

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**NEW YORK DID NOT FULLY COMPLY  
WITH FEDERAL AND STATE  
REQUIREMENTS FOR REPORTING AND  
MONITORING CRITICAL INCIDENTS  
INVOLVING MEDICAID BENEFICIARIES  
WITH DEVELOPMENTAL DISABILITIES**

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# *Office of Inspector General*

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## Report in Brief

Date: February 2021

Report No. A-02-17-01026

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



### Why OIG Did This Audit

We have performed audits in several States, including New York, in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes. 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. CMS requires States to implement a critical incident reporting system to protect the health and welfare of Medicaid beneficiaries receiving waiver services.

Our objective was to determine whether New York ensured that community-based providers 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.

### How OIG Did This Audit

We reviewed the State agency's system for provider reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings for calendar year 2017. We reviewed a sample of 30 incidents of potentially unreported abuse and neglect, and a judgmental sample of 48 reported incidents related to beneficiaries with developmental disabilities covered by the HCBS Medicaid waiver.

## New York Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities

### What OIG Found

New York did not ensure that providers fully complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Of the 30 incidents of potential abuse and neglect in our sample, 23 incidents were properly reported and investigated; however, 7 incidents were not. Specifically, providers did not properly report three incidents and, for all seven incidents, providers did not meet investigation requirements (four incidents were not investigated on time and three were not investigated adequately). These incidents of potential abuse and neglect were not properly reported because the individuals responsible for reporting them either initially reported them to the wrong authority or erroneously believed that another provider was responsible for reporting them. Investigations were not adequately conducted because: (1) some incidents were not reported on time, thereby delaying initiation of the investigations; and (2) providers' internal policies and procedures for investigating internal incidents were either inadequate or were nonexistent. Because incidents of potential abuse and neglect were not properly reported or investigated, beneficiaries were put at an increased risk of harm.

Of the 48 reported and substantiated incidents of abuse and neglect in our judgmental sample, we found that the associated providers complied with the critical incident reporting and monitoring requirements.

### What OIG Recommends and New York's Comments

We recommend that New York: (1) reinforce guidance to the provider community on various specific requirements related to the reporting and investigating of critical incidents; (2) issue guidance and/or provide training to the provider community on the importance of identifying root causes of an incident, and identifying trends in incidents; and (3) review the three internal occurrence investigations identified in our report for compliance with investigative requirements, and make any necessary changes to the incident classifications in accordance with Part 624.

In written comments on our draft report, New York agreed with our recommendations and described steps it has taken and plans to take to address them.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

We have performed audits in several States, including New York, in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes.<sup>1</sup> This request was made in response to nationwide media coverage of deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors.

In New York, individuals with developmental disabilities may reside in certified community-based settings that offer residential and nonresidential services. Provider types within community-based settings include Developmental Disability Services Offices (State-operated agencies) and nonprofit agencies (collectively known as “community-based providers”). New York’s home and community-based services (HCBS) Medicaid waiver and State regulations incorporated under the State’s HCBS Medicaid waiver require that specified types of events—including alleged abuse and neglect—be reported to the New York State Office for People With Developmental Disabilities (OPWDD) for review and followup action.<sup>2</sup> New York’s HCBS Medicaid waiver contains three categories of incidents that must be reported to OPWDD immediately upon or within 24 hours of incident occurrence or discovery.<sup>3</sup> The HCBS Medicaid waiver refers to these incidents as “critical incidents and events.”

### OBJECTIVE

Our objective was to determine whether New York ensured that community-based providers 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.<sup>4, 5</sup>

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<sup>1</sup> See Appendix B for related Office of Inspector General (OIG) reports.

<sup>2</sup> HCBS waiver, Appendix G-1(b) and Title 14, Part 624 of New York Compilation of Codes, Rules, & Regulations.

<sup>3</sup> Categories include reportable incidents, reportable significant incidents, and serious notable occurrences. See HCBS waiver, Appendix G-1(b).

<sup>4</sup> The term “New York” refers collectively to the New York State Department of Health, OPWDD, and the New York State Justice Center for the Protection of People with Special Needs, each of which has a role in the reporting and monitoring of critical incidents under the HCBS waiver.

<sup>5</sup> The monitoring function includes the investigation, review, and followup of critical incidents.

## **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), “developmental disability” means a severe, chronic disability that is attributable to a mental impairment, a physical impairment, or a combination of both; is evident before the age of 22 and likely to continue indefinitely; and results in substantial limitations in three or more of these major life areas: self-care, receptive and expressive language, learning, mobility, self-determination, capacity for independent living, and economic self-sufficiency.<sup>6</sup>

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

### **New York’s Medicaid Home and Community-Based Services Waiver**

Section 1915(c) of the Social Security Act (the Act) authorizes HCBS waiver programs. The program permits a State 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. Waiver services complement or supplement the services that are available to beneficiaries 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.

States must provide certain assurances to the Centers for Medicare & Medicaid Services (CMS) to receive approval for an 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 that the State 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(b)).

In its waiver, New York stated that it has a rigorous and comprehensive system for identifying, reporting, and investigating incidents and reports of abuse, and for assuring appropriate corrective actions to protect from harm individuals receiving services. New York’s waiver specifically cited the State’s regulations at Title 14, Parts 624 and 625 of the New York Compilation of Codes, Rules, & Regulations (NYCRR) as the foundation for its incident management system.

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<sup>6</sup> P.L. No. 106-402 (Oct. 30, 2000).

In New York, OPWDD administers HCBS Medicaid waiver services to individuals with developmental disabilities. OPWDD provides services to individuals—both Medicaid and non-Medicaid beneficiaries—with intellectual and developmental disabilities under a cooperative agreement with the New York State Department of Health (State agency), which administers the State’s Medicaid program.<sup>7</sup>

New York also operates the New York State Justice Center for the Protection of People with Special Needs (Justice Center), which has jurisdiction over a number of State oversight agencies.<sup>8</sup> Created in 2012 by legislation known as the Protection of People with Special Needs Act (Special Needs Act), the Justice Center serves both as a law enforcement agency and as an advocate for people with special needs.<sup>9, 10</sup> The mission of the Justice Center is to support and protect the health, safety, and dignity of all people with special needs and disabilities through advocacy of their civil rights, prevention of mistreatment, and investigations of all allegations of abuse and neglect so that appropriate actions are taken.

### **New York Critical Incident Reporting and Monitoring**

Title 14, Part 624 of the NYCRR sets forth the minimum requirements for managing critical incidents and is applicable to all facilities and programs that are operated, certified, sponsored, or funded by OPWDD for the provision of services to persons with developmental disabilities (14 NYCRR § 624.1(a)). It further requires an incident management system, including the reporting, investigation, review, correction, and monitoring of certain events or situations (14 NYCRR § 624.2(a)). These regulations task two State agencies—OPWDD and the Justice Center—with functions and responsibilities for reporting and monitoring critical incidents in New York’s incident management system.

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<sup>7</sup> OPWDD is responsible for coordinating services for nearly 140,000 New Yorkers with developmental disabilities, including intellectual disabilities, cerebral palsy, Down syndrome, autism spectrum disorders, and other neurological impairments. Approximately 50 percent of waiver enrollees live in their own homes or family homes where they receive services that enable them to live as independently as possible. Many of the participants have intermittent waiver supports such as staff that come to their residence a few days or hours per week. Other participants with greater needs may reside in a certified community setting that is staffed 24 hours a day, 7 days a week, and use an intensive day service such as day habilitation 5 days a week (HCBS waiver, Brief Waiver Description).

<sup>8</sup> The State oversight agencies under the jurisdiction of the Justice Center include OPWDD, the Department of Health, the Office of Mental Health, the Office of Addiction Services and Supports, the Office of Children and Family Services, and the State Education Department.

<sup>9</sup> Ch. 501, Laws of New York (2012).

<sup>10</sup> New York Executive Law, Article 20.

## *Office for People With Developmental Disabilities*

OPWDD has a centralized system for overseeing critical incidents and has designated its Incident Management Unit (IMU) to oversee allegations of abuse, serious reportable incidents, and deaths occurring at community-based providers (i.e., both State-operated and nonprofit agencies).<sup>11</sup> All reportable incidents and serious notable occurrences must be reported immediately to IMU.<sup>12, 13</sup> Other events may be reported as “agency-internal occurrences.”<sup>14</sup> OPWDD also requires community-based providers to develop policies and procedures that conform with Part 624 of the NYCRR to address reporting, recording, investigating, reviewing, and monitoring of reportable incidents and notable occurrences.<sup>15</sup>

IMU’s function is to ensure the protection of persons with disabilities, including notifying law enforcement when required.<sup>16</sup> Incidents are reported through the OPWDD Incident Report and Management Application (IRMA), a secure, web-based, statewide database used by community-based providers for reporting and documenting information to ensure consistency in incident reporting. Allegations of abuse, serious reportable incidents, and all deaths must be reported through IRMA within 24 hours of occurrence or discovery, or by the close of the next business day (whichever is later).<sup>17</sup>

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<sup>11</sup> IMU is part of OPWDD’s Division of Quality Improvement. The Division of Quality Improvement routinely conducts surveys of nonprofit agencies.

<sup>12</sup> HCBS waiver, Appendix G-1(e) and 14 NYCRR § 624.5(c)(1). Reportable incidents are events or situations that meet the definition of abuse, neglect, or a significant incident (14 NYCRR § 624.3(a)). Abuse includes physical abuse, sexual abuse, psychological abuse, deliberate inappropriate use of restraints, aversive conditioning, obstruction of reports of reportable incidents, and unlawful use or administration of a controlled substance (HCBS waiver, Appendix G-1(b) and 14 NYCRR § 624.3(b)(1 to 7)). Neglect is defined as any action, inaction, or lack of attention that breaches a custodian’s duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of a service recipient (14 NYCRR § 624.3(b)(8)). A significant incident is defined as an incident, other than an incident of abuse or neglect, that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety, or welfare of a person receiving services (14 NYCRR § 624.3(b)(9)).

<sup>13</sup> Serious notable occurrences include the death of any person receiving services, regardless of the cause of death, or a sensitive situation that does not meet any other incident in 14 NYCRR § 624.3 but is of a delicate nature that is reported to ensure awareness of the circumstances (14 NYCRR § 624.4(2)(i)).

<sup>14</sup> Injuries requiring more than first-aid treatment are generally classified as minor notable occurrences (14 NYCRR § 624.4(2)(ii)(b)) and may be reported as agency-internal occurrences (14 NYCRR § 624.5(a) and 14 NYCRR § 624.5(b)(2)(i)). Injuries requiring no more than first-aid treatment do not need to be reported.

<sup>15</sup> 14 NYCRR § 624.5(a)(1).

<sup>16</sup> IMU is available to receive calls 24 hours a day, 7 days a week and provides real-time oversight of critical elements of incident management across the State.

<sup>17</sup> 14 NYCRR § 624.5(f)(ii).

## *The Justice Center*

While the Justice Center is responsible for ensuring the investigation of reportable incidents at community-based providers, it does not conduct every investigation.<sup>18</sup> The Justice Center investigates all allegations of abuse and neglect at State-operated providers and all serious allegations of abuse and neglect at nonprofit agencies. For other allegations of abuse and neglect at nonprofit agencies, the Justice Center determines whether it will complete an investigation or delegate the investigation to OPWDD or the nonprofit agency, as applicable.

The New York Social Services Law (NYSSL) § 492(3)(c) requires that the Justice Center promptly initiate an investigation upon receipt of a report of abuse or neglect. It is also responsible for initiating investigations of all allegations of reportable incidents received by the Vulnerable Persons' Central Register (VPCR). VPCR is a centralized, statewide toll-free hotline and incident reporting system staffed 24 hours a day, 7 days a week, and tracks allegations of abuse, neglect, and significant incidents.

The Justice Center makes the final determination regarding all investigations of alleged abuse and neglect, and is generally required to make that determination within 60 days (NYSSL § 493.1).<sup>19</sup> Regardless of which entity conducts the investigation, the Justice Center reviews the investigation and makes the legal determination as to whether the case is substantiated or unsubstantiated.<sup>20</sup> The Justice Center works with and shares the outcomes of its investigations with other government entities and reports annually on its investigations to the Governor and legislature.<sup>21</sup>

See Appendix C for Federal and State requirements related to New York's HCBS Medicaid waiver.

## **HOW WE CONDUCTED THIS AUDIT**

We reviewed the State agency's system for provider reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities who reside in community-based settings for calendar year 2017 (audit period).<sup>22</sup> We focused on two types of

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<sup>18</sup> The Justice Center investigates all deaths.

<sup>19</sup> An investigation may exceed 60 days if the reason for delay is documented.

<sup>20</sup> If an abuse or neglect investigation determines that there is a preponderance of evidence to support the allegation, the allegation may be substantiated. Conversely, the allegation may be unsubstantiated for various reasons, such as not enough evidence to confirm that the abuse or neglect occurred.

<sup>21</sup> The Justice Center's Annual Report to the Governor and Legislature is available at <https://www.justicecenter.ny.gov/system/files/documents/2019/03/2017-annual-report0.pdf>.

<sup>22</sup> Our audit period was determined based on the most recent data available at the time we began the audit.

incidents: (1) incidents of potential abuse and neglect, and (2) reported and substantiated incidents of abuse and neglect.<sup>23</sup>

To determine whether incidents of potential abuse and neglect were reported, we identified 3,662 emergency room (ER) claims that contained 1 or more of 71 “high-risk” medical diagnosis codes indicative of potential abuse and neglect, and reviewed a sample of 30 of these incidents.<sup>24, 25, 26</sup> We determined whether the community-based provider associated with each incident met and, if applicable, complied with the critical incident reporting and monitoring requirements (including investigation, review, and followup).

From 4,656 reported and substantiated incidents of abuse and neglect, we reviewed a judgmental sample of 48 incidents related to beneficiaries with developmental disabilities covered by the HCBS Medicaid waiver.<sup>27</sup> We determined whether each incident was reported and monitored in accordance with applicable Federal and State requirements.

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 A contains the details of our audit scope and methodology.

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<sup>23</sup> The incidents of potential abuse and neglect consisted of Medicaid reimbursed emergency room (ER) claims with certain high-risk diagnosis codes indicative of potential abuse and neglect for developmentally disabled Medicaid beneficiaries residing in community residences during our audit period. The reported and substantiated incidents of abuse and neglect consisted of those incidents of abuse and neglect contained in the 2017 Annual Report to the Governor and Legislature published by the Justice Center.

<sup>24</sup> The medical diagnosis codes that we included in our audit were determined to be high-risk codes by the OIG Chief Medical Officer.

<sup>25</sup> Appendix D contains a list of the high-risk medical diagnosis codes associated with the 30 sampled incidents of potential abuse and neglect.

<sup>26</sup> Each of the 30 randomly sampled ER claims represented a separate reportable incident; therefore, we refer to these claims as incidents throughout the report, and reviewed all 30 sampled incidents for compliance with applicable Federal and State requirements. Of these 30 sampled incidents of potential abuse and neglect, we found that 6 sampled incidents required reporting to IMU. The remaining 24 sampled incidents were not required to be reported to IMU but were classified by providers as agency-internal occurrences. The providers associated with these 24 incidents were required to keep incident reporting and monitoring records in accordance with their own internal policies and procedures.

<sup>27</sup> We selected incidents associated with beneficiaries who each had five or more substantiated incidents of abuse and neglect during the audit period.

## FINDINGS

New York did not ensure that providers fully complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Of the 30 incidents of potential abuse and neglect in our sample, 23 incidents were properly reported and investigated; however, 7 incidents were not. Specifically, providers did not properly report three incidents and, for all seven incidents, providers did not meet investigation requirements (four incidents were not investigated on time and three were not investigated adequately). These incidents of potential abuse and neglect were not properly reported because the individuals responsible for reporting them either initially reported them to the wrong authority or erroneously believed that another provider was responsible for reporting them. Investigations were not adequately conducted because: (1) some incidents were not reported on time, thereby delaying the initiation of the investigations; and (2) providers' internal policies and procedures for investigating internal incidents were either inadequate or nonexistent. Because incidents of potential abuse and neglect were not properly reported or investigated, beneficiaries were put at increased risk of harm.

For the 48 reported and substantiated incidents of abuse and neglect in our judgmental sample, we found that the associated providers complied with the critical incident reporting and monitoring requirements.

### UNREPORTED INCIDENTS OF POTENTIAL ABUSE AND NEGLECT

We found that 7 of the 30 sampled incidents of potential abuse and neglect were not properly reported and investigated. Specifically, providers did not properly report three incidents, and for all seven incidents providers did not meet investigation requirements (four incidents were not investigated on time and three were not investigated properly or adequately).

#### Critical Incidents Not Reported On Time or Properly

All reportable incidents and serious notable occurrences must be reported immediately to IMU by telephone (14 NYCRR § 624.5(c)(1)).<sup>28, 29</sup> Responsible provider officials (known as custodians) must submit a report of a reportable incident to VPCR immediately upon discovery

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<sup>28</sup> A State official informed us that the State interprets "reported immediately" to mean reported within 24 hours of discovery.

<sup>29</sup> HCBS waiver, Appendix G-1(e). Providers must make notifications to IMU by telephone. IMU has staff available to receive notifications by telephone 24 hours a day, 7 days a week, including state holidays (14 NYCRR § 624.5(c) Commentary).

of a reportable incident (14 NYCRR § 624.5(d)(3)).<sup>30</sup> In addition, all reportable incidents and serious notable occurrences must be reported to the provider's chief executive officer (or designee) immediately upon occurrence or discovery (14 NYCRR § 624.5(b)(2)(ii)). All minor notable occurrences must be reported to the provider's chief executive officer (or designee) within 48 hours of occurrence or discovery (14 NYCRR 624.5(b)(2)(i)).

Two incidents that required reporting to IMU were not reported immediately or by telephone.<sup>31</sup> Rather, the provider reported the incidents 1 day and 12 days, respectively, after being made aware of them. Additionally, the provider reported the incidents by email rather than by telephone, as required. These errors occurred because the individuals responsible for reporting the incidents failed to report them to the appropriate authority (i.e., a supervisor). Instead, they reported them to nurses who were not supervisors and who also did not report the incidents. Upon discovery of the initial reporting failures, the provider's quality assurance staff reported the incidents to IMU.

A third incident, classified by the provider as a minor notable occurrence, was reported internally to some staff but not to the provider's chief executive officer (or designee) within 48 hours of the occurrence or discovery. This error occurred because a group home supervisor erroneously believed that another provider was required to report the incident. (We noted that the group home supervisor was subsequently terminated, in part for not reporting the incident.)

As a result of delays in reporting, investigations into the incidents were delayed; therefore, corrective actions by the providers may have been delayed and beneficiaries were put at potential risk of harm.

### **Investigations Not Initiated or Completed On Time**

Any report of a reportable incident or notable occurrence (whether serious or minor) must be thoroughly investigated (14 NYCRR § 624.5(h)(1)). Investigations of all reportable incidents and notable occurrences must be initiated immediately (14 NYCRR § 624.5(h)(2)). The investigation must be completed no later than 30 days (for OPWDD or community-based provider investigations) or 60 days (for Justice Center investigations) after the incident is reported. An investigation is considered complete upon completion of the investigative report. The timeframe for completion of a specific investigation may be extended beyond the 30-day or 60-day timeframe if there is adequate justification to do so and the justification is documented

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<sup>30</sup> Discovery occurs when the mandated reporter witnesses a suspected reportable incident or when another party, including an individual receiving services, comes before the mandated reporter in the mandated reporter's professional or official capacity and provides the mandated reporter with reasonable cause to suspect that the individual has been subjected to a reportable incident (14 NYCRR § 624.5(d)(3)(i)).

<sup>31</sup> Both incidents occurred at the same provider and were classified by the provider as reportable incidents of neglect.

(14 NYCRR §§ 624.5(n)(1) and (2), 11 New York Social Services Law (NYSSL) § 493.1, and HCBS waiver, Appendix G-1(d)).

For 4 of the 30 sampled incidents, investigations were not initiated or completed on time. Specifically:

- One investigation by a provider was initiated 20 days after the incident was discovered and reported. The investigation was completed 35 days after it was reported (5 days late) with no documented justification for the delay.
- One investigation by a provider was initiated on time but completed 92 days after it was reported (62 days late) with no documented justification for the delay.
- One investigation by the Justice Center was initiated 1 day after the incident was reported.
- One investigation by the Justice Center was initiated 12 days after the incident was reported.

Two investigations were not conducted in a timely manner because providers failed to follow applicable regulations.<sup>32</sup> The remaining two investigations (conducted by the Justice Center) were initiated late because providers did not report the incidents on time. These late investigations could have delayed corrective actions by the providers, and beneficiaries were put at increased risk of harm.

### **Investigations Were Not Adequate**

Providers are also responsible for determining how potentially harmful internal events other than reportable incidents and notable occurrences are to be documented, processed, corrected, monitored, and analyzed for trends through the development of policies and procedures that are in compliance with 14 NYCRR, and to develop a mechanism for review to ensure compliance with such policies and procedures (14 NYCRR § 624.2(e)).

For 3 of the 30 sampled incidents, we found that the incidents were not adequately investigated or analyzed for trends. Two of the incidents involved beneficiaries with histories of self-injurious behavior who suffered self-inflicted head injuries. The remaining incident involved a beneficiary who fell while wearing leg braces. The incidents all resulted from injuries to the beneficiaries that required no more than first aid and were reported and investigated by the providers as “agency-internal occurrences.” Such incidents should be adequately investigated and analyzed for trends in accordance with the providers’ own internal policies

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<sup>32</sup> We noted that one provider terminated the supervisor responsible for the investigation for poor oversight. The second provider was subsequently cited by OPWDD for needing improvement in completing investigations within the required timeframe.

and procedures that comply with 14 NYCRR. However, we determined that all three incidents were not adequately investigated because internal investigation reports relating to them: (1) failed to identify applicable precautions and protective oversights contained in the beneficiaries' care plans that were intended to prevent these types of injuries; and (2) did not identify whether providers followed these precautions and protective oversights. Additionally, these events also were not analyzed for trends. One of these incidents is summarized below.

<b>Example: Series of Self-Inflicted Injuries</b>
<p>One beneficiary's care plan noted a history of self-injurious behavior and indicated that constant supervision was necessary. The provider staff noticed a scratch on the beneficiary's head that appeared to be aggravated because the beneficiary continuously picked at it. A nurse was notified of the injury and applied bacitracin ointment to the scratch. The beneficiary was taken to an ER to address it.</p> <p>We found that the incident was the second in a series of 10 similar incidents over a 3-month period during which the beneficiary suffered self-inflicted scratches, all of which were treated with first aid. All 10 incidents were reported and investigated by the provider as agency-internal occurrences in accordance with its own internal policies and procedures. However, in response to a question in a form used in all 10 investigations, we found that the provider indicated that no related incidents had been previously reported, or the provider did not respond to the question. Each of the investigative reports focused on documenting an individual incident—not the beneficiary's history of self-injurious behavior, the need for constant supervision, or whether such supervision was provided. We noted that the 10 incidents were investigated by 7 different investigators, none of whom identified a trend of similar incidents.</p>

These incidents occurred because: (1) one provider did not have internal policies and procedures in place to address internal incidents; and (2) two providers' internal policies and procedures did not require identification of the root cause of an incident. Because providers were not required to identify the root causes of these incidents, such as the apparent failure to properly follow care plans, they were not adequately investigated, and each could have been misclassified as an agency-internal occurrence rather than as a reportable incident. For example, as with the incident described above, the beneficiary's self-inflicted head injuries were classified by the provider as agency-internal occurrences; therefore, they were not reported to IMU. However, the provider's internal investigations did not determine whether proper supervision described in the beneficiary's care plan was provided. Failure to provide such supervision constitutes a reportable incident of neglect.<sup>33</sup> Therefore, such an incident may

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<sup>33</sup> Neglect is defined as any action, inaction, or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of a service recipient (14 NYCRR § 624.3(b)(8)). Neglect includes failure to provide proper supervision (14 NYCRR § 624.3(b)(8)(i)).

have been misclassified and not properly reported. Additionally, failure to identify trends in a beneficiary's behavior, such as those described in the example, hinders the prevention of recurring incidents.

## **REPORTED AND SUBSTANTIATED INCIDENTS OF ABUSE AND NEGLECT**

### **Providers Complied With Critical Incident Reporting and Monitoring Requirements**

We selected a judgmental sample of 48 reported and substantiated incidents of abuse and neglect.<sup>34</sup> The providers associated with these incidents complied with critical incident reporting and monitoring requirements (including investigation, review, and followup). We reviewed the investigative reports and corrective action plans associated with the 48 sampled incidents and determined that the providers recommended appropriate, corrective actions.

Appendix E contains our analysis of the reported and substantiated incidents of abuse and neglect.

## **RECOMMENDATIONS**

We recommend that the New York State Department of Health work with the Office for People With Developmental Disabilities and the Justice Center to:

- reinforce guidance to the provider community on requirements related to:
  - the timing and method of initially reporting incidents,
  - the timely completion of incident investigations, and
  - the need to document justifications for investigative delays;
- issue guidance and/or provide training to the provider community on the importance of identifying the root causes of incidents;
- issue guidance and/or provide training to the provider community on the importance of identifying trends in incidents; and
- review the three internal occurrence investigations identified in our report to determine whether the providers complied with applicable requirements, and make any necessary changes to the incident classifications in accordance with Part 624.

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<sup>34</sup> These 48 incidents include all incidents associated with 9 beneficiaries who were each involved in 5 or more substantiated incidents of abuse or neglect during the audit period.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the State agency agreed with our recommendations and described steps it has taken and plans to take to address them, including providing refresher training on reporting requirements and developing training on root cause and trend analysis of incidents. The State agency also indicated that it initiated a review of the three internal occurrence investigations identified in our report. In its comments, the State agency also clarified the roles and responsibilities of OPWDD and the Justice Center. Accordingly, we modified our report to reflect these clarifications. The State agency's comments appear in their entirety as Appendix H.

### **OTHER MATTERS: PLACEMENT OF SEX OFFENDERS IN GROUP HOMES AND CONDUCT BETWEEN BENEFICIARIES**

During our audit, we became aware of several media reports of convicted sex offenders with special needs being placed in community-based settings. OPWDD officials stated that convicted sex offenders are placed according to an OPWDD policy dating back to 1999, and placement of a convicted sex offender involves a risk management review. We queried the New York State Sex Offender Registry website for the names of all the beneficiaries associated with the 30 potential incidents of abuse and neglect and the 48 reported and substantiated incidents of abuse and neglect that we reviewed.<sup>35</sup> We found no matches; however, 1 of the 48 reported and substantiated incidents of abuse and neglect that we reviewed involved sexual conduct between 2 beneficiaries.

The incident involved two adult beneficiaries (Beneficiaries A and B) who resided in the same group home and the care workers assigned to each of them. Beneficiary A allegedly sexually assaulted Beneficiary B in the bathroom of the group home, according to the incident report. The report also indicated that Beneficiary A had allegedly sexually assaulted another beneficiary in the bathroom 2 weeks prior to allegedly sexually assaulting Beneficiary B.<sup>36</sup>

We believe New York could work with CMS to determine whether additional safeguards are needed under the HCBS Medicaid waiver to protect all beneficiaries in situations involving nonconsensual sexual contact between beneficiaries or any other conduct between beneficiaries.

Appendix F contains further details on these two matters.

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<sup>35</sup> New York State Sex Offender Registry, <https://www.criminaljustice.ny.gov/nsor/>.

<sup>36</sup> Both alleged sexual assaults were identified in the incident reports as rape.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

We reviewed the State agency's reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings for calendar year 2017 (audit period). Specifically, we focused on two types of incidents: (1) incidents of potential abuse and neglect, and (2) reported and substantiated incidents of abuse and neglect.

For incidents of potential abuse and neglect, we identified 3,662 ER claims that contained 1 or more of 71 "high-risk" medical diagnosis codes indicative of potential abuse and neglect, and reviewed a sample of 30 of these incidents.<sup>37</sup> We determined whether the community-based provider associated with each incident met and, if applicable, complied with the critical incident reporting and monitoring requirements (including investigation, review, and followup).

From 4,656 reported and substantiated incidents of abuse and neglect, we reviewed a judgmental sample of 48 incidents related to beneficiaries with developmental disabilities covered by the HCBS Medicaid waiver. We determined whether each incident was reported and monitored in accordance with Federal and State requirements.

We did not assess the State's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our audit objective.

We conducted our fieldwork at the State agency and OPWDD offices in Albany, New York, and at the Justice Center office in Delmar, New York.

### METHODOLOGY

To accomplish our objective, we:

- reviewed Federal Medicaid waiver and State laws and regulations referenced under the waiver related to reporting and monitoring critical incidents of abuse and neglect involving vulnerable populations;

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<sup>37</sup> Each of the 30 randomly sampled ER claims represented a separate reportable incident; therefore, we refer to these claims as incidents, and reviewed all 30 sampled incidents for compliance with applicable Federal and State requirements. Of these 30 sampled incidents of potential abuse and neglect, we found that incidents related to 6 sampled incidents required reporting to IMU. The remaining 24 sampled incidents were not required to be reported to IMU but were classified by providers as agency-internal occurrences. The providers associated with these 24 incidents were required to keep incident reporting and monitoring records in accordance with their own internal policies and procedures.

- held discussions with New York officials regarding the State’s monitoring, tracking, investigation, and resolution of allegations of abuse and neglect involving individuals with developmental disabilities;
- reviewed incidents of potential abuse and neglect by:
  - developing a sampling frame of 3,662 Medicaid claims with 1 or more medical high-risk diagnosis codes associated with ER services provided to individuals with developmental disabilities residing in community-based settings;
  - comparing the Medicaid Management Information System claims to OPWDD claims submitted by community-based providers to establish reasonable assurance of the accuracy of the data; and
  - randomly selecting a sample of 30 claims and, for each incident associated with a sample claim:
    - reviewed medical record documentation obtained from community-based providers and OPWDD for a 3-month period to determine whether: (1) the incident that led to the ER service met critical incident reporting, recording, or investigation requirements, and (2) if applicable, the incidents were correctly reported, recorded, or investigated; and
    - determined whether the Medicaid beneficiary involved in the incident was a registered sex offender;<sup>38</sup>
- reviewed, reported, and substantiated incidents of abuse and neglect by:
  - obtaining from the Justice Center an Excel file containing a list of 4,656 OPWDD-reported and substantiated incidents of abuse and neglect related to approximately 4,000 Medicaid beneficiaries during the audit period;<sup>39</sup>
  - comparing the number of OPWDD-reported and substantiated incidents to the 2017 annual report published by the Justice Center to establish reasonable assurance of the accuracy of the data;<sup>40</sup>

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<sup>38</sup> We queried the New York State Sex Offender Registry for the names of associated beneficiaries.

<sup>39</sup> Total incidents include beneficiaries involved in more than one incident.

<sup>40</sup> 2017 Annual Report to the Governor and Legislature, Mar. 5, 2018, available at <https://www.justicecenter.ny.gov/system/files/documents/2019/03/2017-annual-report0.pdf>.

- selecting a judgmental sample of 48 incidents associated with 9 Medicaid beneficiaries who were each involved in 5 or more reported incidents during the audit period, and for each reported incident:
  - reviewed OPWDD Investigative Report Form 149 obtained from the Justice Center to determine whether the Medicaid beneficiary involved in the incident was a registered sex offender,<sup>41</sup> and
  - reviewed deficiencies cited in the investigative report to determine the causes of the incidents and types of corrective actions recommended;<sup>42</sup> and
- discussed the results of our audit with State agency officials.

See Appendix G for the details of our statistical sampling methodology.

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.

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<sup>41</sup> OPWDD Form 149 is required for investigations of reportable incidents, serious notable occurrences, and minor notable occurrences.

<sup>42</sup> If deficiencies are found that rise to the level of egregious, systemic, or pervasive, the community-based provider will receive a Statement of Deficiency requiring a Corrective Action Plan.

**APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Texas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<a href="#">A-06-17-04003</a>	7/9/2020
<i>Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities</i>	<a href="#">A-07-18-06081</a>	3/27/2020
<i>Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<a href="#">A-03-17-00202</a>	1/17/2020
<i>Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<a href="#">A-09-17-02006</a>	6/11/2019
<i>Joint Report: Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight</i>	<a href="#">Joint Report</a> <sup>43</sup>	1/17/2018
<i>Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<a href="#">A-01-16-00001</a>	8/9/2017
<i>Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	<a href="#">A-01-14-00008</a>	7/13/2016
<i>Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	<a href="#">A-01-14-00002</a>	5/25/2016
<i>Review of Intermediate Care Facilities in New York With High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries</i>	<a href="#">A-02-14-01011</a>	9/28/2015

<sup>43</sup> This report was jointly prepared by the Department of Health and Human Services' OIG, Administration for Community Living, and Office for Civil Rights.

## APPENDIX C: FEDERAL WAIVER AND STATE REQUIREMENTS

### MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER

States must provide CMS with certain assurances to receive approval for an HCBS Medicaid waiver, including that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the service.<sup>44</sup> The State agency must provide CMS with information regarding these participant safeguards in the HCBS waiver, Appendix G, *Participant Safeguards*. A State must provide assurances regarding three main categories of safeguards:

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

The HCBS waiver, Appendix G-1, “Participant Safeguards: Response to Critical Events or Incidents,” in G-1(b) states, “All providers of service must have a system that complies with Part 624 . . . including appropriate policies and procedures that address all regulatory components and one or more Incident Review Committees (IRC) to review and monitor reportable incidents of abuse/neglect, significant incidents, and notable occurrences.” The HCBS waiver specifies that the IRC assures that the agency has taken necessary corrective and protective actions; determines whether additional measures are necessary; determines whether the agency reporting and/or review was adequate; identifies trends; and makes recommendations to the agency’s director for improvements. The provider where the incident occurred is further required to take appropriate action to minimize the potential for recurrence of the incident and similar incidents. Title 14, Part 624 of the NYCRR specifies the standards for identifying, reporting, investigating, reviewing, and following up on all reportable incidents, including reports of abuse, significant incidents, and notable occurrences under the auspices of an agency. The HCBS waiver requires that reportable incidents, including all reports of abuse and neglect, significant incidents, and serious notable occurrences must be reported to OPWDD immediately and then subsequently entered into IRMA. The waiver further states, “Immediate protective measures must be put in place to protect the person(s) served.” It also specifies that for facilities operated or certified by OPWDD, agencies must report all reportable incidents to the Justice Center’s VPCR. All reportable incidents and notable occurrences must be investigated. All reports of abuse or neglect must include a finding of whether the report is substantiated or unsubstantiated. The waiver also states, “Effective 1/1/2015, corrective action plans are required of the provider agency if any deficiencies are identified; submitted into IRMA and reviewed by OPWDD IMU staff to ensure that the corrective action plan is adequate . . . . [E]ach corrective action plan must also include documentation of each corrective action. This is also reviewed during site visits by OPWDDs [sic] Bureau of Program Certification.”

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<sup>44</sup> 42 CFR § 441.302(a).

The HCBS waiver, Appendix G-1, "Participant Safeguards: Response to Critical Events or Incidents," in G-1(d), "Responsibility for Review of and Response to Critical Events or Incidents" states, "For all reportable incidents, including reports of abuse and neglect and notable occurrences the investigation must begin immediately." Final investigative reports must be completed in the format required by OPWDD no later than 30 days after the incident occurred or was discovered, unless the agency has been granted an extension after a review of the circumstances.

The HCBS waiver, Appendix G-1, "Participant Safeguards: Response to Critical Events or Incidents," in G-1(e), "Responsibility for Oversight of Critical Events or Incidents" states, "OPWDD has centralized its oversight of critical incidents and events. All oversight activities are assigned to OPWDD's Division of Quality Improvement. OPWDD's IMU provides real time oversight of critical elements of incident management across the state. Both Voluntary Providers and State Operations Offices must notify the IMU of Reportable Incidents and Serious Notable Occurrences. Appropriate notifications to IMU are made by telephone for Reportable Incidents. Notification may be made by email for incidents that do not fall in the Reportable category." The waiver specifies again that all reportable incidents, including all abuse and neglect and serious notable occurrences must be reported to OPWDD immediately and subsequently entered into IRMA. The review of incident reporting systems is a component of the Division of Quality Improvement's annual routine survey activity for all service providers, including HCBS waiver providers. The OPWDD Statewide Committee on Incident Review reviews data on incident reports and disseminates best practices and guidance based on this review to assist in the management and prevention of incidents.

### **Home and Community-Based Services Waiver Program in New York**

New York requires an incident management system, including the reporting, investigation, review, correction, and monitoring of certain events or situations in order to protect individuals receiving services (to the extent possible) from harm; ensure that individuals are free from abuse and neglect; and enhance the quality of their services and care (14 NYCRR § 624.2(a)).

It is the intent of 14 NYCRR, Part 624 to require a process whereby those events or situations that endanger a person's well-being while under the auspices of an agency, which are defined as "reportable incidents" and "notable occurrences," are reported, investigated, and reviewed, and that protective, corrective, and remedial actions are taken as necessary (14 NYCRR § 624.2(d)).

"Person receiving services" or "service recipient" shall mean an individual who resides or is an inpatient in a residential facility or who receives services from a facility or provider agency (11 NYSSL § 488.9).

"Mandated reporter" shall mean a custodian or a human services professional, but shall not include a service recipient (11 NYSSL § 488.5).

“Custodian” means a director, operator, employee or volunteer at a facility or provider agency; or a consultant or an employee or volunteer at a corporation, partnership, organization, or governmental entity that provides goods or services to a facility or provider agency pursuant to a contract or other arrangement that permits such person to have regular and substantial contact with individuals who are cared for by the facility or provider agency (11 NYSSL § 488.2).

“Human services professional” shall mean any: physician; registered physician assistant; surgeon; medical examiner; coroner; dentist; dental hygienist; osteopath; optometrist; chiropractor; podiatrist; resident; intern; psychologist; registered nurse; licensed practical nurse; nurse practitioner; social worker; emergency medical technician; licensed creative arts therapist; licensed marriage and family therapist; licensed mental health counselor; licensed psychoanalyst; licensed behavior analyst; certified behavior analyst assistant; licensed speech/language pathologist or audiologist; licensed physical therapist; licensed occupational therapist; hospital personnel engaged in the admission, examination, care, or treatment of persons; Christian Science practitioner; school official including but not limited to school teacher, school guidance counselor, school psychologist, school social worker, school nurse, school administrator, or other school personnel required to hold a teaching or administrative license or certificate; full- or part-time school employee who is required to hold a temporary coaching license or professional coaching certificate; social services worker; any other child care or foster care worker; mental health professional; person credentialed by the Office of Alcoholism and Substance Abuse Services; peace officer; police officer; district attorney or assistant district attorney; investigator employed in the office of a district attorney; or other law enforcement official (11 NYSSL § 488.5-a).

“State oversight agency” shall mean the State agency that operates, licenses, or certifies an applicable facility or provider agency provided, however, that such term shall only include the following entities: Office of Mental Health; Office for People with Developmental Disabilities; Office of Alcoholism and Substance Abuse Services; Office of Children and Family Services; Department of Health; and State Education Department. “State oversight agency” does not include agencies that are certification agencies pursuant to Federal law or regulation (11 NYSSL § 488.4-a).

### **Critical Incident Reporting for Community-Based Providers**

Providers must develop policies and procedures that are in conformance with Part 624 for reporting, recording, investigating, reviewing, and monitoring reportable incidents and notable occurrences (14 NYCRR § 624.5(a)).

All community-based providers are responsible for making appropriate notifications to OPWDD IMU (14 NYCRR § 624.5(b)-(c) and Appendix G-1(e)).

All reportable incidents and serious notable occurrences must be reported immediately to OPWDD IMU (14 NYCRR § 624.5(c)(1) and HCBS waiver, Appendix G-1(e)). OPWDD IMU has staff available to receive notifications by telephone 24 hours a day, 7 days a week (14 NYCRR § 624.5(c) Commentary).

VPCR shall receive reports of allegations of reportable incidents 24 hours a day, 7 days a week (11 NYSSL § 492.2(b)).

The Justice Center is responsible for commencing investigations of all allegations of reportable incidents that are accepted by VPCR. With respect to such an investigation, the Justice Center shall, upon acceptance of a report of a reportable incident by VPCR, promptly commence an appropriate investigation (11 NYSSL § 492.3(c)).

Within 60 days of VPCR accepting a report of an allegation of abuse or neglect, the Justice Center shall cause the findings of the investigation to be entered into VPCR. The Justice Center may take additional time to enter such findings into VPCR provided, however, that the reasons for any delay have been documented and such findings submitted as soon thereafter as practicably possible (11 NYSSL § 493.1).

**APPENDIX D: “HIGH-RISK” MEDICAL DIAGNOSIS CODES IN SAMPLED CLAIMS**

Table 1 describes the medical diagnosis codes associated with the 30 sampled ER claims associated with incidents of potential abuse and neglect.

**Table 1: Diagnosis Codes Associated With Sampled Claims**

<b>Medical Diagnosis Code</b>	<b>Diagnosis Code Description</b>	<b>Number of Claims</b>
S09.90XA	Unspecified injury of head, initial encounter	17
J69.0	Pneumonitis due to inhalation of food and vomit	4
S09.8XXA	Other specified injuries of head, initial encounter	2
S00.01XA	Abrasion of scalp, initial encounter	1
S09.93XA	Unspecified injury of face, initial encounter	1
T18.128A	Food in esophagus causing other injury, initial encounter	1
T42.0X4A	Poisoning by hydantoin derivatives, undetermined, initial encounter	1
T74.11XA	Adult physical abuse confirmed, initial encounter	1
Z04.3	Encounter for examination and observation following other accident	1
Z04.41	Encounter for examination and observation following alleged adult rape	1
	<b>Total</b>	<b>30</b>

**APPENDIX E: ANALYSIS OF REPORTED AND SUBSTANTIATED  
INCIDENTS OF ABUSE AND NEGLECT**

Community-based providers are generally required by OPWDD to investigate and submit corrective action plans for incidents of reportable abuse and neglect under the jurisdiction of the Justice Center (14 NYCRR § 624.5(l)). We reviewed the investigation reports and corrective action plans associated with the 48 sampled incidents to determine the causes of the incidents and types of corrective actions recommended.<sup>45, 46, 47</sup> Table 2 summarizes the causes of the incidents listed in the investigation reports, and Table 3 summarizes the corrective actions recommended in the corrective action plans.

**Table 2: Causes of Incidents of Abuse and Neglect**

Cause of Incident	Number of Occurrences
Failure To Follow Staffing Levels or Supervision Levels Noted in the Care Plan	36
Mistreatment	9
Failure To Follow Other Care Plan Requirements	7
Failure To Provide Adequate Medical Services	3
Physical Abuse	3
Transportation Issues – Speeding, Texting, or Both	3
Deliberate, Inappropriate Use of Restraints	2
Falsifying Records With Intent To Deceive	2
Teasing and Taunting	2
Aversive Conditioning	1
Failure To Report an Incident <sup>48</sup>	1
Endangering the Welfare of an Incompetent or Physically Disabled Person (Criminal Offense)	1
Disorderly Conduct (Criminal Offense)	1
<b>Total</b>	<b>71</b>

<sup>45</sup> OPWDD uses the Form OPWDD 161 Corrective Action Plan Submission Form for this purpose. The completed Form OPWDD 161 as well as all supporting documentation are uploaded to IRMA.

<sup>46</sup> OPWDD Form 149 is required for investigations of reportable incidents, serious notable occurrences, and minor notable occurrences.

<sup>47</sup> Incidents of reportable abuse and neglect must be investigated by community-based providers unless OPWDD or the Justice Center advises the provider that the incident will be investigated by OPWDD or the Justice Center and specifically relieves the provider of the obligation to investigate (14 NYCRR § 624.5(h)(1)).

<sup>48</sup> In this case, the initial incident reporting by one staff member was timely; however, the subsequent investigation concluded that another staff member should have reported the incident but failed to do so.

**Table 3: Corrective Actions Recommended as a Result of Incidents of Abuse and Neglect**

<b>Corrective Actions</b>	<b>Number of Occurrences</b>
Staff Training/Retraining	43
Staff Termination/Resignation	26
Written or Verbal Warnings to Staff	20
Beneficiary Care Plan Updated	9
Policy or Procedure Change	7
Staff Transferred to Another Facility	2
<b>Total</b>	<b>107</b>

## APPENDIX F: OTHER MATTERS, DETAILS

### PLACEMENT OF SEX OFFENDERS IN GROUP HOMES

During our audit, we became aware of several media reports of convicted sex offenders with special needs being placed in OPWDD-certified group homes. OPWDD officials stated that such individuals are placed according to the New York Sexual Assault Reform Act (SARA) and are registered pursuant to the New York Sex Offender Registration Act (SORA).<sup>49, 50, 51</sup> The applicable OPWDD policy on such placement dates back to 1999 and involves a risk management review by the Statewide Forensic Advisory Committee (SFAC).<sup>52, 53</sup> Of the approximately 37,000 individuals residing in certified group homes, 143 were registered sex offenders.<sup>54</sup> Officials also cited 45 CFR § 164.502 and New York Mental Hygiene Law § 33.13 as relevant criteria for the nondisclosure of the placement of these individuals to other group home residents and those residents' families.

We queried the New York State Sex Offender Registry website for the names of all the beneficiaries associated with the 30 incidents of potential abuse and neglect and the 48 reported and substantiated incidents of abuse and neglect that we reviewed. We found no matches. Also, we reviewed a risk assessment and risk management plan for a beneficiary randomly selected by OPWDD who was a registered sex offender. We found that the risk management plan appeared to adequately address the assessed risks.

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<sup>49</sup> Consolidated Laws of New York-Executive Law § 259-c.

<sup>50</sup> Consolidated Laws of New York-Correction Law § 168.

<sup>51</sup> The New York State Division of Criminal Justice Services is responsible for establishing and maintaining a file of individuals required to register pursuant to SORA. The division operates a free-of-charge telephone number that the public may call and inquire whether an individual is a registered sex offender, and a subdirectory of level two (medium risk of repeat offense) and level three (high risk of repeat offense) sex offenders available at all times on the internet via the division's home page.

<sup>52</sup> A risk management review includes a risk assessment and a risk management plan. A risk assessment is prepared by a medical professional, such as a psychologist or a behavioral specialist. A risk management plan is designed to mitigate identified risks, is updated annually, and may include components to mitigate risk such as supervision levels and other mitigating strategies.

<sup>53</sup> The purpose of the SFAC is to advise and offer recommendations to applicable officials in an effort to ensure that the necessary treatment, supervision, and support are provided for individuals with histories of sexually abusive behavior, individuals with histories of involvement in the criminal justice system being considered for movement to less-restrictive settings, and individuals being considered for discharge from designated secure facilities.

<sup>54</sup> These data are not regularly maintained by OPWDD and was current as of Aug. 29, 2018.

## CONDUCT BETWEEN BENEFICIARIES

One of the 48 reported and substantiated incidents of abuse and neglect in our audit involved sexual conduct between two beneficiaries. The incident involved two adult male beneficiaries (Beneficiaries A and B) who resided in the same group home and the care workers assigned to each of them. Beneficiary A allegedly sexually assaulted Beneficiary B in the bathroom of the group home, according to the incident report. Local law enforcement was contacted the same day. Beneficiary B (the alleged victim) stated that he did not want to press charges. Records indicate that one week later, local law enforcement advised the group home that they would not be prosecuting Beneficiary A. Incident-reporting details indicate that Beneficiary A had allegedly sexually assaulted another beneficiary in the bathroom 2 weeks prior to allegedly sexually assaulting Beneficiary B.<sup>55</sup>

Based on Beneficiary A's Risk Management Plan, we determined that Beneficiary A was convicted as a juvenile for endangering the welfare of a child after being charged with sexually abusing a minor. Beneficiary B, who has a documented psychological diagnosis of pedophilia, was also charged as a juvenile for sexually abusing two boys, for which he was sentenced to probation. Neither beneficiary is a registered sex offender. Prior to the alleged sexual assault of Beneficiary B by Beneficiary A, OPWDD evaluated the ability of each beneficiary to grant/give sexual consent, as is common practice for all beneficiaries. OPWDD determined that Beneficiary A was capable of sexual consent while Beneficiary B was not determined capable of sexual consent.

The incident was reported, investigated, and substantiated as an incident of neglect as a result of a breach of duty by a custodian (i.e., care worker). The incident investigation focused on whether care workers failed to maintain the beneficiaries' levels of supervision and whether sexual contact occurred between the beneficiaries. The investigation concluded that one care worker failed to maintain the proper level of supervision, constituting neglect under State regulations.<sup>56</sup> The investigation's recommendations included retraining staff on proper levels of supervision and appropriate disciplinary action. The corrective action plan indicated that both care workers were retrained on proper levels of supervision and both received disciplinary action; one received a written warning and one received a verbal warning. Additionally, Beneficiary A's (the aggressor's) risk management procedures were updated from range of scan within 15 feet in common areas to direct supervision by one care worker within 10 feet of Beneficiary A at all times. Justice Center officials stated that they have no jurisdiction to prosecute beneficiaries.

Beneficiary A, who is alleged to have committed two sexual assaults in the same group home within weeks of each other, faced only the ramifications of having a care worker 5 feet closer than before this incident. Immediate precautions taken after the incident were all directed

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<sup>55</sup> Both alleged sexual assaults were identified in the incident reports as rape.

<sup>56</sup> 14 NYCRR § 624.3(b)(8).

toward Beneficiary A and retraining the care workers. Beneficiary B (the alleged victim) was not addressed. Both beneficiaries were continuing to reside in the same group home as of August 2020.

We believe New York could work with CMS to determine whether additional safeguards are needed under the HCBS Medicaid waiver to protect all beneficiaries in situations involving nonconsensual sexual contact between beneficiaries or any other conduct between beneficiaries.

## **APPENDIX G: STATISTICAL SAMPLING METHODOLOGY**

### **SAMPLING FRAME**

The sampling frame for the incidents of potential abuse and neglect was an Access database containing 3,662 paid ER claims with 71 of 298 high-risk diagnosis codes totaling \$32,551 (\$16,328 Federal share) for which providers received Medicaid reimbursement for services provided to developmentally disabled beneficiaries during the period January 1, 2017, through December 31, 2017.<sup>57</sup> The data were extracted from the New York State Medicaid Management Information System.

### **SAMPLE UNIT**

A Medicaid ER visit claim.

### **SAMPLE DESIGN**

We chose to review incidents of potential abuse and neglect using discovery sampling which, in conjunction with our other audit evidence, would have provided assurance that OPWDD's controls are reasonably effective, as designed, if no errors were identified in our sample.

### **SAMPLE SIZE**

We selected a sample size of 30 ER visit claims. Each of the 30 sampled ER claims represented a separate reportable incident; therefore, we refer to these claims as incidents in this report.

### **SOURCE OF RANDOM NUMBERS**

We used the Office of Inspector General, Office of Audit Services' statistical software to generate the random numbers.

### **METHOD OF SELECTING SAMPLE UNITS**

We consecutively numbered the sample units from 1 to 3,662. After generating the random numbers, we selected the corresponding frame items.

### **ESTIMATION METHODOLOGY**

Since our review of 30 incidents of potential abuse and neglect found 7 incidents that failed to meet reporting requirements, we were unable to conclude that OPWDD's controls are reasonably effective. The specific errors identified in the sample are described in the report.

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<sup>57</sup> High-risk diagnosis codes were based on a list of codes developed, reviewed, and approved by the OIG Chief Medical Officer.

## APPENDIX H: STATE AGENCY COMMENTS



**ANDREW M. CUOMO**  
Governor

**Department  
of Health**

**HOWARD A. ZUCKER, M.D., J.D.**  
Commissioner

**LISA J. PINO, M.A., J.D.**  
Executive Deputy Commissioner

Date: January 14, 2021

Ms. Brenda Tierney  
Regional Inspector General for Audit Services  
Department of Health and Human Services - Region II  
Jacob Javitz Federal Building  
26 Federal Plaza  
New York, New York 10278

Ref. No: A-02-17-01026

Dear Ms. Tierney:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-17-01026 entitled, "New York Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicare Beneficiaries With Developmental Disabilities."

Thank you for the opportunity to comment.

Sincerely,

Lisa J. Pino, M.A., J.D.  
Executive Deputy Commissioner

Enclosure

cc: Diane Christensen  
Theresa Egan  
Brett Friedman  
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**New York State Department of Health  
Comments on the  
Department of Health and Human Services  
Office of Inspector General  
Draft Audit Report A-02-17-01026 entitled  
“New York Did Not Fully Comply With Federal and State  
Requirements for  
Reporting and Monitoring Critical Incidents Involving Medicaid  
Beneficiaries With Developmental Disabilities”**

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The following are the New York State Department of Health’s (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-17-01026 entitled, “New York Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities” (Report).

**General Comments**

Pursuant to New York’s HCBS waiver and applicable regulations, providers of services to individuals with developmental disabilities are required to report serious incidents involving recipients of those services to the New York Office for People With Developmental Disabilities (“OPWDD”) and to the Justice Center for the Protection of People with Special Needs (“The Justice Center”). The OPWDD service system currently includes more than 600 agencies providing services to beneficiaries residing in New York State with intellectual and/or developmental disabilities (I/DD). Providers report an average of 20,000 serious incidents to OPWDD annually. OPWDD provides oversight of incidents through its Division of Quality Improvement (DQI), which is composed of the Incident Management Unit and the Bureau of Program Certification. DQI’s oversight includes the use of the Incident Report and Management Application (IRMA), OPWDD’s statewide web-based database for reporting serious incidents. Providers are also responsible for reporting minor notable occurrences and internal agency occurrences. DQI’s Bureau of Program Certification also conducts remote survey activities to ensure providers are compliant with state and federal regulations. OPWDD’s Incident Management Unit has Incident Compliance Officers on duty 24/7 to receive reports from providers, ensure immediate protective measures are in place to protect beneficiaries and to provide technical assistance to provider agencies as needed. The Bureau of Program Certification also reviews incidents during its survey activities. Incident Management requirements are outlined in OPWDD’s Incident Management Regulations, Title 14 New York Codes Rules and Regulations (NYCRR) Part 624. In addition, OPWDD provides additional guidance to providers as needed and through the Part 624 Handbook found at <https://opwdd.ny.gov/system/files/documents/2020/01/final-part-624-hanbook-updated-9-2019.pdf>.

The Justice Center was established by the “Protection of People with Special Needs Act” (PPSNA), enacted as Chapter 501 of the Laws of 2012. The intent of the act was to create a durable set of consistent safeguards for all vulnerable persons that will protect them against abuse, neglect and other conduct that may jeopardize their health, safety and welfare. The PPSNA also serves to provide fair treatment and due process to the employees upon whom individuals with I/DD depend. The PPSNA identifies certain people who are defined as mandated reporters and requires these people to report reportable incidents involving

vulnerable persons to the Justice Center's Vulnerable Person's Central Register (VPCR). This statutory obligation for custodians and human service professionals to report incidents of abuse and neglect to the Justice Center is an important individual legal obligation, and the Justice Center is committed to educating the public regarding this responsibility.

#### **The Department's Response to the OIG's Findings**

OIG reviewed 30 incidents involving community non-profit providers licensed by OPWDD for the 2017 calendar year and found that 7 of them were not properly reported or investigated. :

- The Department agrees with OIG's finding that OPWDD has a centralized system for overseeing critical incidents and has designated its Incident Management Unit (IMU) to oversee allegations of abuse, serious reportable incidents, and deaths occurring at nonprofit agencies. (Report, page 4).
- The Department provides the following information to clarify such finding: In addition to community providers, OPWDD also oversees state-operated providers. All state-operated providers are responsible for complying with OPWDD regulations for incident management, including the use of IRMA for reporting and documenting information. Current incident classifications are reportable incidents of abuse and neglect and significant incidents.
- The Department agrees with OIG's finding that the Justice Center is responsible for investigating all reportable incidents of abuse, neglect, and significant incidents involving vulnerable persons, and for commencing investigations of all allegations of reportable incidents received by the VPCR. (Report, page 5).

The Department provides the following information to clarify such finding: The Justice Center is responsible for ensuring the investigation of reportable incidents but does not conduct every investigation. The Justice Center determines whether it will complete the investigation of abuse or neglect or if the investigation will be delegated to OPWDD's Office of Investigations and Internal Affairs or to the community provider for investigation. The Justice Center investigates allegations of abuse and neglect in state operated settings, and serious allegations of abuse and neglect in non-state operated settings. Regardless of which entity conducts the investigation, the Justice Center reviews the investigation and makes the legal determination as to whether the case is substantiated or unsubstantiated.

#### **The Department's Response to OIG's Recommendations**

##### **Recommendation #1**

Reinforce guidance to the provider community on requirements related to (1) the timing and method of initially reporting incidents, (2) the timely completion of incident investigations, and (3) the need to document justifications for investigative delays.

##### **Response #1**

The Department agrees with this recommendation. OPWDD and the Justice Center are committed to ongoing education efforts for state-operated and community providers. OPWDD provided refresher training on incident reporting requirements at its statewide semi-annual

provider trainings on 10/24/2019 and 10/21/2020. OPWDD has also included these requirements in regularly scheduled trainings on the incident management process. OPWDD has provided guidance through quarterly letters to providers on performance trends identified in the area of incident management. In addition, on a quarterly basis, OPWDD identifies providers that need improvement in the area of initiating and completing investigations and issues correspondence to these providers that specifies OPWDD's expectations. OPWDD is currently utilizing its Statewide Committee on Incident Review (SCIR) to create a tool for investigators to use that will guide them on the investigation milestones that should be completed within certain timeframes in order to achieve the required timeframe for completion.

Additionally, OPWDD is currently developing additional training that will be available to providers and their staff on the Statewide Learning Management System (SLMS). This training will include the importance of immediately identifying an incident as well as the importance of timely reporting and determining appropriate immediate protections to put into place to protect beneficiaries. This training will also include the importance of completing a root cause analysis of an incident to aid in the prevention of recurrence of similar incidents. This analysis will illustrate the importance of identifying trends. The training will stress information direct support professionals (DSPs) and supervisors must understand about incidents and will give examples of common reasons delays occur and how to avoid this. The target audience will be DSPs and front-line supervisors as well as quality assurance staff.

Similarly, the Justice Center offers a range of resources and trainings specifically focused on the responsibilities of mandated reporters. The agency's mandated reporter trainings provide an overview of the Justice Center and the PPSNA which includes the definition of a mandated reporter and the associated duty to report abuse and neglect. The trainings review what is reportable, how to make a report, and what happens once a report is made, including a simulated call to the VPCR hotline to help reporters know what to expect when making the call. <https://www.justicecenter.ny.gov/reporting-incident#mandated-reporting> The Justice Center also offers several live trainings regarding mandated reporting responsibilities each year. The agency often partners with State Oversight Agencies (SOA) or private providers under the agency's jurisdiction to reach as many people as possible. The Justice Center has a training unit that is available to answer questions about reporting and provide additional trainings upon request. The agency also prints and distributes hundreds of posters every year that promote the VPCR hotline number and the requirement to report abuse. The poster is made available in several languages.

The PPSNA also requires that direct care workers who will have regular and substantial contact with individuals receiving services must sign a Code of Conduct when the individual is hired in a setting under the Justice Center's jurisdiction (NYS Exec. Law Section 554). The Code of Conduct is a framework for direct care workers to help people with special needs "live self-directed, meaningful lives in their communities, free from abuse and neglect, and protected from harm." This document also reinforces the responsibility to report abuse and neglect to appropriate entities. DSPs must sign the Code of Conduct on an annual basis as well. <https://www.justicecenter.ny.gov/code-conduct>. The Justice Center offers trainings on the requirements contained within the Code of Conduct. In 2018, the Justice Center launched an interactive, online training to provide an overview of the Code of Conduct which includes real-life scenarios that ask the participant to apply the Code of Conduct provisions. The training is not mandatory but is offered as a resource to DSPs and to provider agencies for employee training. In furtherance of these efforts, the Justice Center, along with the National Alliance for Direct Support Professionals (NADSP), designed a training to give providers the resources they need to provide their staff in-person training on the Code of Conduct. To continue support in this

area, the Justice Center and NADSP have begun development of a Code of Conduct train-the-trainer curriculum that may be offered virtually, and the Justice Center is planning to schedule up to six sessions for 2021.

The Justice Center also offers a training focused on investigatory requirements for a SOA or facility-led investigations. The Justice Center provided 20 of these trainings in 2018, 13 in 2019, and three in 2020. The training directly addresses the statutory requirement of investigation determination within 60 days of an abuse or neglect report to the VPCR and the requirement to document in the VPCR delays that impact this deadline. The time to complete investigations of alleged abuse or neglect may vary depending on a number of factors. Through the investigative process, if certain allegations are found to have no merit, the case can be closed quickly. Others can have multiple victims, suspects, and allegations that can require lengthy investigation. Criminal cases are likely to result in the corresponding administrative case being held in abeyance until the legal process has advanced to a point where the administrative case can be finalized and closed. In addition, the VPCR contains a mandatory field to provide this information. The Justice Center will be providing more guidance to the SOAs/provider community on investigatory questions and related directives, with the plan of scheduling up to eight investigative trainings for 2021.

#### **Recommendation #2**

Issue guidance and/or provide training to the provider community on the importance of identifying the root causes of an incident.

#### **Response #2**

The Department agrees with this recommendation. OPWDD provided training on the root causes of incidents at its statewide semi-annual provider training on 10/21/2020. This training emphasized the importance of, and outlined the steps for, conducting a root cause analysis. Additionally, OPWDD has also included more detailed information on conducting a root cause analysis in its regularly scheduled trainings on the incident management process and is developing additional training on this topic through SLMS.

#### **Recommendation #3**

Issue guidance and/or provide training to the provider community on the importance of identifying trends in incidents.

#### **Response #3**

The Department agrees with this recommendation. OPWDD provided training on these requirements at its statewide semi-annual provider training on 10/21/2020 and additionally emphasized the importance of the Agency's Incident Review Committee role in trend analysis of all incidents. Additionally, OPWDD has also included more detailed information on trend analysis requirements in its regularly scheduled trainings on the incident management process. OPWDD will also utilize its SCIR Committee to review existing resources and develop additional resources to providers on conducting a trend analysis of incidents.

#### **Recommendation #4**

Review the three internal occurrence investigations identified in our report to determine

whether the providers complied with applicable requirements and make any necessary changes to the incident classifications in accordance with Part 624.

**Response #4**

The Department agrees with this recommendation. OPWDD has initiated a thorough review to ensure that investigations identified in OIG's report were conducted in accordance with OPWDD requirements and that these incidents were classified appropriately.