that 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 through EIS.

Hospital-Based Mandated Reporters Did Not Report All Critical Incidents With Reasonable Suspicion of Abuse, Neglect, or Exploitation to the State Agency

This issue was outside the scope of our review; however, it is significant and worthy of the State agency's attention.

Mandated reporters include doctors, nurses, social workers, and other treatment staff. A mandated reporter must report to the State agency when he or she has reasonable cause to suspect that an incapacitated or dependent adult has been or is likely to be abused, neglected, or exploited (Maine Revised Statutes, Title 22, chapter 958-A, subsection 3477 (1)).

Mandated reporters are also required to make reasonable efforts to take color photographs of any areas of trauma they see on a person with developmental disabilities and make these photographs available to the State agency as soon as possible (Maine Revised Statutes, Title 22, chapter 958-A, subsection 3477 (6)).

During our audit period, 705 Medicaid beneficiaries with developmental disabilities made 2,243 emergency room visits at 39 hospitals. We examined 104 of the visits we identified as high risk and found that hospital-based mandated reporters did not report any of these high-risk critical incidents as potential abuse, neglect, or exploitation of a Medicaid beneficiary with developmental disabilities.[9] We also reviewed the 104 medical records associated with these high-risk emergency room visits and found that none contained photographs of the trauma described.

[9] We did not make a determination whether hospital-based mandated reporters should have reported all 104 high-risk critical incidents as potential abuse, neglect, or exploitation. Rather, we are bringing to the State agency's attention that the 104 incidents were associated with diagnosis codes that we determined to be indicative of a high risk for suspected abuse or neglect, but none were reported by hospital-based mandated reporters.

A Representative Example of a Hospital's Unreported Critical Incident

A hospital did not report to the State agency a critical incident involving a beneficiary with a history of developmental disabilities and autism at a community-based provider. The beneficiary was taken to a hospital emergency room complaining of bruising to her right shoulder and lack of motion. The community-based provider's staff told the hospital staff that 3 days earlier the beneficiary fell out of bed, and staff found her on the floor alert on her right side. Medical imaging revealed that the beneficiary had suffered a fractured right clavicle.

Because there was reasonable cause to suspect potential abuse or neglect of this beneficiary based on the combination of the injuries suffered and the delay in seeking treatment, the hospital's physicians, nurses, or other hospital personnel, as well as any other mandated reporters aware of this condition, should have reported this incident to the State agency.

COMMUNITY-BASED PROVIDERS DID NOT CONDUCT ADMINISTRATIVE REVIEWS OF ALL CRITICAL INCIDENTS INVOLVING SERIOUS INJURY, DANGEROUS SITUATIONS, OR SUICIDAL ACTS AND SUBMIT THEIR FINDINGS WITHIN 30 DAYS

Community-based providers are required to conduct an administrative review of all critical incidents excluding allegations of abuse, neglect, exploitation, and rights violations.[10] The review must attempt to identify the cause of a critical incident and recommend preventive or corrective action as necessary. Findings must be reported to the State agency within 30 days of the incident. The State agency either accepts the results of the review and closes the case or requests further action by the community-based provider (HCBS waiver, Appendix G-1(d)).

Furthermore, the administrative review must be in writing, kept on file by the provider, and be made available for review when requested by the State agency (14-197 Code of Maine Rules, State agency, chapter 12, 6.04 (B)(2)).

Community-based providers did not always conduct administrative reviews that attempted to identify the cause of critical incidents and recommend preventive or corrective action as necessary and submit the report findings to the State agency within 30 days. In this regard, community-based providers reported through EIS to the State agency 8,678 critical incidents involving serious injuries, dangerous situations, and suicidal acts for 1,781 beneficiaries during

[10] Allegations of abuse, neglect, or exploitation are required to be investigated by the State agency. Allegations of rights violations may be investigated directly by DRM or in cooperation with the State agency.

our audit period.[11] These reports documented critical incidents that potentially jeopardized the health, safety, and rights of the beneficiaries and included injuries of unknown origin, emergency room visits for serious injuries, and lack of beneficiary supervision that resulted in repeated elopements.[12] The State agency, however, was unable to provide us with copies of the 8,678 administrative reviews associated with these critical incidents. We then requested copies of administrative reviews from five large community-based providers.[13] The documentation provided by the five providers indicated that they had some form of internal review process for critical incidents. However, these reviews varied greatly in nature and scope and frequently did not identify the cause of the critical incidents or contain recommendations for corrective actions. Furthermore, all five providers stated they did not submit their reviews to the State agency within 30 days of the critical incident.

We interviewed officials from the five large community-based providers. These officials informed us that the State agency instructed the community-based providers to discontinue performing and submitting administrative reviews sometime between late 2012 and early 2013. However, the State agency maintains that it never provided such instructions to the community-based providers. Nevertheless, the State agency was unable to explain why the community-based providers did not submit the administrative reviews or why it did not detect that the community-based providers did not report findings to the State agency for the 8,678 critical incidents.

Without the results of the community-based providers' administrative reviews, the State agency was unable to either close the cases or request further action by the community-based providers to ensure that the Medicaid beneficiaries with developmental disabilities were adequately safeguarded.[14]

A Representative Example of an Administrative Review Critical Incident Finding Not Submitted to the State Agency Within 30 Days

A community-based provider did not submit the findings to the State agency of an administrative review for a critical incident involving a change in medical condition that resulted in harm to one of its residents. Therefore, the State agency could neither

[11] We limited our review of administrative reviews to the categories of serious injuries, dangerous situations, and suicidal acts because these categories had the most critical incidents that did not require the State agency to investigate or report to DRM.

[12] An "elopement" occurs when a beneficiary leaves an area without caregiver supervision or permission.

[13] We selected these five community-based providers based on a combination of the provider's size, geographical location, and types of critical incidents the provider reported to the State agency.

[14] Although community-based providers did not submit administrative review findings for these 8,678 critical incidents, the State agency provided oversight for some of them. Specifically, we found that the State agency accepted for investigation 58 reported critical incidents (40 dangerous situations, 17 serious injuries, and 1 suicidal act) for 51 beneficiaries.

accept the results of the review and close the case nor request further action by the community-based provider.

The beneficiary ingested laundry soap while assisting the community-based provider's staff in cleaning up urine on the floor. The beneficiary also put some laundry soap in her eyes. The community-based provider's staff rinsed the beneficiary's face and mouth, contacted poison control, and took the beneficiary to a hospital's emergency room. The beneficiary was then admitted to the hospital for observation. The next day, the hospital performed a medical procedure to determine whether the beneficiary had been injured from ingesting the laundry soap. The medical procedure showed the beneficiary's stomach was ulcerated in areas and her throat was red and was sloughing skin. The critical incident report noted that the beneficiary incurred no permanent damage.

Because the injuries met the State agency's definition of a critical incident involving a serious injury but did not involve allegations of abuse, neglect, exploitation, or a rights violation, the group home should have conducted an administrative review that identified the cause of the critical incident, recommended preventive or corrective action, and reported the findings of the review to the State agency within 30 days.

THE STATE AGENCY DID NOT REPORT ALL RESTRAINT USAGE AND RIGHTS VIOLATIONS TO DISABILITY RIGHTS MAINE

All restraints (both approved and unapproved) and rights violations, including all incidents of abuse, neglect, and exploitation, must be sent to DRM by the State agency, and DRM must be provided access to all critical incident reports (HCBS waiver, Appendix G-1(d); 14-197 Code of Maine Rules, State agency, chapter 12, 6.03 (F)(2) and (4)). The reportable events system (through EIS) provides the means for collecting individual events, analyzing individual data, and analyzing provider data in a specific residential setting (HCBS waiver, Appendix G-2).

Furthermore, anyone with knowledge of an alleged rights violation of an individual with developmental disabilities must promptly report the alleged violation to DRM; a monthly summary of all daily records of the use of restraints pertaining to all persons must be relayed to DRM by the State agency (Maine Revised Statutes, Title 34-B, chapter 5, subchapter 4, §§ 5604-A (3) and 5605 (14-A)). In addition, State agency investigators must promptly report suspected rights violations in a separate report to DRM (14-197 Code of Maine Rules, State agency, chapter 12, 6.04 (F)(4)).

The State agency did not send reports of all restraint usage and rights violations to DRM, but it did provide DRM with access to all critical incident reports contained in EIS. Furthermore, the State agency did not send a monthly summary of all daily restraint records to DRM, and State agency investigators did not report suspected rights violations in a separate report to DRM.

DRM officials stated that having access to EIS is not equivalent to receiving summary reports from the State agency. The reason is that thousands of critical incident reports are submitted to the State agency each year, and DRM does not have the resources to continually monitor EIS for submitted reports. Summary reports notify DRM of specific incidents and allow DRM staff to access the critical incidents reports contained in EIS if DRM needs additional information.

We reviewed all critical incident reports for restraints and rights violations, including all incidents of abuse, neglect, and exploitation. Our analysis disclosed that while the State agency gave DRM access to all critical incident reports in EIS, it did not separately send to DRM critical incident reports for:

- 7,721 (98 percent) of the 7,858 critical incidents classified in EIS as physical or verbal abuse (6,317), neglect (885), sexual abuse (329), or nonsexual exploitation (327);[15]

- 5,806 (99 percent) of the 5,863 critical incidents involving restraint usage; and

- 197 (19 percent) of the 1,045 critical incidents involving rights violations.

Examples of the rights violations not sent to DRM included threats or intimidation by the staff in group homes, denial of access to religious services, denial of access to medical treatment, and unnecessary restraint or use of unapproved restraint techniques, such as floor takedowns.[16]

The State agency did not send reports on all restraints and incidents involving abuse, neglect, or exploitation to DRM because it maintained that providing DRM access to EIS was equivalent to sending DRM the required reports. Furthermore, the State agency did not report all rights violations to DRM because the State agency's incident data specialists did not always select the correct event category type within EIS. The correct event category would have included the rights violations in the electronic notifications sent to DRM. Accordingly, DRM was not always able to pursue legal, administrative, and other appropriate remedies to protect and advocate for the rights of individuals with developmental disabilities. The State agency informed us that it has taken corrective action to address some of these issues. Specifically, the State agency

[15] These 7,721 critical incidents were not sent to DRM as rights violations. Because the incidents involved abuse, neglect, or exploitation, the State agency should have ensured the critical incident reports were classified as rights violations and sent them in a separate report to DRM.

[16] A "floor takedown" is a restraint technique that involves physically restraining a beneficiary on the floor.

said it would begin generating a monthly event report for DRM containing the use of all restraints.[17]

A Representative Example of a Rights Violation That Was Not Sent to Disability Rights Maine

The State agency did not report to DRM the alleged rights violation of a beneficiary at a community-based provider.

A community-based provider's staff member allegedly threatened and intimidated a beneficiary. The beneficiary reported to her case manager that the staff member at the home told her that she had to go to her room because of her behavior. The beneficiary replied that she did not think she was doing anything wrong and refused to go. According to the beneficiary, the staff member then stated that, if she did not go to her room, he would assist her and that he remarked, "I don't want to hurt you." The beneficiary stated that the staff member previously told her he was a soldier and that she witnessed him restrain other residents. The beneficiary went to her room because she was frightened. The case manager talked to the beneficiary about her rights and informed her that she could not be punished by being forced to go to her room. While the community-based provider submitted a critical incident report in EIS as a rights violation, the State agency did not send the report to DRM.

This critical incident should have been sent to DRM because it met the State agency's definition of an alleged rights violation.

THE STATE AGENCY DID NOT REVIEW AND ANALYZE DATA ON ALL CRITICAL INCIDENTS

The State agency is responsible for the oversight of critical incidents and events. This oversight includes the collection and compilation of critical incidents reported through EIS. Specifically, the State agency should develop reports every 3 to 4 months that identify patterns and trends[18] to prevent reoccurrences of critical incidents (HCBS waiver, Appendix G-1(d) and (e)).

[17] DRM identified issues with the use of improper or unauthorized restraints in its annual *Developmental Services Advocacy Report* for the year ended June 30, 2015. Specifically, DRM conducted a targeted review of the use of restraints reported to the State agency and found that an overwhelming number of individuals receiving services were subjected to types of physical restraints that were prohibited by the service provider's certification. DRM also stated that while the use of restraints is generally reported, it is often reported without detail or having been reviewed.

[18] Referred to in this report as "trend analysis."

The State agency must also perform a 100-percent review of critical incidents and determine on an ongoing basis the number and percentage of critical incidents reported within required timeframes (HCBS waiver, Appendix G, subsection (a)(i)(a)).

The State agency generally did not conduct a trend analysis every 3 to 4 months of critical incidents reported through EIS. One of the five community-based providers we visited was able to provide us with the results of one review conducted by the State agency from July 1, 2013, through June 30, 2014. This review included a trend analysis on 698 critical incidents involving 53 Medicaid beneficiaries with developmental disabilities residing at 10 of the community-based provider's 38 residences. The State agency did not provide us with any other reports of similar reviews it conducted during the audit period.

We, therefore, performed a trend analysis for 2 of the 11 types of critical incident reports detailed in Table 1. Specifically, we performed a trend analysis on the 3,300 critical incidents involving serious injuries to 1,163 Medicaid beneficiaries with developmental disabilities.[19] We determined that 11 beneficiaries (1 percent of the 1,163 beneficiaries) were involved with 266 (8 percent) of the 3,300 critical incidents. We also performed a trend analysis on the 13,039 critical incident reports involving medication issues for 1,565 Medicaid beneficiaries with developmental disabilities.[20] We identified eight beneficiaries who each had at least 100 critical incidents (one of whom had 333 critical incidents involving medication issues) totaling 1,228 incidents involving medication issues[21] during our audit period. Accordingly, the State agency could have identified patterns and trends to prevent reoccurrences of similar critical incidents. (See Appendix E for more details about the results of our trend analysis.)

The State agency also generally did not determine on an ongoing basis the number and percentage of critical incidents reported within applicable timeframes. While the State agency provided us with a report regarding the timeliness of critical incident reporting from January 1 through June 30, 2014, it did not provide us with any documentation regarding the remainder of the audit period. The State agency's review was limited to a 5-percent random sample of critical incidents contained in EIS. Furthermore, the State agency did not reconcile critical incidents contained in EIS with Medicaid claims data contained in MMIS. This reconciliation is key to detecting whether beneficiaries with developmental disabilities were involved with critical incidents and whether those critical incidents were reported and investigated within required timeframes. For example, the reconciliation of critical incidents in EIS to MMIS would have allowed the State agency to identify serious injuries that required emergency room treatment or hospital admission and were not subsequently reported by the community-based provider. The State agency officials did not provide a clear explanation of why the State agency

[19] None of the 1,163 beneficiaries was included in the State agency's review.

[20] Eight hundred ninety-five Medicaid beneficiaries with developmental disabilities had reportable critical incidents in both the serious injury and medication issue categories. They were, therefore, included in the trend analysis of both categories.

[21] Of these critical incidents, 1,049 of the 1,228 involved the beneficiaries' refusal of their medications.

did not always conduct trend analysis or always determine on an ongoing basis the number and percentage of critical incidents reported within required timeframes. Without conducting a trend analysis or data match, the State agency would have difficulty identifying patterns that, if addressed, could prevent reoccurrences of similar critical incidents or could detect critical incidents that community-based providers do not report. Accordingly, the State agency did not ensure that Medicaid beneficiaries were adequately protected from potential abuse or neglect.

THE STATE AGENCY DID NOT INVESTIGATE AND IMMEDIATELY REPORT TO A DISTRICT ATTORNEY'S OFFICE OR LAW ENFORCEMENT CRITICAL INCIDENTS INVOLVING POTENTIAL ABUSE, NEGLECT, OR EXPLOITATION

Abuse includes the infliction of injury and sexual abuse or exploitation. Neglect includes the failure to provide medical attention or necessary medication (HCBS waiver, Appendix G-1(b)).

An adult protective investigation must take place for all allegations of abuse, neglect, or exploitation, and the State agency must document an investigation in a uniform way. Such investigations must be completed within 30 days of their initiation. The investigation's findings and recommendations will be submitted promptly to the community-based provider (HCBS waiver, Appendix G-1(d)).

An "investigation" is the process of gathering and evaluating facts, as well as making findings and documenting conclusions regarding the capacity of, dependency of , and danger or substantial risk of danger to beneficiaries, including the ability to give informed consent (14-197 Code of Maine Rules, State agency, chapter 12, 6.02 (BB)).

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, whether or not the State agency chooses to investigate. In addition, the State agency must notify the appropriate district attorney or law enforcement agency upon finding evidence that a person has abused, neglected, or exploited an incapacitated or dependent adult, resulting in serious harm (Maine Revised Statutes, Title 22, chapter 958-A, subsection 3485 (1) and (2)).

The State agency did not investigate all critical incidents involving potential abuse or neglect or provide the findings and recommendations of all investigations it conducted to the community-based providers. Furthermore, 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 through EIS 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. The State agency accepted for investigation 767 (5 percent) of the 15,897 critical incidents. Although the State agency accepted 767 incidents for investigation, officials from five community-based providers informed us that they were generally not

provided with investigative findings or recommendations by the State agency.[22] See Tables 2 and 3 and Appendix F for further details.

Table 2: Number of Critical Incidents Involving Potential Abuse or Neglect Reviewed by the State Agency

Category	Accepted for Investigation	Not Accepted for Investigation[23]	Total
Physical or Verbal Abuse	306 (5%)	6,011 (95%)	6,317
Neglect	262 (30%)	614 (70%)	876
Nonsexual Exploitation	113 (35%)	214 (65%)	327
Sexual Abuse or Sexual Exploitation	79 (27%)	217 (73%)	296
Medication Management Errors[24]	7 (0.1%)	8,074 (99.9%)	8,081
Total Investigations	**767 (5%)**	**15,130 (95%)**	**15,897**

[22] The five community-based providers made 1,655 reports of allegations of abuse, neglect, or sexual and nonsexual exploitation but were only able to provide us with 19 investigation reports from the State agency. We did not confirm with the remaining community-based providers whether the State agency provided the results of other investigations to them.

[23] 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 that the State agency (1) completed an assessment for 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.

[24] We reviewed 13,039 critical incident reports related to medication issues and determined that 8,081 of these involved potential abuse, neglect, or rights violations. Specifically, the incidents involved a failure to provide medical attention or necessary medication. See Appendix F for further details.

Table 3: Result of Actions Taken by the State Agency on Critical Incidents Involving Allegations of Potential Abuse or Neglect Referred for Investigation

Action Taken[25]	Number	Percentage of Accepted Investigations	Percentage of Total Incidents
Allegations Substantiated	140	18%	0.88%
Allegations Unsubstantiated	126	17%	0.79%
Failure To Substantiate Allegations	145	19%	0.91%
No Disposition of Allegations Indicated in EIS	134	17%	0.84%
Allegations Referred to Regional or District Office	90	12%	0.57%
Accepted Provider Resolution of Allegations	128	17%	0.80%
Allegations Referred to Other Agencies	4	0%	0.03%
Total Investigations[26]	**767**	**100%**	**4.82%**

We visited the State agency district offices and met with State agency senior staff and incident data specialists to review critical incident reports, assessments, and other EIS reports for all 296 critical incidents involving sexual abuse or sexual exploitation. The State agency informed us that any referrals to district attorneys' offices should be documented in EIS. During our review process, we found evidence in EIS that 5 of the 296 incidents were referred to the appropriate district attorney's office. However, it was not always clear in the critical incident reports, assessments, and other EIS records whether the State agency or other parties made these referrals. We also noted that the State agency does not maintain a list of incidents that were referred to a district attorney's office.

In addition, we selected 44 critical incident reports involving sexual abuse or sexual exploitation, neglect, physical or verbal abuse, and nonsexual exploitation that were investigated and resulted in substantiated findings. We reviewed the reports, assessments, and other EIS records provided by the State agency to determine if it notified the appropriate district attorney's office or law enforcement agency. Of the 44 critical incident reports, we found evidence in EIS that 21 critical incidents (48 percent) were referred to a district attorney, law enforcement, or both. However, it was not always clear in the critical incident reports, assessments, and other EIS records whether the State agency or other parties made these referrals. We were unable to verify that the remaining 23 reports (52 percent) were referred to the appropriate district attorney's office or law enforcement agency.

[25] "Unsubstantiated" means that while abuse or neglect may be found by a preponderance of the evidence, the individual named as the perpetrator is not responsible or is not the cause of the abuse or neglect. "Failure to Substantiate Allegations" means that the State agency investigator cannot find, by a preponderance of evidence, that acts or omissions that constitute abuse, neglect, or exploitation actually occurred.

[26] The information contained in Table 3 is for informational purposes only. We did not review these investigations and, therefore, are not expressing an opinion on them.

The State agency did not provide a complete explanation of why it did not investigate all allegations of abuse, neglect, or exploitation or immediately report such critical incidents to the appropriate district attorney's office. Various State agency officials indicated that these problems occurred in part because the State agency reorganized, the wording of the HCBS waiver needed to be revised, the State agency generally did not investigate resident-on-resident incidents, and it did not believe medication management errors always met the definition of neglect.[27] In addition, State agency officials informed us that investigative findings and recommendations were not always provided to the community-based providers due to confidentiality concerns. Accordingly, the State agency did not ensure that Medicaid beneficiaries were adequately protected from potential abuse or neglect.[28]

A Representative Example of an Uninvestigated Critical Incident Involving Potential Abuse or Neglect

The State agency did not investigate two separate allegations of potential abuse of a beneficiary at a community-based provider.

The first critical incident report stated that the beneficiary told a mandated reporter that she was uncomfortable with one of the community-based provider's staff because of the way he touched her. According to the critical incident report, when the beneficiary was in the bathroom "to get something off of her face," the staff person gave her a hug and "touched her butt." The beneficiary also stated that when this staff person was with her, he held her hand, pushed her onto his lap, and rubbed her leg.

A second critical incident report was filed a week later by a different mandated reporter regarding the same two allegations. It stated again that the same staff person "touched her bottom" and squeezed her "butt cheeks." The beneficiary told the second mandated reporter that the touching was inappropriate. The beneficiary also told the second mandated reporter that these allegations had already been reported but she did not feel anything was being done. The beneficiary stated that the staff person had been moved to the other side of the home where other female residents live. Because the staff person was still on the property, the beneficiary reported feeling "very shaken." The beneficiary said that the staff person was now spending time near where her friend resides.

[27] We refer to critical incidents in which both the alleged victim and perpetrator are residents with developmental disabilities of community residences as "resident-on-resident" incidents. These residents may have resided in the same or different community residences. We reviewed 473 total incidents involving resident-on-resident sexual abuse, sexual exploitation, or physical or verbal abuse. We determined that the State agency only accepted four of these incidents for investigation. See Appendix F for details.

[28] See Appendix G for a detailed example.

In that second critical incident report, the beneficiary also implied that there was a pattern to this staff person's behavior. She said on a separate occasion that the staff member held her hand inappropriately ("as couples would"), told her to sit on his lap, physically pulled her onto his lap, and rubbed her thigh while asking, "Do you like that, does that feel good?" The beneficiary reported that she then removed herself from this situation. The second mandated reporter did not think the incident was ever reported to the police.[29]

According to the community-based provider, "the beneficiary [has] a long history of making false accusations against male staff as a way of managing difficult emotions." Despite this, the State agency should have immediately investigated these incidents and reported them to a district attorney's office because allegations of potential abuse had been made on behalf of the beneficiary.

THE STATE AGENCY DID NOT ENSURE THAT COMMUNITY-BASED PROVIDERS REPORTED ALL BENEFICIARY DEATHS AND THAT THE STATE AGENCY ANALYZED, INVESTIGATED, AND REPORTED THESE DEATHS TO LAW ENFORCEMENT OR THE OFFICE OF CHIEF MEDICAL EXAMINER

Every death of an adult with developmental disabilities or autism, regardless of cause, must be immediately reported by community-based providers to the State agency (HCBS waiver, Appendix G(b)).

The State agency official must obtain "as much specific information" as possible from the person making the critical incident report. This specific information should include the nature and extent of the alleged abuse, neglect, or exploitation or the facts demonstrating the substantial risk thereof and nature and gravity of the condition or injury resulting from the reported abuse, neglect, or exploitation (14-197 Code of Maine Rules, State agency, chapter 12, 6.04 (C)(3)).

All critical incidents except medication errors and restraint usage must be forwarded by the State agency's regional office staff for review to the adult protective services unit of the State agency. The quality assurance unit of the State agency must review aggregate reports and search for trends that may need to be addressed by the State agency. Furthermore, an adult protective investigation must take place for all allegations of abuse, neglect, or exploitation (HCBS waiver, Appendix G-1(d)).

The State must demonstrate on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death (of beneficiaries covered under the waiver). The State agency must review deaths to determine the number and

[29] We were unable to determine from EIS if these allegations were immediately reported to a district attorney's office.

percentage of unexplained, suspicious, and untimely deaths for which investigations resulted in the identification of preventable causes (HCBS waiver, Appendix G, subsection (a)(i)(a)).
A person required to report cases of known or suspected abuse or neglect who knows or has reasonable cause to suspect that an adult has died because of abuse or neglect must report that fact to a law enforcement officer or OCME. A "person" includes public servants, corporations, partnerships, any other legal entity, and any governmental unit (Maine Revised Statutes, Title 22, chapter 958-A, subsection 3478; chapter 711, subsection 3026 (1)).

The State agency did not ensure that community-based providers properly reported all beneficiary deaths. The community-based provider did not report 1 of the 133 beneficiary deaths to the State agency. Furthermore, the State agency's Mortality Review Committee[30] did not take action on 7 of the 132 (5 percent) reported beneficiary deaths specifically because of the lack of information in the critical incident reports submitted by the community-based providers.[31]

In addition, the State agency did not review all deaths or review aggregated death reports to search for trends that it must address; did not demonstrate on an ongoing basis that it identified, addressed, or sought to prevent instances of untimely death; and did not determine the number and percentage of unexplained, suspicious, and untimely deaths for which investigations resulted in the identification of preventable causes.

The State agency maintained that its Mortality Review Committee reviewed 54 of the 133 total beneficiary deaths. However, the State agency was only able to provide us with a spreadsheet containing those 54 beneficiary names and some general information regarding each death.[32] This spreadsheet did not contain the details of the State agency's review. It did not specify any trends the State agency identified, what its reviews entailed, or the outcomes of the reviews,

[30] According to the State agency, its Mortality Review Committee reviews significant or serious events related to beneficiary deaths. The State agency was unable to provide any documentation regarding the Mortality Review Committee's frequency of meetings or minutes of meetings during our audit period.

[31] The "Death and Mortality Workflow" flowchart, dated August 14, 2014, provided by the State agency's Mortality Review Committee indicates that a death report not completed to State agency guidelines should be returned to the beneficiary's case manager for completion. Despite our requests, the State agency's Mortality Review Committee did not provide us details of the review process in effect from January 1, 2013, through August 13, 2014.

[32] The State agency's Mortality Review Committee spreadsheet contained the beneficiaries' names, dates of death, preliminary cause of death (if available), general action taken (if any) by the Mortality Review Committee, whether the death was anticipated (if known), and whether an autopsy was requested. However, many of the data fields in this spreadsheet were blank. A Death and Mortality Review Assessment was also completed in EIS by the beneficiary's case manager for 70 (53 percent) of the 133 beneficiary deaths. These assessments summarized the information that was submitted in the critical incident report for the beneficiary death, the events preceding the beneficiary's death, the beneficiary's medical history, and other personal information. The assessments also did not include recommendations, corrective actions, preventable causes, or a determination of whether the death involved potential abuse or neglect.

including potential corrective actions.[33] Furthermore, the State agency did not investigate any deaths of beneficiaries with developmental disabilities involving allegations of abuse, neglect, or exploitation and did not immediately report these beneficiary deaths to the appropriate district attorney's office or OCME.[34]

We, therefore, reviewed the critical incident reports for each of the 133 beneficiary deaths. Specifically, we compared the information contained in the critical incident reports with the State's requirements regarding potential abuse and neglect, including State laws, regulations, and other guidance, such as training material. Our review of the critical incident reports found that 9 of the 133 beneficiary deaths were unexplained, suspicious, and untimely,[35] and corrective action could have been taken or preventable causes could have been identified for some of these beneficiary deaths, especially those that resulted from a lack of training of community residence staff or a delay in care (Appendix H). An additional 32 (24 percent) of the 133 beneficiary death critical incident records in EIS did not contain enough information for us to make a determination of whether the deaths were unexplained, suspicious, and untimely.[36]

State agency officials said that the State agency did not ensure that all beneficiary deaths were appropriately reported, investigated, analyzed, and reported to law enforcement or OCME as appropriate because the State agency does not generally investigate beneficiary deaths, even if the deaths involve allegations of abuse, neglect, or exploitation. Instead, the State agency maintained that all beneficiary deaths were initially reviewed by OCME and investigated if they met the OCME's criteria for accepting cases, and some deaths were referred to and investigated by law enforcement if criminal acts were suspected. Accordingly, the State agency did not ensure that Medicaid beneficiaries with developmental disabilities were adequately protected.

[33] The spreadsheet stated that no further action was taken regarding the 54 beneficiary deaths.

[34] OCME informed us that it receives all reported deaths in Maine and typically reviews or investigates sudden, unexpected, or violent deaths. It reviewed 13 of the 133 beneficiary deaths through its normal review process, but it did not identify potential abuse or neglect in these 13 beneficiary deaths. OCME further stated that its primary objective is to determine the cause and manner of death, but it will typically forward any cases involving potentially criminal acts or negligence to the State's Health Care Crimes Unit within the Attorney General's office. However, we noted that the State's Health Care Crimes Unit did not investigate any of the 133 beneficiary deaths. The State agency also confirmed that none of the 133 beneficiary deaths had investigations opened by law enforcement. Law enforcement officers responded to the emergency calls for 10 (8 percent) of the beneficiary deaths, but the State agency said law enforcement did not open any investigations.

[35] Three of the nine beneficiary deaths we identified were reviewed by the State agency's Mortality Review Committee.

[36] The State agency's Mortality Review Committee did not provide an explanation for why it did not take any further action regarding these 32 beneficiary deaths.

A Representative Example of an Uninvestigated Beneficiary Death Involving Potential Abuse or Neglect

A beneficiary of a community-based provider fell in the bathtub while she was unattended and drowned. The critical incident report indicated that a staff person was physically assisting the beneficiary and that the beneficiary "pushed" the staff person away; therefore, the staff person gave the beneficiary time alone. According to the staff person, she checked on the beneficiary 5 minutes later and was again "pushed away," so the staff person left the bathroom and went into the office area inside the residence. The staff person stated that she subsequently heard a "thud" and immediately went into the bathroom where she found the beneficiary with her face under water and her arm over the side of the tub. The residence staff reported that they immediately contacted emergency personnel and tried to resuscitate the beneficiary. Attempts to revive the beneficiary were unsuccessful. OCME later determined the beneficiary died because of accidental drowning.

The beneficiary's death was not investigated by the State agency as an untimely death. Therefore, preventable causes, such as the lack of bathing safety or adequate beneficiary monitoring, were not identified.

CAUSES OF NONCOMPLIANCE WITH FEDERAL WAIVER AND STATE REQUIREMENTS

The State agency did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents for a variety of reasons. Specifically, the State agency did not appropriately report all rights violations and restraint usage to DRM because the State agency believed that providing DRM access to EIS was sufficient for reporting rights violations. State agency employees also selected incorrect categories of critical incident in EIS, which prevented reports of potential rights violations from being sent to DRM. State agency officials indicated that the State agency did not investigate and report immediately to the appropriate district attorney's office or law enforcement all critical incidents involving suspected abuse, neglect, or exploitation because the State agency underwent a reorganization, the language of the HCBS waiver needed to be revised, the State agency did not generally investigate resident-on-resident critical incidents, and the State agency did not believe that medication management errors constituted neglect. Further, the State agency did not investigate beneficiary deaths because officials believed instead that OCME, law enforcement, or both did so if the beneficiary deaths met the respective agencies' criteria for accepting cases. The State agency was unable to explain why the other conditions we identified occurred.

Accordingly, the State agency did not fulfill numerous participant safeguard assurances it provided to CMS in its Medicaid HCBS waiver. Therefore, the State agency failed to demonstrate that it has a system to ensure the health, welfare, and safety of the 2,640

Medicaid beneficiaries with developmental disabilities covered by the Medicaid waiver in accordance with 42 CFR 441.302(a).

RECOMMENDATIONS

We recommend that the State agency fully implement its own regulations regarding the reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community residences. Specifically, we recommend that the State agency:

- work with community-based providers on how to identify and report all critical incidents;
- work with community-based providers to ensure that administrative reviews are conducted and reported appropriately;
- report appropriately all restraint usage and rights violations to DRM;
- perform trend analysis and analytical procedures, such as a data match, to provide community-based providers with reports that identify patterns and trends to prevent reoccurrences of critical incidents and determine the number and percentage of critical incidents reported in required timeframes;
- investigate and immediately report to the appropriate district attorney's office or law enforcement all critical incidents involving suspected abuse, neglect, or exploitation;
- ensure community-based providers report to the State agency all beneficiary deaths and that the State agency analyzes, investigates, and reports these deaths to law enforcement or OCME; and
- provide training to the State agency's and community-based providers' staffs regarding the HCBS waiver and State requirements for critical incident reporting.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed with our second and fourth findings and partially agreed with our third and sixth findings. However, the State agency disagreed with our first and fifth findings.

In addition, the State agency generally agreed with our first, second, third, fourth, and seventh recommendations and partially agreed with our fifth and sixth recommendations. Specifically, it agreed to:

- work with community-based providers to ensure that all critical incidents are reported;

- work with community-based providers to clarify expectations related to administrative reviews and reporting known or suspected abuse, neglect, and exploitation;

- provide DRM with monthly summary reports on restraints;

- perform trend analysis on a regular basis, including manual data matches, and meet quarterly with each community-based provider agency to share the trend analysis findings;

- provide training to staff to ensure referrals to law enforcement and district attorney's offices are made appropriately and documented concurrently;

- work with community-based providers to ensure that no beneficiary deaths remain unreported in the future; and

- provide training to the staff at the State agency and community-based providers regarding the HCBS waiver and State requirements for critical incident reporting.

We appreciate that the State agency is taking these steps to address our recommendations. However, we maintain that the State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities. Therefore, the State agency failed to demonstrate that it has a system to ensure the health, welfare, and safety of the 2,640 Medicaid beneficiaries with developmental disabilities covered by the HCBS waiver. Below is a summary of the State agency's concerns with the draft report and comments on the findings, as well as our response to those concerns and comments.

The State agency's comments appear in their entirety as Appendix I.

REQUESTED CHANGES TO THE DRAFT REPORT

State Agency Comments

The State agency stated that it agreed in part with multiple findings and has already adopted many of our recommendations. However, the State agency noted that the draft report "contains some inaccurate information and unclear methodology" and requested the following changes to the draft report:

- The State agency stated that the draft report included "multiple references to statements made by 'State agency officials' that are not representative of the State agency's position on certain topics." The State agency requested that the references to verbal statements or opinions from State agency officials be removed from the draft report as "the data collected during the audit can speak for itself."

- The State agency noted that many of the representative examples related to each finding, as well as Appendix G, "Critical Incident Detailed Example," and Appendix H, "Summary of Nine Unexplained, Suspicious, or Untimely Beneficiary Deaths Not Reviewed or Investigated by the State Agency," contain "sufficient detail that may allow individuals familiar with the events, such as caregivers, beneficiaries, and beneficiaries' family members, to recognize the specific incidents being described." The State agency requested that the level of detail within the examples be reduced to respect the privacy of individuals served by the State agency.

- The State agency requested that Appendix C, "Federal Waiver and State Requirements," be amended to incorporate full quoted text from Maine's HCBS waiver application, statutes, and State agency rules (Code of Maine Rules), rather than paraphrased information.

Office of Inspector General Response

For the following reasons we did not make the State agency's first two requested changes to our draft report, but we modified our draft report to include the full quoted text from the Federal waiver and State requirements to address the third requested change:

- We did not remove the references to verbal statements made by State agency officials in response to our queries during the audit. We acknowledged in the draft report that State agency officials gave us various reasons why the State agency did not comply with the Federal waiver and State requirements. For this reason, we requested on multiple occasions that the State agency provide an explanation in writing as to why it did not comply with these requirements. In fact, the State agency informed us throughout our audit that it was going to give us written "remedial steps" in response to our preliminary audit findings. However, the State agency never gave us that documentation. For report clarification purposes, we emailed the State agency on February 24, 2017, to ask the State agency to provide a written response explaining why the conditions that we identified occurred. The State agency stated it would respond in its written comments to the draft report.

- We do not believe the level of detail we use exposes protected personally identifiable information. We further maintain that the level of detail within the representative examples related to each finding, as well as in our Appendices G and H, is necessary to describe the specific incidents.

FINDING 1—COMMUNITY-BASED PROVIDERS DID NOT REPORT ALL CRITICAL INCIDENTS TO THE STATE AGENCY

State Agency Comments

The State agency disagreed that OIG's findings related to this topic support the conclusion that the State failed to comply with Federal and State requirements. Specifically:

- The State agency expressed concerns with the limited definition of "serious illness or injury" in the draft report and requested that we include the full definition as it appears in the HCBS waiver. The State agency also maintained that every emergency room visit does not meet the definition of a "serious injury or illness." The State agency stated, "It appears that the OIG is equating emergency room visits with hospitalizations, which is inaccurate."

- The State agency questioned the reasonableness of our methodology to identify "high-risk critical incidents" and our conclusions based on this methodology. The State agency stated our draft report suggests that the 104 high-risk critical incidents "should have been reported by mandated reporters as suspected abuse or neglect, based solely on the diagnosis codes associated with each emergency room visit." The State agency maintains that we determined emergency room visits that included any of the 50 codes on our diagnosis code list had to be reported to the State agency as suspected abuse, neglect, or exploitation and that the criteria used to establish the diagnosis code list and the expertise of those involved in developing the list are unclear. The State agency also requested that we indicate whether medical professionals were consulted to develop the "high risk critical incident" diagnosis code list.

- The State agency disagreed with our conclusion that "the State agency and DRM were not always able to pursue legal, administrative, and other appropriate remedies to protect and advocate for the rights of individuals with developmental disabilities under all applicable Federal and State laws because not all critical incidents were reported to them." The State agency maintained that DRM does not have a role in responding to reports of serious illness or injury.

Notwithstanding the issues it had with our analysis, the State agency recognized that not every critical incident during the audit period was reported to the State agency by community-based providers. Further, the State agency recognized that emergency room visits can, and regularly do, meet the definition of "serious illness or injury" as set out in the waiver application. The State agency also stated it is engaged in ongoing communication with community-based provider agencies to improve critical incident reporting.

Office of Inspector General Response

We maintain that our finding is valid for the following reasons:

- On the basis of the State agency comments, we included in the body of the report and in Appendix C the full definition of "serious illness or injury." We believe the modified definition supports our conclusion that all 2,243 emergency room visits met the State definition of a "critical incident." In addition, the modified definition is consistent with the State agency's critical incident instructions for completing reportable event forms, as well as the State agency's reportable event training to community-based providers.

Community-based providers must report "serious illness and injuries that include any change in medical conditions caused by an accident or illness that requires medical attention, including initial emergency room visits."[37] The *State Agency Office of Aging and Disability Services Reportable Events Training* also noted that serious or significant illness or injuries that include any change in medical condition caused by an accident or illness that require medical attention, including initial emergency room visits, need to be reported by community-based providers.

- We disagree that our draft report suggests that all 104 high-risk critical incidents should be reported as suspected abuse or neglect. We maintain that all 104 incidents should have been reported as critical incidents by the community-based providers to the State agency. We also brought to the State agency's attention our observation that hospital-based mandated reporters did not report any of the 104 high-risk critical incidents to the State agency, even though they were associated with diagnosis codes that we determined to be indicative of a high risk for suspected abuse or neglect. We did not consult with medical professionals to identify the 50 high-risk diagnosis codes listed in Appendix D. Rather, as discussed in footnote 6, we believe these codes were indicative of an increased risk of abuse or neglect, as the codes involved head injuries, bodily injuries, certain medical services, and safety issues. These high-risk conditions were similar to many of the causes of the death identified in the Connecticut Office of Protection and Advocacy's 2012 report reviewing the deaths of individuals with developmental disabilities in that State. This report is publicly available on Connecticut's website. We modified footnote 6 to reflect this fact.

  We also provided the medical records for the 104 high-risk critical incidents to the State agency's medical staff to make a determination of whether these emergency room visits represented critical incidents. The State agency's medical staff confirmed that the community-based providers should have reported all 104 emergency room visits as critical incidents.

- We respectfully disagree with the State agency's assertion that DRM does not have a role in responding to reports of serious illness or injury. All rights violations, including all incidents of abuse, neglect, and exploitation, must be sent to DRM, and DRM must be provided access to all critical incident reports (HCBS waiver, Appendix G-1(d); 14-197 Code of Maine Rules, State agency, chapter 12, 6.03 (F)(2) and (4)).

  We recognize that not all critical incidents for serious illness or injury that resulted in emergency room visits involved potential abuse or neglect. A determination of whether abuse or neglect caused these critical incidents would typically require an investigation. Our review was limited to assessing whether the State agency appropriately responded to critical incidents, and we did not investigate critical incidents to determine if abuse or neglect occurred. However, some of the 104 undetected high-risk critical incidents that

[37] *Department of Health and Human Service Adult Developmental Services Reportable Events, Instruction for Completing the Reportable Event Form*, September 2014.

we reviewed may have involved potential abuse or neglect that required additional analysis and may have required an investigation.

Using the 50 high-risk diagnosis codes, we identified that hospitals treated 82 beneficiaries for severe injuries involving broken bones, lacerations, and abrasions to the head and body that could have been the result of abuse or neglect, as well as life-threatening medical or safety issues. However, we determined that the State agency did not receive any critical incident reports from the community-based providers related to these critical incidents. In addition, based on our review, we determined that the State agency did not receive a report from other mandated reporters, such as doctors, nurses, social workers, and other treatment staff, who had reasonable cause to suspect that the incapacitated or dependent adult had been or was likely to be abused, neglected, or exploited, for any of the 104 high-risk critical incidents. As a result, the State agency was unable to evaluate any of the 104 high-risk critical incidents to determine if an investigation was required because the critical incidents involved potential abuse or neglect or if the incidents should have been reported to DRM. In addition, the State agency could not analyze the critical incidents to identify patterns and trends and to prevent reoccurrences of the incidents.

We appreciate the State agency's commitment to ensuring that community-based providers accurately report critical incidents. We also appreciate that the State agency's written comments recognize that emergency room visits can, and regularly do, meet the definition of a serious illness or injury as set out in the waiver application.

FINDING 2—COMMUNITY-BASED PROVIDERS DID NOT CONDUCT ADMINISTRATIVE REVIEWS OF ALL CRITICAL INCIDENTS INVOLVING SERIOUS INJURY, DANGEROUS SITUATIONS, OR SUICIDAL ACTS AND SUBMIT THEIR FINDINGS WITHIN 30 DAYS

State Agency Comments

The State agency agreed with this finding and acknowledged that community-based providers did not forward to the State agency copies of administrative reviews conducted related to reportable events for event categories not involving known or suspected abuse, neglect, or exploitation. The State agency stated that it is in the process of updating its rules and that the updated rules will contain a requirement that community-based providers electronically document the corrective actions taken by providers following each reportable event. In addition to formally updating applicable rules, the State agency has issued a notice to community-based provider agencies to clarify expectations related to administrative reviews and reporting known or suspected abuse, neglect, and exploitation.

Office of Inspector General Response

We commend the State agency for agreeing to work with community-based providers to ensure that administrative reviews are conducted and reported appropriately.

FINDING 3—THE STATE AGENCY DID NOT REPORT ALL RESTRAINT USAGE AND RIGHTS VIOLATIONS TO DISABILITY RIGHTS MAINE

State Agency Comments

The State agency partially agreed with the finding that it did not report all restraints and rights violations, including all incidents of abuse, neglect, and exploitation, to DRM. Specifically, the State agency acknowledged that it did not forward all critical incident reports on restraints and rights violations to DRM but noted that DRM was provided access to the reports through EIS. The State agency stated that our draft report "suggests that providing access to reports through an electronic system is not equivalent to forwarding individual reports to DRM." The State agency maintained that "DRM was not precluded from performing its protection and advocacy role by given means to access individual reports rather than receiving reports separately forwarded by the State agency." The State agency also stated that it began forwarding a monthly summary report to DRM on restraints in January 2017.

Office of Inspector General Response

The HCBS waiver requires that all restraints and rights violations, including all incidents of abuse, neglect, and exploitation, must be sent to DRM (Appendix G-1, *Participant Safeguards: Responsibility for Review of and Response to Critical Events or Incidents*, G-1(d) "Department Responsibilities for Receiving and Referring Reports"). State requirements also state that DRM must be provided access to all critical incident reports (14-197 Code of Maine Rules, State agency, chapter 12, 6.03 (F)(2) and (4)), a monthly summary of the use of restraints must be sent to DRM (Maine Revised Statutes, Title 34-B, chapter 5, subchapter 4, § 5605(14-A)), and the State agency must promptly report suspected rights violations in a separate report to DRM (14-197 Code of Maine Rules, State agency, chapter 12, 6.04 (F)(4)). The State agency did not meet all of these requirements. We agree that the State agency identified in its HCBS waiver that it would use EIS to collect and analyze reports of critical incidents. However, we continue to maintain the validity of our finding.

In addition, while DRM officials confirmed that they do have access to EIS, they also noted that it is difficult to monitor the use of improper or unauthorized restraints unless they are informed when the specific incidents occurred. In this regard, thousands of critical incident reports for restraint usage are submitted to the State agency each year, and DRM does not have the resources to continually monitor EIS for submitted reports. Accordingly, we commend the State agency for starting to send monthly summary reports on restraints to DRM after our audit concluded. We also modified our draft report to include details of our discussions with DRM officials.

FINDING 4—THE STATE AGENCY DID NOT REVIEW AND ANALYZE DATA ON ALL CRITICAL INCIDENTS

State Agency Comments

The State agency agreed with our finding and acknowledged that formal trend analysis and claims data comparisons were not performed on a regular basis during the audit period. However, the State agency stated that it currently performs trend analysis on a regular basis and conducts quarterly meetings with each community-based provider agency to share its findings. The State agency noted that the definition of "medication error" in effect during our audit period broadly covered many medication-related incidents that are routine (e.g., a client declining to take a daily vitamin) and stated that it intends to adjust the definition so that valuable information can be drawn from future trend analyses.

Office of Inspector General Response

We commend the State agency for currently performing trend analysis on a regular basis and discussing the results of the analysis with community-based providers. We also commend the State agency for planning to update its definition of "medication error." We acknowledge that 4,958 (38 percent) of the 13,039 critical incident reports submitted during our audit period for medication issues involved routine incidents such as beneficiaries' refusal of medication. However, the remaining 8,081 (62 percent) involved potential abuse, neglect, or rights violations because they involved failure to provide medical attention or necessary medication. As detailed in Table 9 in Appendix F, these incidents included not providing medication to beneficiaries, as well as providing medications with incorrect doses or medication type, at incorrect times, or to the incorrect beneficiary. We noted that the State agency only investigated 7 (0.1 percent) of these 8,081 incidents. By updating the definition to differentiate between routine and nonroutine incidents, we believe the State agency will be better able to identify which medication management errors involve potential abuse or neglect and require an investigation.

FINDING 5—THE STATE AGENCY DID NOT INVESTIGATE OR IMMEDIATELY REPORT TO A DISTRICT ATTORNEY'S OFFICE OR LAW ENFORCEMENT CRITICAL INCIDENTS INVOLVING POTENTIAL ABUSE, NEGLECT, OR EXPLOITATION

State Agency Comments

The State agency disagreed with our finding that it did not investigate and report immediately to the appropriate district attorney's office or to law enforcement all critical incidents involving suspected abuse, neglect, or exploitation. Specifically:

- The State agency stated that our draft report indicated 767 of 15,897 critical incidents related to potential abuse or neglect during the audit period were "accepted for investigation." The State agency noted that, during the audit period, "accepted for investigation" was a technical term within its electronic systems to express that a

caseworker or investigator was assigned to conduct an in-depth investigation. The State agency asserted that every report involving allegations of abuse, neglect, or exploitation, whether or not ultimately "accepted for investigation," underwent an assessment within the State agency. The State agency stated that reported allegations during our audit period were evaluated by State agency staff and regularly referred to Adult Protective Service Unit (APS) supervisors for further review. The State agency maintained that the language in the draft report suggests that the State agency failed to entirely evaluate or assess 95 percent of critical incidents reporting suspected abuse or neglect and that this finding is inaccurate unless the draft report clarifies the steps in the State agency's assessment process, including a more comprehensive definition of the word "investigate."

- The State agency maintains that Maine Revised Statutes, Title 22, chapter 958-A, *Adult Protective Services*, subsection 3485, cannot be interpreted to mean that every report involving suspected abuse, neglect, or exploitation must be relayed to district attorneys' offices. Rather, the State agency states that it is required to notify the appropriate district attorney's office or law enforcement when a crime is suspected based on the information the State agency receives or based on the evidence obtained during the course of an investigation.

- The State agency noted that the draft report included multiple statements attributed to State agency officials on this finding. The State agency suggested that verbal representations or opinions from unnamed State agency staff on an undisclosed date should not serve to support audit findings focused on data. The State agency questioned the following statements:

    - The State agency noted that the draft report states, "The State agency informed us that any referrals to district attorneys' offices should be documented in EIS." The State agency stated that it is unable to confirm whether any State agency official made the above statement, and, if such a statement had been made, that it was in error. The State agency stated that a note that a referral was made to a district attorney's office may be included in EIS, but referral information generally would appear in the APS investigation tracking system. The State agency added that the finding is indeterminate if we relied on EIS data alone, without consulting the APS investigation tracking system to support this finding.

    - The State agency also noted that the draft report states, "State agency officials informed us that investigative findings and recommendations were not always provided to the community-based providers or the district attorneys' offices due to confidentiality concerns." The State agency maintained that this is an inaccurate statement. The State agency stated that investigative findings and recommendations are not forwarded to community-based providers because Maine Revised Statutes, Title 22, chapter 958-4, *Adult Protective Services Act*, subsection 3474, protects the confidentiality of adult protective records and

limits their disclosure. However, the State agency explained that such records are in fact shared with district attorneys' offices pursuant to this statute.

- The State agency agreed that law enforcement and district attorneys' offices must be notified of reports related to known or suspected abuse, neglect, and exploitation and investigations of the same that indicate a crime may have been committed. The State agency recognized that, during the audit period, referrals to law enforcement and district attorneys' offices were not documented electronically in a consistent way. Accordingly, the State agency will continue to provide training to staff to ensure that referrals to law enforcement and district attorneys' offices are made appropriately and documented concurrently.

Office of Inspector General Response

We maintain that our finding is valid. Specifically, for the following reasons we maintain that the State agency did not investigate and report immediately to the appropriate district attorney's office or to law enforcement all critical incidents involving suspected abuse, neglect, or exploitation:

- We do not dispute that some level of review was performed by the State agency, whether it was an evaluation by State agency staff or a referral to an APS supervisor for further assessment. We modified our draft report to include the definition of an investigation and to add further clarification of the assessment process in footnote 19. However, Appendix G-1(d) of the HCBS waiver states that an adult protective investigation must take place for all allegations of abuse, neglect, or exploitation and that the investigation's findings and recommendations must be submitted promptly to the community-based provider. We do not believe that an evaluation or assessment by State agency staff or an APS supervisor is equivalent to a formal investigation. An "investigation" is defined as the process of gathering and evaluating facts, as well as making findings and documenting conclusions regarding the capacity, dependency, and danger or substantial risk of danger, including the ability to give informed consent, regarding a person with developmental disabilities (14-197 Code of Maine Rules, State agency, chapter 12, 6.02 (BB)). Chapter 12, 6.04 (G)(2) also states that a written report shall be prepared in all assigned investigations and that "the written report shall . . . set forth the findings, conclusions and recommendations." In addition, Chapter 12, 6.04 (J)(1) states, "For all APS Investigations, the APS Unit shall make recommendations to protect individuals, as well as for preventative and corrective action. . . ." Further, chapter 12, 6.04 (I) states that findings that may be made by an APS investigator include failure to find neglect or abuse, not substantiated, substantiated level I, substantiated level II, and program substantiation. Because the incidents in question were not assigned to an investigator and there was not a written report with findings, conclusions, and recommendations, we maintain that our finding is valid.

- We disagree with the State agency's interpretation of the applicable statute. Maine Revised Statutes, Title 22, chapter 958-A, *Adult Protective Services Act*, subsection 3485,

"Reporting Abuse," (1) "Immediate Report," states that "when the [State agency] receives a report . . . that a person is suspected of abusing, neglecting, or exploiting an incapacitated or dependent adult, the [State agency] shall immediately report the suspected abuse, neglect, or exploitation to the appropriate district attorney's office, whether or not the State agency investigates the report." The statute states that all reports of suspected abuse, neglect, or exploitation must be immediately reported to the appropriate district attorney's office. The statute specifically does not exempt reports of suspected abuse or neglect if the State agency chooses not to investigate. As a result, the statute implements a broad requirement to report suspected abuse, neglect, and exploitation to appropriate district attorneys.

- The verbal representations or opinions from State agency staff are not the sole basis for our findings. Specifically:

    - We provided the State agency with a list of critical incidents involving sexual abuse and asked the State agency to identify which incidents were referred to the appropriate district attorney's office or law enforcement. The State agency did not respond to this request. Therefore, we visited the State agency district offices and met with State agency officials, including program administrators and incident data specialists, to review critical incident reports, assessments, and other EIS reports for 296 critical incidents involving sexual abuse or sexual exploitation. The State agency staff informed us that any referrals to district attorneys' offices should be documented in EIS. The staff showed us all relevant documentation for the 296 incidents, including the APS investigation tracking system record when appropriate. However, the staff also informed us that the APS investigation tracking system was not used by the State agency for our entire audit period because it was not implemented until July 2014. During our review of this documentation, we found evidence that 5 of the 296 incidents were referred to the appropriate district attorney's office.

      In addition, we selected 44 critical incident reports involving sexual abuse or sexual exploitation, neglect, physical or verbal abuse, and nonsexual exploitation that were investigated and resulted in substantiated findings. We asked the State agency if it notified the appropriate district attorney's office or law enforcement agency for any of the 44 incidents. In response, the State agency provided us with reports, assessments, and other EIS records so that we could determine which incidents were referred. During our review of this documentation, we found evidence that 21 of the 44 incidents were referred to the appropriate district attorney's office or law enforcement agency.

      We also noted that the State agency did not maintain a list of incidents that were referred to a district attorney's office or law enforcement. Since such a list was not available, the review of the documentation made accessible by the State agency served as the basis of our findings. We gave the State agency the opportunity to identify which of the 296 critical incidents involving sexual abuse

or sexual exploitation and the 44 critical incident reports with substantiated findings were referred to a district attorney's office or law enforcement, but it failed to do so.

- We have modified our draft report in response to the State agency's clarification that investigative findings and recommendations are in fact shared with the district attorneys' offices and are not withheld due to confidentiality concerns.

It is also important to note that we have records of all statements made by State agency officials detailed in the report. These records include names, titles, dates, and locations. However, the State agency never requested this information.

We commend the State agency for continuing to provide training to staff to ensure that referrals to law enforcement and district attorneys' offices are made appropriately and documented concurrently.

FINDING 6—THE STATE AGENCY DID NOT ENSURE THAT COMMUNITY-BASED PROVIDERS REPORTED ALL BENEFICIARY DEATHS AND THAT THE STATE AGENCY ANALYZED, INVESTIGATED, AND REPORTED THESE DEATHS TO LAW ENFORCEMENT OR THE OFFICE OF THE CHIEF MEDICAL EXAMINER

State Agency Comments

The State agency partially agreed with our finding that it did not ensure that community-based providers reported all beneficiary deaths and that it analyzed, investigated, and reported these deaths to law enforcement or OCME. Specifically:

- The State agency did not dispute that one beneficiary death was not reported and stated that it intends to work with community-based providers to ensure all beneficiary deaths are reported in the future. However, the State agency neither agreed nor disagreed with our finding that it did not analyze, investigate, or report all beneficiary deaths. Instead, the State agency described its current practice. The State agency initiates a review process when it is notified of a beneficiary death. If abuse, neglect, or exploitation may have been a factor in the death, the State agency conducts an investigation and notifies law enforcement if another party has not done so already. In addition, the Mortality Review Committee meets regularly to conduct trend analysis associated with beneficiary deaths and to determine whether there are any identifiable patterns or trends that can be addressed with community-based providers.

- The State agency requested that we indicate whether medical professionals were consulted as a part of our review process for the 133 beneficiary deaths.

- The State agency requested that we remove two statements about OCME from the draft report. The draft report states "the State agency maintained that all beneficiary deaths were reviewed by the OCME" and "the State agency did not investigate beneficiary

deaths because officials believed that the OCME did so instead." The State agency maintained that these statements do not accurately represent its position.

Office of Inspector General Response

We maintain that our finding is valid for the following reasons:

- The State agency did not investigate any of the 133 beneficiary deaths during our audit period and also confirmed that investigations had not been opened by law enforcement for any of the 133 beneficiary deaths. Furthermore, the State agency did not provide any evidence that the Mortality Review Committee identified any trends associated with beneficiary deaths and discussed these trends with the community-service providers. Although the State agency stated that the Mortality Review Committee reviewed 54 of the 133 beneficiary deaths, the documentation provided by the State agency did not detail what the reviews entailed or the outcome of the reviews, including potential corrective action. While OCME did review 13 of the 133 beneficiary deaths, OCME did not receive referrals from or share the results of the reviews with the State agency. Finally, the State agency described its current practice regarding beneficiary deaths in its written comments to the draft report, but it did not specify if these practices or some other practices were in effect during our audit period.

- We did not consult medical professionals in our review of the 133 beneficiary deaths. Consultation was not necessary because the objective of our review was only to determine whether the State agency's review process for the deaths met Federal and State requirements. To accomplish this objective, we compared the information contained in the critical incident reports with Maine's requirements regarding potential abuse and neglect, including State laws, regulations, and other guidance, such as training material. Based on our review, we identified nine beneficiary deaths that appeared to be unexplained, suspicious, and untimely (Appendix H). We did not make any determinations regarding the cause and circumstances surrounding the deaths or whether abuse or neglect contributed to the deaths.

- The two statements in question regarding the OCME review of beneficiary deaths were first made at a meeting on May 26, 2016, that included various State agency officials, including the director of the Office of Aging and Disability Services. Specifically, State agency officials stated that the State agency does not generally investigate beneficiary deaths and that beneficiary deaths are typically reviewed or investigated by OCME and law enforcement if the deaths meet the respective agency's criteria. We believe that the oral responses to our inquiries represent sufficient, appropriate audit evidence because they were obtained from knowledgeable persons within this State agency and were supported by our review of the records within EIS. Nevertheless, we modified our draft report to further clarify the two statements in question.

As we previously noted, on multiple occasions we requested that the State agency provide an explanation in writing for the causes of all of our audit findings, including the reason it did not

analyze, investigate, and report all beneficiary deaths. Beneficiary deaths represent the most serious critical incidents, and it was of concern that the State agency did not provide evidence that any of the beneficiary deaths were investigated or that any trends or potential corrective actions had been identified. The State agency declined to provide further explanation during our audit. For example, during a meeting with State agency officials on September 22, 2016, we stated that we identified one beneficiary death after our audit period (June 2016) that was investigated by the State agency according to the EIS records. We asked the State agency if its practices regarding the investigation of beneficiary deaths had changed. The State agency responded that it was going to provide a "statement of facts" to clarify its policy but did not provide one before the State agency's written comments on the draft report.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00008	July 2016
Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00002	May 2016
Review of Intermediate Care Facilities in New York with High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries	A-02-14-01011	September 2015

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

The State agency provided services to 2,640 Medicaid beneficiaries with developmental disabilities residing at community-based providers from January 2013 through June 2015. During this period, the State agency received 36,616 critical incident reports involving these 2,640 beneficiaries from community-based providers and other mandated reporters. Of the 2,640 beneficiaries, 705 had 2,264 Medicaid claims representing 2,243 emergency room visits for all diagnosis codes. We reviewed 82 beneficiaries at community-based providers who had 105 emergency room claims for 104 emergency room visits and were diagnosed with at least 1 of 50 conditions that we determined to be indicative of high risk for suspected abuse or neglect. We also reviewed critical incident reports contained in EIS to determine if the State agency followed Federal and State requirements regarding critical incident reporting.

In performing our review, we established reasonable assurance that the claims data contained in the MMIS were accurate. We did not review the overall internal control structure of the State agency. We limited our internal control review to obtaining an understanding of the State agency's policies and procedures related to critical incidents.

We performed our fieldwork at the State agency and community-based provider offices in Auburn, Augusta, Bangor, Hermon, Lewiston, South Portland, and Westbrook, Maine, from October 2015 through December 2016.

METHODOLOGY

To accomplish our audit objective, we:

- reviewed applicable Federal waiver and State requirements;
- held discussions with CMS officials to gain an understanding of the HCBS waiver for beneficiaries with developmental disabilities residing in community-based settings;
- held discussions with officials from various State agencies and DRM to gain an understanding of State policies and controls as they relate to the mandatory reporting of potential abuse and neglect of beneficiaries with developmental disabilities;
- obtained a computer-generated file from the State agency of information on all 2,640 Medicaid beneficiaries with developmental disabilities residing in community-based settings from January 1, 2013, through June 30, 2015;
- extracted a computer-generated file from MMIS containing claims for 2,243 emergency room visits that included 7,348 medical services for 705 Medicaid beneficiaries with developmental disabilities from January 1, 2013, through June 30, 2015;

- reconciled the MMIS claims data to the Maine Medicaid eligibility records to verify the accuracy of the MMIS claims data;

- obtained access to EIS from the State agency;

- compared the EIS data to the MMIS data and medical records to determine which of the 2,243 emergency room visits were not reported to the State agency;

- evaluated claims for 2,243 emergency room visits to identify those that resulted in one or more of the 50 diagnosis codes that indicated an increased risk of abuse or neglect;

- reviewed State agency's files and notes to determine if investigations were conducted;

- reviewed and analyzed the 105 Medicaid emergency room claims that contained at least 1 of the 50 diagnosis codes for the 82 Medicaid beneficiaries with developmental disabilities aged 18 or older who resided in community-based settings in Maine and who had 104 emergency room visits during our audit period;

- reviewed the medical records for all 104 emergency room visits;

- contacted 17 hospitals that provided services to 28 Medicaid beneficiaries with developmental disabilities during 30 judgmentally selected emergency room visits to determine whether the hospitals reported these visits to the State and, if so, which State entity they contacted and, if not, why;

- performed trend analysis of 3,300 critical incidents involving serious injuries and 8,081 critical incidents involving medication management errors to identify reoccurrences of critical incidents;[38]

- reviewed EIS data, including critical incident reports and other supporting documentation, to determine if the State agency followed Federal and State requirements regarding critical incident reporting for:

    - 13,039 critical incidents involving medication issues,

    - 6,317 critical incidents involving physical or verbal abuse,

    - 885 critical incidents involving neglect,

[38] There were 13,039 critical incidents involving medication issues reported by the community-based providers; 4,958 of these critical incidents involved the beneficiary's refusal of medications. The remaining 8,081 critical incidents involved other medication management errors, such as an incorrect dose being administered or medications not being administered.

  - 329 critical incidents involving sexual abuse and exploitation,
  - 327 critical incidents involving nonsexual exploitation, and
  - 133 critical incidents involving beneficiary deaths;

- visited five community-based providers to determine why these providers did or did not take action regarding critical incidents; and
- discussed the results of our audit with State agency officials.

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

APPENDIX C: FEDERAL WAIVER AND STATE REQUIREMENTS

MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER

States must provide certain assurances to CMS to receive approval for an HCBS waiver, including that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the service (42 CFR § 441.302). The State agency must provide CMS with information regarding these participant safeguards in HCBS waiver, Appendix G, *Participant Safeguards*. A State must provide assurances regarding three main categories of safeguards:

- response to critical events or incidents (including alleged abuse, neglect, and exploitation);
- safeguards concerning the restraints and restrictive interventions; and
- medication management and administration.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements," states that abuse includes the infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm or pain or mental anguish, sexual abuse or exploitation, or the willful deprivation of essential needs. Injuries do not need to be inflicted intentionally to be reportable and do not need to leave visible marks or bruises.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements" also states that neglect is a threat to the health and welfare of a beneficiary with developmental disabilities by physical or mental injury or impairment, deprivation of essential needs, or lack of protection from these (physical or mental injuries or impairments or the deprivation of essential needs). Neglect includes failure to provide medical attention or necessary medication as well as the failure to perform work such as changing wet clothing or providing assistance in a timely fashion. Neglect also includes situations in which caregivers are under the influence of drugs or alcohol.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements," further states that serious illness or injury must be reported and "include any change in medical conditions caused by accident or illness that requires hospitalization; nonroutine treatment not identified in the person's plan; significant adverse reactions to medication; sexually transmitted diseases; etc."

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements," requires providers to report to the State agency critical incidents involving Medicaid beneficiaries with developmental disabilities. Critical incidents that must be reported to the State agency immediately include abuse, neglect, serious illness or injury, and death regardless of cause.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(d) "Responsibility for Review of and Response to Critical Events or Incidents," requires providers to conduct an administrative review of all critical incidents except allegations of abuse, neglect, exploitation, or rights violations. The review must attempt to identify the cause of a critical incident and recommend preventive or corrective action as necessary. Findings must be reported to the State agency within 30 days of the incident. The State agency will then either accept the results of the review and close the case or request further action by the community-based provider.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Responsibility for Review of and Response to Critical Events or Incidents*, G-1(d) "Department Responsibilities for Receiving and Referring Reports," requires the State agency to send DRM all restraints and rights violations including all incidents of abuse, neglect, and exploitation.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(d) "Responsibility for Review of and Response to Critical Events or Incidents," states that all critical incidents with the exception of medication errors and restraints will be forwarded by the State agency's regional office staff for review to the adult protective services unit. The quality assurance unit will review aggregate reports and search for trends that may need to be addressed by the agency (provider) or the State agency.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(d) "Responsibility for Review of and Response to Critical Events or Incidents," states that an adult protective investigation must take place for all allegations of abuse, neglect or exploitation. Allegations of rights violations may be investigated directly by DRM or in conjunction with the State agency.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(d), "Responsibility for Review of and Response to Critical Events or Incidents," states that written reports of an investigation must be documented in a uniform way, which should include, at a minimum, a statement of the facts or allegations contained in the initial report; who was interviewed and the results of the interviews; what records were reviewed; and an evaluation of the facts, conclusions, and recommendations. Findings and recommendations will be promptly submitted to the State agency, provider, guardian (except when the guardian is the subject of an investigation), and case manager. Investigations must be performed and completed within 30 days of the initiation of the investigation. The participant is notified once the investigation is complete and the results are in.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(d), "Responsibility for Review of and Response to Critical Events or Incidents," states that medication errors must be forwarded to and reviewed by the case manager. If the case manager has concern about whether a medication error rises to the level of abuse or neglect, the concern must be brought to the adult protective service unit immediately.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(e) "Responsibility for Oversight of Critical Incidents and Events," states that the State agency is responsible for the oversight of critical incidents and events. This oversight includes the collection and compilation of critical incidents reported through EIS. Specifically, reports that identify patterns and trends to prevent reoccurrences of critical incidents should be developed by the State agency before meetings with the community-based providers. These oversight activities are required to occur every 3 to 4 months.

The HCBS waiver, Appendix G, *Participant Safeguards*, *Quality Improvement: Health and Welfare*, subsection (a)(i), *Methods for Discovery: Health and Welfare*, (a) "Sub-Assurances," states that the State agency must demonstrate on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death. The State agency will review deaths to determine the number and percentage of unexplained, suspicious, and untimely deaths for which an investigation resulted in the identification of preventable causes.

The HCBS waiver, Appendix G, *Participant Safeguards*, *Quality Improvement: Health and Welfare*, subsection (a)(i), *Methods for Discovery: Health and Welfare*, (a) "Sub-Assurances," "Performance Measure: Number and Percentage of Reportable Events That Were Reported Within Required Timeframes Per State Agency Policy," requires the State agency to perform a 100-percent review of critical incidents and determine on an ongoing basis the number and percentage of critical incidents reported within required timeframes.

MAINE STATUTES

Maine Revised Statutes, Title 22, chapter 958-A, *Adult Protective Services Act*, subsection 3477, "Persons Mandated to Report Suspected Abuse, Neglect or Exploitation," (1) "Report Required," states that mandated reporters include doctors, nurses, social workers, and other treatment staff. Furthermore, mandated reporters must report to the State agency when the person knows or has reasonable cause to suspect that an incapacitated or dependent adult has been or is likely to be abused, neglected, or exploited.

Maine Revised Statutes, Title 22, chapter 958-A, *Adult Protective Services Act*, subsection 3477, "Persons Mandated to Report Suspected Abuse, Neglect or Exploitation," (6) "Photographs of Visible Trauma," states that mandated reporters such as hospital staff and law enforcement are also required to make reasonable efforts to take color photographs of any areas of trauma they see on a person with developmental disabilities and make these photographs available to the State agency as soon as possible.

Maine Revised Statutes, Title 22, chapter 958-A, *Adult Protective Services Act*, subsection 3478, "Mandatory Reporting to Medical Examiner for Post-Mortem Investigation," and Maine Revised Statutes, Title 22, chapter 711, *Medical Examiner Act*, subsection 3026, (1) "Persons Suspecting Medical Examiner Case," state that a person required to report cases of known or suspected abuse or neglect who knows or has reasonable cause to suspect that an adult has died as a result of abuse or neglect must report that fact to a law enforcement officer or OCME. A

"person" includes public servants, corporations, partnerships, any other legal entity, and any governmental unit.

Maine Revised Statutes, Title 22, chapter 958-A, *Adult Protective Services Act*, subsection 3485, "Reporting Abuse," (1) "Immediate Report," states that when the State agency receives a report that a person is suspected of abusing, neglecting, or exploiting an incapacitated or dependent adult, the State agency must immediately report the suspected abuse, neglect, or exploitation to the appropriate district attorney's office, whether or not the State agency investigates the report.

Maine Revised Statutes, Title 22, chapter 958-A, *Adult Protective Services Act*, subsection 3485, "Reporting Abuse," (2) "After Investigation," states that when the State agency finds evidence indicating that a person has abused, neglected, or exploited an incapacitated or dependent adult, resulting in serious harm, the State agency shall notify the appropriate district attorney or law enforcement agency of that finding.

Maine Revised Statutes, Title 34-B *Behavioral and Developmental Services Heading*, chapter 5 *Intellectual Disabilities and Autism*, subchapter 4 *Rights of Persons with Intellectual Disabilities or Autism*, section 5604-A (1) "Report Incident," states that a person with knowledge of an incident related to client care, including client-to-client (resident-to-resident) assault, staff-to-client (staff-to-resident) assault, use of excessive restraints, questionable psychiatric or medical practices, or any other alleged abuse or neglect must immediately report the details of that incident in accordance with State agency requirements.

Maine Revised Statutes, Title 34-B *Behavioral and Developmental Services Heading*, chapter 5 *Intellectual Disabilities and Autism*, subchapter 4 *Rights of Persons With Intellectual Disabilities or Autism*, section 5604-A (3) "Violation," states that all persons with knowledge of an alleged violation of the rights of an individual with developmental disabilities must promptly report the details of the alleged violation to DRM.

Maine Revised Statutes, Title 34-B *Behavioral and Developmental Services Heading*, chapter 5 *Intellectual Disabilities and Autism*, subchapter 4 *Rights of Persons with Intellectual Disabilities or Autism*, section 5605 "Rights and Basic Protections of a Person with Intellectual Disabilities or Autism," states that a person with an intellectual disability or autism is entitled to certain rights and basic protections such as humane treatment (e.g., dignity, practice of religion, prompt and adequate medical care, and freedom from restraints except the use of approved techniques on a short-term basis to prevent injury).

Maine Revised Statutes, Title 34-B *Behavioral and Developmental Services Heading*, chapter 5 *Intellectual Disabilities and Autism*, subchapter 4 *Rights of Persons with Intellectual Disabilities or Autism*, section 5605 "Rights and Basic Protections of a Person with Intellectual Disability or Autism," (8) "Medical Care," states that a person with developmental disabilities is entitled to receive prompt and appropriate medical and dental treatment and care for physical and mental ailments.

Maine Revised Statutes, Title 34-B *Behavioral and Developmental Services Heading*, chapter 5 *Intellectual Disabilities and Autism*, subchapter 4 *Rights of Persons with Intellectual Disabilities or Autism*, section 5605 "Rights and Basic Protections of a Person with Intellectual Disabilities or Autism," (14-A) "Restraints," states that a monthly summary of all daily records of the use of restraints pertaining to all persons must be sent to DRM.

MAINE REQUIREMENTS

Code of Maine Rules (14-197), Department of Health and Human Services (State agency), chapter 12 *Regulations Governing Reportable Events, Adult Protective Investigations, and Substantiation Hearings Regarding Persons With Mental Retardation or Autism*, 6.03 "Reportable Events and Protective Responsibilities" (F)(2) and (4), states that DRM must be provided access to all critical incident reports and that all restraints and rights violations (including all incidents of abuse, neglect, and exploitation) must also be sent to DRM.

Code of Maine Rules (14-197), State agency, chapter 12 *Regulations Governing Reportable Events, Adult Protective Investigations and Substantiation Hearings Regarding Persons With Mental Retardation or Autism*, 6.04 "APS Investigations" (B)(2), states that the provider's administrative review must attempt to identify the cause of an event and recommend preventative or corrective action as necessary. The review must be in writing, kept on file by the provider, and be made available for review when requested by the State agency.

Code of Maine Rules (14-197), State agency, chapter 12 *Regulations Governing Reportable Events, Adult Protective Investigations, And Substantiation Hearings Regarding Persons With Mental Retardation or Autism*, 6.04 "APS Investigations," (C)(3), requires that as much specific information as possible must be obtained by the State agency official from the person making the critical incident report. This specific information should include the nature and extent of the alleged abuse, neglect, or exploitation or the facts demonstrating the substantial risk thereof and nature and gravity of condition or injury resulting from the reported abuse, neglect, or exploitation.

Code of Maine Rules (14-197), State agency, chapter 12 *Regulations Governing Reportable Events, Adult Protective Investigations, and Substantiation Hearings Regarding Persons With Mental Retardation or Autism*, 6.04 "APS Investigations," (F)(4), states that assigned investigators must promptly report suspected rights violations in a separate report to DRM.

State Agency Office of Aging and Disability Services Reportable Events Training, page 13, states that serious illness or injury is defined as any change in medical conditions caused by accident or illness that requires hospitalization, including initial emergency room visits.

APPENDIX D: INJURY CATEGORY STATISTICS

Category	Diagnosis Code	Description	No. of ER Visits	No. of Beneficiaries
Head				
1	4321	Subdural hemorrhage	1	1
2	8020	Closed nasal bones fracture	1	1
3	8300	Closed dislocation jaw	1	1
4	8500	Concussion, no loss of consciousness	1	1
5	87200	Open wound to external ear	1	1
6	8730	Open wound to scalp	3	3
7	87341	Open wound to cheek	1	1
8	87342	Open wound to forehead	5	4
9	87343	Open wound to lip	1	1
10	87363	Open wound to tooth	2	2
11	87371	Open wound to inner mouth	1	1
12	9100	Abrasion/friction burn to head	2	2
13	920	Contusion to face, scalp or neck	11	11
14	95901	Head injury, unspecified	9	9
15	95909	Injury of face or neck	1	1
Subtotal			**41**	**40**
Bodily				
1	80709	Closed fracture multiple ribs	2	1
2	81002	Closed fracture clavicle (shaft)	1	1
3	81342	Closed fracture radius distal end	1	1
4	83402	Closed dislocation of hand	2	2
5	8363	Closed dislocation of patella	4	1
6	8439	Hip & thigh sprain	1	1
7	88100	Open wound to forearm	1	1
8	8830	Open wound to fingers	1	1
9	8860	Traumatic amputation of finger	1	1
10	9140	Abrasion/friction burn to hand	2	2
11	9221	Contusion to chest wall	1	1
12	9222	Contusion to abdominal wall	1	1
13	92300	Contusion to shoulder	1	1
14	92311	Contusion to elbow	1	1
15	9239	Contusion to upper limb, unspecified	1	1
16	92401	Contusion to hip	1	1

Category	Diagnosis Code	Description	No. of ER Visits	No. of Beneficiaries
17	92410	Contusion to lower leg	1	1
18	9283	Crushing injury to toe	1	1
19	95914	External injury to genitals	1	1
20	95919	Injury to the trunk	1	1
Subtotal			**26**	**22**
Medical				
1	27651	Dehydration	7	7
2	5070	Pneumonitis due to inhalation of food or vomitus	3	3
3	5780	Hematemesis	1	1
4	5990	Urinary tract infection	9	9
5	59970	Hematuria	3	3
Subtotal			**23**	**23**
Safety				
1	30300	Alcohol dependence intoxication	1	1
2	30301	Alcohol dependence intoxication, continuous	3	1
3	30500	Alcohol abuse	2	1
4	9330	Foreign body in pharynx	1	1
5	9351	Foreign body in esophagus	1	1
6	9661	Poisoning by hydantoin derivatives	1	1
7	9778	Poisoning by drugs or medicinal substance	2	2
8	9895	Toxic effect—venom	1	1
9	99520	Adverse effect from drugs/medicine, unspecified	1	1
10	99529	Adverse effect from drugs/medicine, other	1	1
Subtotal			**14**	**11**
		14 beneficiaries with more than 1 ER visit		**(14)**
TOTAL			**104**	**82**

APPENDIX E: TREND ANALYSIS

We performed a trend analysis of the 3,300 critical incidents involving serious injuries to 1,163 Medicaid beneficiaries with developmental disabilities and identified 11 beneficiaries involved with 266 of these serious injuries.[39] Each of these 11 beneficiaries had at least 15 and as many as 78 serious injuries during the audit period. We reviewed the 266 associated critical incident reports and determined that 143 critical incidents involved medical conditions, such as chest pains and seizure symptoms. We performed additional analyses of the remaining 123 critical incident reports and identified 10 beneficiaries who were involved in potentially neglectful[40] situations, including:

- Six beneficiaries had 82 critical incidents involving serious injuries, such as bruises, bite marks, scratches, abrasions of unknown origin, hip and shoulder strains, a fractured femur, a concussion, heat stroke, lacerations from a knife cut requiring sutures or staples, and a dog bite on the arm and thigh.

- One beneficiary had one critical incident report after she was brought to a hospital emergency room with a black eye, swollen cheek, and bruised and scratched head after another beneficiary assaulted her earlier in the day. The critical incident report noted, "The doctor expressed concerns about the [beneficiary's] safety in the house she was staying." The State agency received another critical incident report in which the beneficiary asked the incoming day staff to look at her swollen foot. The beneficiary had a badly bruised foot. The overnight staff did not know how the injury happened.

- One beneficiary had 14 critical incident reports; the beneficiary was brought to a hospital emergency room 12 times and a urologist once over a 17-month period because of urinary catheter issues.[41] After the third critical incident—all of which happened in 6 months—the critical incident report noted that the beneficiary's urologist had been requesting periodic in-home nursing care staff for over a year. However, the critical incident report noted the beneficiary's "needs continue to be unmet with the result being recurrent trips to the emergency room in between urology appointments" because the State agency did not provide this service.[42] The provider submitted the remaining 11 critical incident reports for 10 critical incidents involving catheter issues over the next 11 months to the State agency.

[39] Six hundred twenty-nine of the 1,163 beneficiaries had more than 1 critical incident reported during the audit period.

[40] As defined in the HCBS waiver, Appendix G-1(b).

[41] Six of the 13 visits were caused by infections related to the urinary catheter, 5 of the 13 visits were for catheter changes or catheter flushing, and 2 of the 13 visits were for pain management in the catheter area.

[42] We did not verify whether the nursing services in question were provided to the beneficiary.

- One beneficiary had 10 critical incident reports for 8 critical incidents.[43] She was brought to a hospital emergency room because her stomach feeding tube fell out (5 critical incidents) or was clogged (3 critical incidents).

- One beneficiary had 15 critical incident reports involving her diabetes. In one instance, the beneficiary was hospitalized in April 2013 as a result of complications from diabetic conditions. The critical incident report noted the "beneficiary may need to have her toes amputated on her right foot due to her condition." In May 2014, the beneficiary's program manager, community living coordinator, and community support services coordinator[44] conducted an unannounced visit to the beneficiary's shared-living residence because of concerns about the beneficiary's serious illness, frailty, and unsteadiness that required her to live in an environment that was safe and free from clutter and other obstacles. The critical incident report noted that the shared-living provider had cancelled the past few scheduled residential visits. The critical incident report stated:

  > The home was in disrepair; all smoke detectors were taken down. The exit that the beneficiary would use in case of a fire had gas cans in front of it from the floor to the ceiling. There was an [overpowering] smell of cat urine; the steps leading to the front door are not sturdy. The room was very unkempt with clutter throughout making it difficult to get around. Another exit was blocked with heavy furniture. Due to the beneficiary's brittle diabetes, the condition of this home impacted the beneficiary's health and safety.

  Two months after the unannounced visit, the State agency received a critical incident report that the beneficiary received treatment in an emergency room after falling down five stairs. The beneficiary was moved to another location 2 days later.

We also reviewed 13,039 critical incident reports involving medication issues for 1,565 beneficiaries to determine if they contained any identifiable patterns or trends. We found that 4,958 of these 13,039 critical incidents involved beneficiaries refusing their medication, which we did not consider potential abuse, neglect, or rights violations. We did, however, identify 8 beneficiaries who each had at least 100 critical incidents involving medication issues (1 of whom had 333 critical incidents involving medication issues) during our audit period.[45]

[43] Three different mandated reporters submitted separate reports to notify the State agency of one of the critical incidents.

[44] These individuals were employees of a community-based provider that contracts with the State agency to provide community living support to Medicaid beneficiaries with developmental disabilities.

[45] These 8 beneficiaries had a total of 1,228 critical incidents involving medication issues.

Accordingly, we further reviewed the 1,228 critical incident reports for these 8 beneficiaries and determined that 1,049 (85 percent) involved medication refusals. For the remaining 179 (15 percent) of these critical incidents, Table 4 lists the number and type of incidents.

Table 4: Number and Type of Critical Incidents Involving Medication Management Errors for Eight Beneficiaries

Type	Number
Medication Not Provided (Omissions)	65
Incorrect Dose or Time	57
Unavailable Medication	57
Total	**179**

Examples of the 179 medications that beneficiaries did not receive included opioids, insulin, antibiotics, antipsychotic drugs, and other medications used to treat conditions such as depression, seizures, angina, and high blood pressure.

APPENDIX F: DETAILS OF CRITICAL INCIDENTS INVOLVING UNIVESTIGATED POTENTIAL ABUSE OR NEGLECT

UNINVESTIGATED CRITICAL INCIDENTS INVOLVING POTENTIAL PHYSICAL OR VERBAL ABUSE

During the audit period, the State agency received 6,317 critical incident reports related to physical or verbal abuse involving 1,226 beneficiaries from community-based providers through EIS.[46] We found that the State agency accepted for investigation 306 (5 percent) of the 6,317 critical incidents. Of the 306 accepted investigations, 53 resulted in substantiated findings. See Table 5 for further details.

Table 5: Result of State Agency Investigations

Action Taken	Number	Percentage of Accepted Investigations	Percentage of Total Incidents
Substantiated	53	17%	0.84%
Unsubstantiated	54	18%	0.85%
Failure to Substantiate	60	20%	0.95%
No Disposition Indicated	54	18%	0.85%
Referred to Regional or District Office	41	13%	0.65%
Accepted Provider Resolution	44	14%	0.70%
Total Investigations[47]	**306**	**100%**	**5%***

* Numbers do not add because of rounding.

We also reviewed all 6,317 critical incidents involving physical or verbal abuse and determined that the largest categories of incidents included resident-on-resident physical or verbal abuse (3,166 or 50 percent), self-abuse (1,186 or 19 percent), and provider-on-resident physical or verbal abuse (256 or 4 percent).[48]

Of the 6,317 critical incidents, 3,166 were related to resident-on-resident physical or verbal abuse. We reviewed 316 (10 percent) of these critical incidents in more detail and determined that 301 of the 316 critical incidents (95 percent) were categorized on the critical incident report as a "general incident" by the State agency incident data specialist. The State agency did not complete an investigation assessment for general incidents or for the remaining 15 critical incidents (5 percent). Based on our review of the critical incident reports, assessments, and

[46] Eight hundred twelve beneficiaries had more than one critical incident related to physical or verbal abuse reported during the audit period.

[47] The information contained in Table 5 is for informational purposes only. We did not review these investigations and, therefore, are not expressing an opinion on them.

[48] We created 20 categories of critical incident reports for physical or verbal abuse based on our review of the supporting documentation.

discussions with State agency senior staff and incident data specialists in the district offices, we determined that the State agency did not generally investigate resident-on-resident incidents.

UNINVESTIGATED CRITICAL INCIDENTS INVOLVING POTENTIAL NEGLECT

The State agency received 885 critical incident reports related to neglect involving 876 individual incidents and 548 beneficiaries during the audit period from community-based providers through EIS.[49] We found that the State agency accepted for investigation 262 (30 percent) of the critical incidents.

Of the 262 accepted investigations, 56 resulted in substantiated findings. See Table 6 for further details.

Table 6: Result of State Agency Investigations

Action Taken	Number	Percentage of Accepted Investigations	Percentage of Total Incidents
Substantiated	56	21%	6%
Unsubstantiated	39	15%	5%
Failure to Substantiate	36	14%	4%
No Disposition Indicated	48	18%	5%
Referred to Regional or District Office	25	10%	3%
Accepted Provider Resolution	56	21%	6%
Allegations Referred to Other Agencies	2	0.8%	0.2%
Total Investigations[50]	**262**	**100%***	**30%***

* Numbers do not add because of rounding.

We also reviewed all 876 critical incidents involving neglect and determined that the largest categories of incidents included lack of supervision (267 or 30 percent), staff sleeping on duty (169 or 19 percent), medical neglect (91 or 10 percent), and staff intoxication (66 or 8 percent).[51]

[49] Eight critical incidents were reported more than once, and 185 beneficiaries had more than 1 critical incident reported during the audit period.

[50] The information contained in this table is for informational purposes only. We did not review these investigations and, therefore, are not expressing an opinion on them.

[51] We created a total of 11 categories of critical incident reports for neglect based on our review of the supporting documentation.

UNINVESTIGATED CRITICAL INCIDENTS INVOLVING POTENTIAL NONSEXUAL EXPLOITATION

During the audit period, the State agency received 327 critical incident reports related to nonsexual exploitation involving 264 beneficiaries from community-based providers through EIS.[52] We found that the State agency accepted for investigation 113 (35 percent) of the 327 incidents.

Of the 113 accepted investigations, 20 resulted in substantiated findings. See Table 7 for further details.

Table 7: Result of State Agency Investigations

Action Taken	Number	Percentage of Accepted Investigations	Percentage of Total Incidents
Substantiated	20	18%	6%
Unsubstantiated	12	11%	4%
Failure to Substantiate	24	21%	7%
No Disposition Indicated	24	21%	7%
Referred to Regional or District Office	12	11%	4%
Accepted Provider Resolution	21	19%	7%
Total Investigations[53]	**113**	**100%***	**35%**

* Numbers do not add because of rounding.

We also reviewed all 327 critical incidents involving nonsexual exploitation and determined that the largest categories of incidents were financial exploitation—including financial mismanagement, unaccounted funds, or theft of funds (212 or 65 percent)—and theft or destruction of property (52 or 16 percent).[54]

UNINVESTIGATED CRITICAL INCIDENTS INVOLVING POTENTIAL SEXUAL ABUSE OR SEXUAL EXPLOITATION

During the audit period, the State agency received 329 critical incident reports related to sexual abuse or sexual exploitation involving 296 individual incidents and 196 beneficiaries from

[52] Forty beneficiaries had more than 1 critical incident reported during the audit period.

[53] The information contained in this table is for informational purposes only. We did not review these investigations and, therefore, are not expressing an opinion on them.

[54] We created a total of three categories of critical incident reports for nonsexual exploitation based on our review of the supporting documentation.

community-based providers through EIS.[55] We found that the State agency accepted for investigation 79 (27 percent) of the 296 incidents.

Of the 79 accepted investigations, 11 resulted in substantiated findings. See Table 8 for further details.

Table 8: Result of State Agency Investigations

Action Taken	Number	Percentage of Accepted Investigations	Percentage of Total Incidents
Substantiated	11	14%	4%
Unsubstantiated	21	27%	7%
Failure to Substantiate	24	30%	8%
Allegations Referred to Other Agencies	2	3%	1%
No Disposition Indicated	6	8%	2%
Referred to Regional or District Office	9	11%	3%
Accepted Provider Resolution	6	8%	2%
Total Investigations[56]	**79**	**100%***	**27%**

* Numbers do not add because of rounding.

We also reviewed all 296 critical incidents involving sexual abuse or sexual exploitation and determined that the largest categories of incidents included resident-on-resident (157 or 53 percent) and provider-on-resident (76 or 26 percent) sexual abuse or sexual exploitation.[57]

Of the 296 critical incidents, 157 were related to resident-on-resident sexual abuse or sexual exploitation. We reviewed these critical incidents in more detail and determined that 122 (77 percent) of the 157 critical incidents were categorized on the critical incident report as a "general incident" by the State agency incident data specialist. The State agency did not complete an investigation assessment for general incidents. The State agency did complete an investigation assessment for 34 critical incidents and accepted only 4 critical incidents for investigation (3 percent of the 157). The State agency did not accept 30 (19 percent of the 157) critical incidents for investigation. In addition, it was not indicated in the critical incident report whether the State agency accepted the remaining 1 critical incident for investigation (less than 1 percent of the 157). Based on our review of the critical incident reports, assessments, and

[55] Twenty-five critical incidents were reported more than once, and 69 beneficiaries had more than 1 critical incident reported during the audit period.

[56] The information contained in this table is for informational purposes only. We did not review these investigations and, therefore, are not expressing an opinion on them.

[57] We created a total of six categories of critical incident reports for sexual abuse or sexual exploitation based on our review of the supporting documentation.

discussions with State agency senior staff and incident data specialists in the district offices, we determined that the State agency did not generally investigate resident-on-resident incidents.

UNINVESTIGATED MEDICATION MANAGEMENT ERRORS

During the audit period, the State agency received 13,039 critical incident reports related to medication issues involving 1,565 beneficiaries from community-based providers through EIS. We reviewed these critical incident reports and determined that 4,958 (38 percent) of the 13,039 critical incident reports involved the beneficiaries' refusal of their medication. We did not consider these incidents potential abuse, neglect, or rights violations. However, we determined that the remaining 8,081 critical incident reports for 1,402 beneficiaries involved potential abuse, neglect, or rights violations because they involved a failure to provide medical attention or necessary medication.[58] The results of our analysis are summarized in Table 9.[59]

Table 9: Number and Type of Critical Incidents Involving Medication Management Errors

Type	Number
Medication Not Provided (Omissions)	4,726
Incorrect Dose	1,428
Incorrect Time	881
Unavailable Medication	704
Incorrect Medication	208
Incorrect Beneficiary	58
Improper Use	33
Incorrect Dose at Incorrect Time	26
Neglect	10
Overdose	6
Lack of Proper Consent	1
Total	**8,081**

We found that the State agency accepted for investigation 7 (0.1 percent) of the 8,081 incidents. Of the seven accepted investigations, none resulted in substantiated findings. See Table 10 on the next page for further details.

[58] One thousand eighty-five beneficiaries had more than one critical incident reported during the audit period.

[59] We created these categories based on the critical incident event names contained in EIS. We created a category called "neglect" because neglect was specifically mentioned in the critical incident event name and each of the incidents involved beneficiary neglect that would not fit into any of the other categories.

Table 10: Result of State Agency Investigations

Action Taken	Number	Percentage of Accepted Investigations	Percentage of Total Incidents
Failure to Substantiate	1	14%	0%
No Disposition Indicated	2	29%	0%
Referred to Regional or District Office	3	43%	0%
Accepted Provider Resolution	1	14%	0%
Total Investigations[60]	**7**	**100%**	**0.1%***

* Numbers do not add because of rounding.

The State agency did not forward any of these 8,081 critical incidents to DRM as potential rights violations.[61]

[60] The information contained in this table is for informational purposes only. We did not review these investigations and, therefore, are not expressing an opinion on them.

[61] State agency officials stated that they do not have a system that readily tracks or monitors case manager involvement with critical incident reports. Therefore, the State agency's system is not capable of computing the number of critical incidents involving medications that were forwarded to and reviewed by case managers and that case managers determined rose to the level of abuse or neglect and brought the concern to the State agency.

APPENDIX G: CRITICAL INCIDENT DETAILED EXAMPLE

Jane A. Doe was a nonverbal beneficiary with severe developmental disabilities, including autistic psychosis features, living at a community-based provider. The community-based provider reported through EIS to the State agency the following 13 critical incidents involving the physical assault[62] of Ms. Doe:

- Critical incident reports noted six incidents of hair pulling by another resident. One of the critical incident reports stated that the individual who assaulted Ms. Doe was "funded to have a 1:1 with her.[63] Staff should always position themselves so the client has no access to pulling the client's hair." Another critical incident report stated that the community-based provider's staff found a bald spot on Ms. Doe's head the morning after the hair pulling incident, but the staff did not notice when the critical incident occurred and did not report the injury to their supervisor immediately after discovering it. This critical incident report also stated that the individual believed to have assaulted Ms. Doe required one-on-one supervision. Finally, the critical incident report also indicated that Ms. Doe's guardian "was very upset because it is not the first time a clump of hair has been pulled out."

- Critical incident reports noted six incidents of Ms. Doe having been pushed by other residents. One critical incident report stated that Ms. Doe is "often the target of aggression as she does not protect herself or respond aggressively." In another critical incident report, Ms. Doe was said to have been pushed to the floor at the gym and hit her head. She was unresponsive for 7 minutes and started convulsing and vomiting. She was transported to the hospital and admitted to the intensive care unit.

- Critical incident reports noted one incident of Ms. Doe having been choked by another resident. Before choking her, the individual who assaulted Ms. Doe also inappropriately grabbed Ms. Doe's arm twice over approximately 15 minutes.

The State agency did not investigate 12 of the 13 critical incidents because the regional incident data specialist classified these 12 critical incidents as "general incident(s)." State agency officials informed us that they do not usually investigate general incidents for abuse or neglect. One of the 13 critical incidents was reviewed by the State agency as potential neglect but not accepted for investigation.

We noted that Ms. Doe was also assaulted and pushed to the ground in August 2015, 2 months after our audit period. The community-based provider's staff noticed that Ms. Doe would not move her right arm the next day. Her right wrist and elbow were swollen, and her right shoulder appeared to be drooping slightly. The staff took Ms. Doe to the hospital, where she

[62] Twelve of these critical incidents were reported as "physical or verbal abuse," and one was reported as "physical or verbal abuse" and "neglect."

[63] One-on-one supervision requires the community-based provider to assign one staff member to supervise the resident in question.

was diagnosed with a broken clavicle. The individual who pushed Ms. Doe in this incident is the same person who previously pushed Ms. Doe, resulting in her admission to the intensive care unit of the hospital.

APPENDIX H: SUMMARY OF NINE UNEXPLAINED, SUSPICIOUS, OR UNTIMELY BENEFICIARY DEATHS NOT REVIEWED OR INVESTIGATED BY THE STATE AGENCY

1. A 58-year-old beneficiary died because of an "accidental death." The critical incident report indicated that the beneficiary choked to death on a hot dog. The community-based provider staff had given the hot dog to him while he rode in the back seat of a car. The staff heard the beneficiary choking, pulled the car off the road and began performing the Heimlich maneuver, chest compressions, and mouth-to-mouth resuscitation. A passer-by called an ambulance. The critical incident report did not identify the exact time and place of death.

   The beneficiary's death was not investigated by the State agency or reviewed by the Mortality Review Committee. OCME reviewed this incident and determined the beneficiary suffered cardiac arrest after choking on the hot dog.

2. A 46-year-old beneficiary died unexpectedly.[64] The critical incident report indicated that she fell in the bathtub while she was unattended and drowned. The community-based provider staff was physically assisting the beneficiary, but the beneficiary reportedly pushed the staff member away and so was given time alone. The staff member checked in 5 minutes later and again was pushed away by the beneficiary. The staff member then went into the office and heard a thud. The staff member found the beneficiary with her face under water and her arm over the side of the tub. The staff member called 911 and began cardiopulmonary resuscitation. Emergency personnel also tried to revive the beneficiary but were unsuccessful. Police arrived on the scene and questioned staff but did not open an investigation.

   The beneficiary's death was not investigated by the State agency or reviewed by the Mortality Review Committee. OCME reviewed this incident, determined it was an accidental drowning, and stated that the patient routinely asked for privacy while bathing. However, OCME informed us that it determined the cause of death but did not review if the patient's care had been managed properly. OCME explained that it does not typically review how a beneficiary's care was managed unless it receives a specific allegation to act upon.

3. A 32-year-old beneficiary died because of an "unexplained death," according to the critical incident report. The report indicated that the community-based provider's staff found the beneficiary in bed, unresponsive, and not breathing. Emergency services were called, and the beneficiary was declared dead.[65] Police also responded but did not

[64] The critical incident record indicated the type of death as "Other Death (specify)" and stated, "Will not know until autopsy performed." The critical incident record was not updated after the autopsy was performed by OCME.

[65] The records in EIS do not indicate if the beneficiary had a "do-not-resuscitate" order in place.

open an investigation. A critical incident report for serious injury from the prior day stated that the beneficiary suffered multiple seizures. The community-based provider contacted the beneficiary's doctor, who suggested that the staff apply the beneficiary's continuous positive pressure airway (CPAP) machine[66] when he was napping so he could get used to using it. The beneficiary had been diagnosed with sleep apnea a month and a half earlier and had been recommended to wear a CPAP machine at night. The doctor also requested that the beneficiary go to the doctor's office for a blood test in the afternoon. The critical incident report also stated that the community-based provider would monitor the beneficiary's seizure activity and other health issues.

The beneficiary's death was not investigated by the State agency or reviewed by OCME. The Mortality Review Committee reviewed the report, but no corrective actions were taken because of the lack of information reported to the State agency in the critical incident report and other EIS records.

4. A 57-year-old beneficiary passed away as a result of "complication to illness." The critical incident report states that the beneficiary went to the dentist for a cleaning and that the dentist extracted six teeth. One tooth was infected and another was cracked, but the community-based provider did not know why the other four teeth were pulled. The dentist did not prescribe antibiotics following the extraction of the infected tooth or provide the beneficiary with gauze to stop the bleeding because of concerns that she might swallow it. The beneficiary aspirated blood from the site of the extracted teeth and was taken to a hospital emergency room with a fever 5 days after the extraction. The patient was diagnosed with double pneumonia and sepsis and died in the hospital's intensive care unit 2 weeks later.

   The beneficiary's death was not investigated by the State agency or reviewed by OCME. The Mortality Review Committee reviewed the report but no corrective actions were taken and no preventable causes were identified.

5. A 59-year-old beneficiary died due to an "accidental death," according to the critical incident report. The report indicated that she fell down the stairs when leaving another resident's home and hit her head. She had her hand on the railing and fell headfirst onto cement. The community-based provider staff member started resuscitation and called 911. Police arrived with emergency personnel but did not open an investigation. According to the records in EIS, this critical incident "appeared to be a tragic falling accident." However, the report in EIS also stated that the beneficiary "has brittle bones and must not fall."

   The beneficiary's death was not investigated by the State agency or reviewed by the Mortality Review Committee. OCME reviewed this incident and noted that the beneficiary had extensive health issues.

[66] A CPAP machine uses mild positive air pressure to keep a patient's airways open and is used to treat sleep-related breathing disorders such as sleep apnea.

6. A 64-year-old beneficiary died as a result of "complication to illness," according to a critical incident report. One critical incident report stated that the beneficiary's death was because of complications from a urinary tract infection and pneumonia, but a separate critical incident report stated that the cause of death was complications from chronic obstructive pulmonary disease. The beneficiary was brought to a hospital's emergency room on June 27 and again on June 29 because of poor vital signs. The beneficiary was admitted to critical care on June 29 and died six days later. A critical incident report for neglect was also submitted on June 30 and indicated that the community-based provider was not following the beneficiary's plan of care requirement to check his diaper every 15 minutes and to change it if necessary. The report stated that the provider allowed the beneficiary to sit in soaked diapers and clothing for hours, and the reporter (a former employee of the community-based provider) said this may have contributed to the frequent urinary tract infections. The State agency reviewed this critical incident report but did not accept it for investigation.

   The beneficiary's death was not investigated by the State agency or reviewed by OCME. The Mortality Review Committee reviewed the report but did not take any corrective actions or identify any preventable causes.

7. A 72-year-old beneficiary died from "natural causes age related," according to a critical incident report. The beneficiary had seven prior critical incident reports over a 2-month period related to her jaw repeatedly dislocating. Six of these critical incidents required hospital emergency room visits. This injury caused her considerable pain and affected her ability to eat food, drink liquids, and take medication. The beneficiary was also sedated at least four times in the 8 weeks before her death. A critical incident report for neglect was submitted 2 weeks before her death and stated that the hospital emergency room physician was "not gentle" and tried to put her jaw back in place without sedation. According to the critical incident report, the community-based provider also questioned why nothing else had been done to correct the jaw dislocation problem, because all other attempts had failed and her primary care physician and specialist would not see the beneficiary. The State agency reviewed this critical incident report but did not accept it for investigation.[67]

   The beneficiary's death was not investigated by the State agency or reviewed by the Mortality Review Committee or OCME.

[67] The APS assessment stated, "Spoke with collateral on 7/31/2013 and based on information provided as well as the specifics of the report, no appropriate role for APS."

8. A 45-year-old beneficiary died unexpectedly.[68] The critical incident record indicated that the beneficiary complained of being sick at 8 a.m., was shaky, and had flu-like symptoms. He continued not to feel well throughout the day but asked for food and water. At 6:30 p.m. when the beneficiary was called down to dinner, he did not want to eat, had difficulty walking, was short of breath, and was very pale. The beneficiary had pointed to his stomach to indicate that it hurt. The community-based provider's staff called their supervisor and "on-call" staff, and both instructed the staff to keep a close eye on the beneficiary. By 8 p.m., the beneficiary was swaying and very dizzy. He also sat on the floor and was breathing heavily. The staff person again called on-call support and stated that the beneficiary had never looked like this before and the staff person was worried by the beneficiary's appearance. The staff also questioned whether an ambulance should be called. Instead, staff made the decision to wait to take the beneficiary to a hospital emergency room until 9 p.m. when the community-based provider's next staffing shift arrived. However, the beneficiary became unresponsive, turned blue, and stopped breathing between 8:45 p.m. and 9:00 p.m. An ambulance was then called, but the beneficiary died at the hospital.

   The beneficiary's death was not investigated by the State agency or reviewed by the Mortality Review Committee. OCME reviewed this incident and determined that the cause of death was perforated intestine peritonitis.[69]

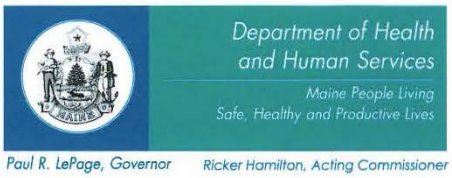
9. A 66-year-old beneficiary died because of "natural causes age related." The critical incident report states that he was not feeling well on the day before his death. He was vomiting brown bile, lethargic, cold and clammy, and had no appetite. He also had stomach pain. The beneficiary was taken to a walk-in clinic at 11:30 a.m. and had blood work done and an x-ray of his abdomen taken. He was then discharged at 7:30 p.m. with instructions to submit a urine and feces sample for testing the next day. A staff person asked the beneficiary if he was okay when he went to bed at 10 p.m. and the beneficiary responded "yes." The beneficiary was found unresponsive on the floor by community-based provider staff the next morning. While the critical incident report notes that the beneficiary did not have a "do not resuscitate" order, it does not indicate that the community-based provider staff attempted to resuscitate the beneficiary. The critical incident report also does not indicate the exact time the beneficiary was found or if the provider's staff checked on the beneficiary throughout the night, given his recent health issues. Police spoke to the community-based provider but did not open an investigation.

   The beneficiary's death was not investigated by the State agency or reviewed by the Mortality Review Committee or OCME.

[68] The critical incident record indicated the type of death as "Other Death (specify)" and stated, "Heart stopped. Waiting for autopsy report." The critical incident record was not updated after OCME performed the autopsy.

[69] Perforated intestine peritonitis is a hole in the wall of the digestive tract that leads to infection.

APPENDIX I: STATE AGENCY COMMENTS



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June 26, 2017

David Lamir, Regional Inspector General for Audit Services
U.S. Department of Health and Human Services
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Boston, Massachusetts 02203

Dear Inspector General Lamir:

The Maine Department of Health and Human Services is in receipt of your draft report dated May 26, 2017. The Department thanks the U.S. Department of Health and Human Services Office of Inspector General for all the work performed in connection with this review and appreciates the opportunity to comment on the draft report.

The Department understands that the draft report reflects the U.S. Department of Health and Human Services Office of Inspector General's audit findings related to the State of Maine's system for reporting and monitoring "critical incidents" involving Medicaid beneficiaries with developmental disabilities residing in community-based settings for the period of January 2013 through June 2015.

The State of Maine's Home and Community Based Benefit for Medicaid (MaineCare) members with Intellectual Disabilities or Autism Spectrum Disorder (10-144 C.M.R. ch. 101, ch. II, § 21) gives eligible members the option to live in their own home or in another home in the community (avoiding institutionalization) and receive support services. Section 21 is administered by the Department's Office of MaineCare Services and the Office of Aging and Disability Services (OADS).[1]

Individuals who provide services to adults with intellectual disabilities or autism spectrum disorder under Section 21 or any other program licensed, funded, or regulated by the Department are required to report certain types of events through the Department's Reportable Events System, the Enterprise Information System (EIS). The Reportable Events System is authorized by statute (34-B M.R.S. § 5604-A) and governed by Department Rule (14-197 C.M.R. ch. 12). Under 14-197 C.M.R. ch. 12, reports must be made for several categories of incidents including abuse, neglect, exploitation, death, "rights violations" as defined in 34-B M.R.S. § 5605, and "serious illness or injury."

Pursuant to Maine's Adult Protective Services Act, 22 M.R.S. § 3470 *et seq.*, individuals in several professions are required to report to the Department when he or she "knows or has reasonable cause to suspect that an incapacitated or dependent adult has been or is likely to be abused, neglected, or exploited." The Department operates a twenty-four (24) hour telephone line through which mandated

[1] During 2012, DHHS merged the Office of Elder Services (OES) and the Office of Cognitive and Physical Disability Services (OACPDS), and the Office of Aging and Disability Services (OADS) was created in their place. Initially, Adult Protective Services protecting individuals other than those with developmental disabilities were handled by APS (historically within OES), and separate staff were dedicated to protective services for developmental services clients. This remained true during some of the OIG audit period. Presently, all reports related to abuse, neglect, or exploitation are handled through the APS unit.

reporters are able to fulfill the statutory mandated reporting requirement. Reports of known or suspected abuse, neglect, or exploitation of an incapacitated or dependent adult are investigated by the Department's Adult Protective Services (APS) unit. APS reports, investigation notes, and findings are documented in an electronic system called the Maine Adult Protective Services Information System (MAPSIS). A section within the Adult Protective Services Act, 22 M.R.S. § 3474, requires that adult protective records be kept confidential by the Department subject to limited disclosure provisions.

Having reviewed the OIG draft report, the Department agrees in part with multiple findings and has already adopted many of the recommendations that are included in the OIG draft report. The Department notes that the OIG draft report contains some inaccurate information and unclear methodology. For example, the OIG draft report includes multiple references to statements made by "State agency officials" that are not representative of the Department's position on certain topics. The Department respectfully requests that references to verbal statements or opinions be removed from the report as the data collected during the audit can speak for itself.

In addition, the Department notes that many of the representative examples related to each finding, as well as Appendix G "Critical Incident Detailed Example," and Appendix H "Summary of Nine Unexplained, Suspicious, or Untimely Beneficiary Deaths Not Reviewed Or Investigated By the State Agency" contain sufficient detail that may allow individuals familiar with the events, such as caregivers, beneficiaries, and beneficiaries' family members, to recognize the specific incidents being described. The Department respectfully requests that the level of detail within the examples be reduced to respect the privacy of individuals served by the Department.

The Department also respectfully requests that Appendix C "Federal Waiver and State Requirements" be amended to incorporate full quoted text from the State of Maine's Section 21 waiver application, statutes, and DHHS Rules (Code of Maine), rather than paraphrased information. In some paragraphs within Appendix C, necessary information is missing. For example, on page 26 of the OIG draft report, the "HCBS waiver, Appendix G-1" "serious illness or injury" definition does not include the complete definition that appears in the waiver application. Other concerns with the report are outlined in more detail below.

The Department responds to each of the OIG's findings and recommendations as follows:

1. **Finding:** The State agency did not ensure that community-based providers report all critical incidents to the State agency.
   Recommendation: The State agency work with community-based providers on how to identify and report all critical incidents

   Response:
   While the Department recognizes that any failure to report critical incidents demonstrates an area for improvement, the Department does not agree that the OIG's audit findings related to this topic support the conclusion that the State failed to comply with Federal and State requirements. In particular, the Department has identified issues with the definitions and methodology employed by the OIG.

   The OIG draft report highlights that the State's Section 21 waiver application includes "serious illness or injury" as a critical incident that must be reported through the Department's Reportable Events System. The OIG draft report does not include the full definition of "serious illness or injury" as it appears in the waiver application. In addition to the language noted in the OIG draft report ("any change in medical conditions caused by accident or illness that requires hospitalization"), the definition of "serious illness or injury" in the waiver application also lists: "non-routine treatment not identified in the person's plan; significant adverse reactions to medication; sexually transmitted diseases; etc."

The OIG draft report indicates that based on the limited definition of "serious illness or injury," the OIG determined that 2,243 emergency room visits qualified as "critical incidents," 769 of which were not reported to the Department. It appears that the OIG is equating emergency room visits with hospitalizations, which is inaccurate. A hospitalization requires a hospital admission, and not all emergency room visits result in an admission. In some instances, individuals visit emergency rooms to address minor issues or as a precaution, even though a visit to a primary care physician or urgent care facility would be sufficient.[2] Whether each of the 769 emergency room visits identified by the OIG resulted in hospitalization or met one of the other requirements to qualify as a "serious illness or injury" under the waiver application definition is unclear. Accordingly, the OIG draft report's conclusion that "the State agency and DRM were not always able to pursue legal, administrative, and other appropriate remedies to protect and advocate for the rights of individuals with developmental disabilities under all applicable Federal and State laws because not all critical incidents were reported to them" does not follow from the findings put forth. In addition, the OIG draft report's inclusion of DRM as a part of this finding is inapposite, as DRM does not have a role in responding to reports of serious illness or injury.

The OIG draft report also highlights 104 of the 769 emergency room visits as qualifying as "high-risk critical incidents," which the OIG suggests should have been reported by mandated reporters as suspected abuse or neglect, based solely on the diagnosis codes associated with each emergency room visit. The Department questions the reasonableness of this approach and, accordingly, the conclusion drawn by the OIG. The OIG relies on a list of fifty diagnosis codes, which the OIG indicates are associated with an "increased risk of abuse or neglect."[3] Under the OIG's methodology, if an emergency room visit record included a diagnosis code for any of the fifty diagnosis codes on the list then abuse, neglect, or exploitation must be suspected by mandated reporters and reported to the Department. The diagnosis code list appears to be related to a 2012 Connecticut Office of Protection and Advocacy report, although the 2012 report is not included as an appendix within the OIG's draft report. The criteria used to establish the diagnosis code list and the expertise of those involved in developing the list are unclear.[4]

The State's mandated reporting statute, 22 M.R.S. § 3477, requires that mandated reporters immediately report to the Department "when the person knows or has *reasonable cause to suspect* that an incapacitated or dependent adult has been or is likely to be abused, neglected, or exploited" (emphasis added). The statute does not identify events that are per se indicative of abuse, neglect, or exploitation. Such an approach oversimplifies the reporter's role in critically evaluating whether a situation requires a report to the Department under 22 M.R.S. § 3477. Moreover, "reasonable cause to suspect" is a legal term that requires objective reasonableness under the circumstances of a particular situation. Ultimately, reliance on medical diagnosis codes alone to trigger a report of suspected abuse, neglect, or exploitation is not considered best practice.

Notwithstanding the issues with the OIG's analysis, the Department recognizes that not every critical incident during the audit period was reported to the Department by community-based providers. The Department is committed to working with community-based providers to ensure that all critical incidents are accurately reported. The Department is engaged in ongoing communication with provider agencies to improve reporting.

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[2] The Department recognizes that emergency room visits can, and regularly do, meet the definition of a serious illness or injury as set out in the waiver application, however, in a review of historical data, assuming that every emergency room visit met the definition will produce inaccurate data.

[3] Medical diagnosis codes are used for billing purposes.

[4] The Department requests that the OIG indicate whether medical professionals were consulted to develop the "high risk critical incident" diagnosis code list.

Currently, the Department is in the process of amending the Reportable Events Rule (14-197 C.M.R. ch. 12) and Adult Protective Services Rules (10-149 C.M.R. ch. 5, §§ 11,12) to 1) incorporate up-to-date terminology, 2) clarify the categories of events that qualify as critical incidents, and 3) delineate between events related to abuse, neglect, or exploitation versus other reportable events, so that the Department is able to initiate the proper response as quickly as possible. The Department will provide community education on the rule changes as they are promulgated to support compliance.

2. **Finding:** The State agency did not ensure that community-based providers conduct administrative reviews of all critical incidents involving serious injuries, dangerous situations or suicidal acts and submit their findings within 30 days.
Recommendation: The State agency work with community-based providers to ensure that administrative reviews are conducted and reported appropriately.

Response:
The Department acknowledges that, during the audit period, community-based providers did not forward to the Department copies of administrative reviews conducted related to reportable events for event categories not involving known or suspected abuse, neglect, or exploitation. As noted above, the Department is in the process of updating its rules related to Reportable Events and Adult Protective Services. Certain components of 14-197 C.M.R. ch. 12 are no longer in line with the current structure of the Adult Protective Services system, and modifying the rule to clarify the Department's expectations is a priority.[5] The Department's updated rules will go through the formal rulemaking process.

In addition to updating applicable rules formally, the Department has issued a notice to community-based provider agencies to clarify expectations related to administrative reviews and reporting known or suspected abuse, neglect, and exploitation. The Department is currently holding meetings with each community-based provider on a quarterly basis to discuss trends and patterns associated with reportable events and address questions related to the Department's expectations.[6] The Department will continue to provide education to providers on these topics.

3. **Finding:** The State agency did not report appropriately all restraint usage and rights violations to Disability Rights of Maine.
Recommendation: The State agency report appropriately all restraint usage and rights violations to DRM.

Response:
The OIG draft report indicates that the Department did not send all reports of restraints, rights violations, and reports of abuse, neglect, or exploitation to Disability Rights Maine (DRM), Maine's Protection and Advocacy Agency. The Department acknowledges that not all reports of restraints, rights violations, and adult protective reports were forwarded to DRM.

Reports of abuse, neglect, and exploitation were not forwarded to DRM as a matter of course during the audit period. As Appendix G – Section (d) of the waiver application indicates, DRM is not responsible for performing Adult Protective investigations of known or suspected abuse, neglect, and exploitation.

The OIG draft report notes that DRM was provided access to critical incident reports on restraints and rights violations through EIS, the Department's Reportable Events system and

[5] The updated version of the Reportable Events Rule will contain a requirement that a community-based provider electronically document corrective actions taken following each reportable event.
[6] Quarterly provider meetings began taking place statewide in January 2017.

that the Department did not separately forward all restraint reports to DRM. The OIG draft report suggests that providing access to reports through an electronic system is not equivalent to forwarding individual reports to DRM. The Department respectfully submits that DRM was not precluded from performing its protection and advocacy role by being given the means to access individual reports rather than receiving reports separately forwarded by the Department.

Currently, the Department forwards a monthly summary report on restraints in addition to providing DRM with electronic access to review restraint and rights violation allegation reports.[7]

4. **Finding:** The State agency did not review and analyze data on all critical incidents.
Recommendation: The State agency perform trend analysis and analytical procedures, such as a data match, to provide community-based providers with reports that identify patterns and trends to prevent reoccurrences of critical incidents and determine the number and percentage of critical incidents reported in required timeframes.

Response:
The Department acknowledges that formal trend analysis and claims data comparisons were not performed on a regular basis during the audit period. Currently, the Department performs trend analysis on a regular basis, including performing manual data matches. As noted above, the Department is conducting quarterly meetings with each community-based provider agency and sharing trend analysis findings in each meeting. In addition, the Department's Mortality Review Committee meets regularly to analyze aggregate data related to beneficiary deaths and determine whether there are any identifiable patterns or trends.

With respect to the trend analysis performed by OIG outlined in the OIG draft report, the Department notes that the definition of a "medication error" within the waiver application and Department rule broadly covers many medication-related incidents that are routine (e.g., a client declining to take a daily vitamin). The Department intends to adjust the definition of a "medication error" within the updated Reportable Events Rule so that valuable information can be drawn from trend analysis conducted in the future. The updated Department rule will also clarify other categories of reportable events to better assist community-based providers in identifying appropriate incidents to report.

5. **Finding:** The State agency did not investigate and immediately report to a District Attorney's Office or to law enforcement critical incidents involving suspected abuse, neglect, or exploitation.
Recommendation: The State agency investigate and immediately report to the appropriate district attorney's office or law enforcement all critical incidents involving suspected abuse, neglect, or exploitation.

Response:
The OIG draft report indicates that "the State agency did not investigate all critical incidents involving potential abuse or neglect or provide the findings and recommendations of all investigations it conducted to the community-based providers." In support of this conclusion, the OIG draft report indicates that, of 15,897 critical incidents related to potential abuse or neglect during the audit period, 767 were "accepted for investigation." The Department notes that, during the audit period, "accepted for investigation" was a technical term within the Department's electronic systems to express that an APS caseworker or investigator was assigned to conduct an in-depth investigation. Every report involving allegations of abuse,

[7] The Department has regularly forwarded monthly summary reports on restraints to DRM since January 2017.

neglect, or exploitation, whether or not ultimately "accepted for investigation," underwent an assessment within the Department. During the audit period, allegations reported were evaluated by Department staff and regularly referred to supervisors for further review.

The language of the OIG draft report suggests that the Department failed entirely to evaluate or assess 95% of critical incidents reporting suspected abuse or neglect. This finding is inaccurate unless the OIG draft report is clarified to incorporate the other steps in the Department's process reflecting a more comprehensive definition of the word "investigate."

The Department acknowledges that the language of 22 M.R.S. § 3485 indicates that reports of suspected abuse, neglect, or exploitation shall be reported to the appropriate district attorney's office and, where during an investigation, evidence is found that a person has abused, neglected, or exploited an incapacitated or dependent adult resulting in serious harm, the Department shall notify the appropriate district attorney or law enforcement agency. Respectfully, the Department suggests that the statute cannot be interpreted to mean that every report that Adult Protective Services fields must be relayed to district attorneys' offices. Rather, APS is to notify the appropriate district attorney's office or law enforcement when a crime is suspected based on the information the Department receives or based on the evidence obtained during the course of an APS investigation.

The OIG draft report also includes multiple statements attributed to State agency officials on this finding. In particular, the OIG draft report states, "The State agency informed us that any referrals to district attorneys' offices should be documented in EIS." *OIG Draft Report*, p. 15. As an initial matter, the Department respectfully suggests that verbal representations or opinions from unnamed Department staff on an undisclosed date should not serve to support audit findings focused on data. The Department is unable to confirm whether any Department official made the above statement, and, if such a statement were made, it was in error. A note that a referral was made to a district attorney's office may be included in EIS, but referral information generally would appear in MAPSIS, where APS records and investigation notes are housed.[8] To the extent the OIG relied on EIS data alone, without consulting MAPSIS to support this finding, the finding is indeterminate.

The OIG draft report further states, "State agency officials informed us that investigative findings and recommendations were not always provided to the community-based providers or the district attorneys' offices due to confidentiality concerns." This is an inaccurate statement. APS records (e.g., investigative findings and recommendations) are not forwarded to community-based providers because 22 M.R.S. § 3474 protects the confidentiality of adult protective records and limits their disclosure. Contrary to the statements included in the OIG draft report, such records are shared with district attorneys' offices pursuant to 22 M.R.S. § 3474.

Ultimately, the Department agrees that law enforcement and district attorneys' offices must be notified of reports related to known or suspected abuse, neglect, and exploitation and investigations of same that indicate a crime may have been committed. The Department recognizes that, during the audit period, referrals to law enforcement and district attorneys' offices were not documented electronically in a consistent way. The Department will continue to provide training to staff to ensure that referrals to law enforcement and district attorneys' offices are made appropriately and documented concurrently.

[8] In 2014, fields within the EIS assessment form were updated, reducing the number of fields associated with APS activities.

6. **Finding:** The State agency did not ensure that community-based providers reported all beneficiary deaths and that the State agency analyzed, investigated, and reported these deaths to law enforcement or the Office of the Chief Medical Examiner.
Recommendation: The State agency ensure community-based providers report to the State all beneficiary deaths and that the State agency analyzes, investigates, and reports these deaths to law enforcement or the OCME.

Response:
The OIG draft report states that community-based providers did not report all beneficiary deaths during the audit period. During the audit period, 133 beneficiaries died, and one (1) of the deaths was not reported to the Department. The Department intends to work with community-based providers to ensure that no deaths remain unreported in the future.

The OIG draft report indicates that the Department did not ensure that beneficiaries with developmental disabilities were adequately protected based on a review of each of the 133 beneficiary deaths.[9] As noted in the OIG draft report, the OCME explained to the OIG that the OCME receives reports for all deaths in Maine and reviews sudden, unexpected, or violent deaths. *OIG Draft Report*, page 18 FN 30. The OCME informed the OIG that thirteen (13) of the 133 beneficiary deaths were reviewed through the OCME review process, "but it did not identify potential abuse or neglect in these 13 beneficiary deaths." *OIG Draft Report*, page 18 FN 30.[10]

The current practice of the Department's Adult Protective Services unit is to initiate a review process when the Department is notified of any beneficiary's death. Where the review indicates that abuse, neglect, or exploitation may have been a factor in the beneficiary's death, an APS investigation will be immediately conducted and, if law enforcement was not immediately notified of the death by another party, then APS will notify law enforcement. As noted above, the Department's Mortality Review Committee meets regularly to conduct trend analysis associated with beneficiaries' deaths and determine whether there are any identifiable patterns or trends that can be addressed with community-based providers to improve the safety of individuals with developmental disabilities served by the Department.

Additional Recommendation: The State agency provide training to the State agency's and community-based providers' staffs regarding the HCBS waiver and State requirements for critical incident reporting.

Response:
The Department agrees that ongoing training for community-based provider agency staff and Department staff is necessary to ensure the protection of individuals with developmental disabilities. As noted above, the Department is engaged in training and education efforts with provider agency staff and Department staff and will conduct additional training as updated Department rules are promulgated. Updated rules will also assist in providing needed clarity and consistency in the reportable events system and the APS system.

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[9] The Department requests that the OIG indicate whether medical professionals were consulted as a part of the review process, given the technical knowledge necessary to examine deaths.

[10] The OIG draft report states "the State agency maintained that all beneficiary deaths were reviewed by the OCME" and "Further, State agency did not investigate beneficiary deaths because officials believed that the OCME did so instead." *OIG Draft Report*, pages 19, 20. Neither statement accurately represents the Department's position. The Department has not maintained that all 133 beneficiary deaths during the audit period underwent OCME review. The Department respectfully requests that the above quoted language on pages 19 and 20 of the report be removed.

The Department is committed to the protection of all individuals who receive services through the Department. The Department is confident that current practices are in line with many of the OIG's recommendations offered and serve to protect individuals with developmental disabilities in Maine.

The Department appreciates the opportunity to respond to the OIG draft report and to resolve the outstanding issues and recommendations. The Department would be happy to address any questions you may have regarding the above responses at your convenience.

Sincerely,

Ricker Hamilton
Acting Commissioner

RH/klv

ACKNOWLEDGMENTS

This report was prepared under the direction of David Lamir, Regional Inspector General for Audit Services in the Boston regional office, and Curtis Roy, Assistant Regional Inspector General for Audit Services.

John Sullivan, Senior Auditor, served as team leader for this audit. Other Office of Audit Services staff from the Boston regional office who conducted the audit include Shawn Dill, Richard Johnson, Charles McKenney III, Richard Miller, LeighAnn Phillips, and Michael Willey. Headquarters and Office of Audit Services CMS Baltimore Division staff provided support.