No Safe Place to Call Home

A Report on the Cycle of Abuse, Neglect, and Injury at the Southwest Idaho Treatment Center

Prepared by DisAbility Rights Idaho

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DisAbility Rights Idaho is the designated federal protection and advocacy system for the State of Idaho and is a member of the National Disability Rights Network.

**Warning: This report details information related to abuse and neglect investigations and contains explicit, derogatory, and sexually inappropriate language directed at or used in front of residents by SWITC staff. Such information may not be suitable for all ages. Reviewer discretion is advised.*

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I. Executive Summary

A person's home is their haven, their refuge, their safe place, their sanctuary from the outside world. For some, home is a house or an apartment. For people with disabilities, home is sometimes a facility or institution where they live so they can receive the care, treatment, or services their disabilities require. **Everyone expects and deserves to feel safe, secure, and respected in his or her home.** For people who live in facilities, feeling safe, secure, and respected in your own home is a right guaranteed by law.

In Nampa, Idaho, approximately twenty-three (23) people[1] with developmental disabilities call the Southwest Idaho Treatment Center (SWITC) home. In addition to intellectual disabilities, many residents have complex needs due to physical impairments such as seizure disorders or spinal cord disorders, or mental illness such as depression, anxiety disorders, bipolar mood disorder, or posttraumatic stress disorder (PTSD). Some have limited communication abilities. They may be non-verbal, only able to speak a few words, or communicate by sign language. Because of their disabilities, most residents require assistance with tasks such as showering, toileting, eating, preparing meals, dressing, communicating, and social interaction. Their chronological age ranges from eleven (11) to forty-seven (47) years. According to criteria found in IDAPA

[1] At the time DRI began its investigation, twenty-three (23) individuals resided at SWITC. According to reports published by the IDHW, SWITC's census remains at twenty-five (25) to thirty (30). *See* Idaho Department of Health and Welfare, *Facts, Figures, and Trends 2016-2017*, https://healthandwelfare.idaho.gov/Portals/0/AboutUs/Publications/FFT2016_2017.pdf (last visited May 30, 2018). *See also* Idaho Department of Health and Welfare, *Facts, Figures, and Trends 2017-2018*, https://healthandwelfare.idaho.gov/Portals/0/AboutUs/Publications/FFT2017_2018.pdf (last visited May 30, 2018).

16.03.10.584.05(a)(b), IDHW requires that residents score a functional skills equivalent to an eight (8) year old or below in order to be admitted to the facility.

None of the residents at SWITC have chosen to live there. In fact, SWITC's own Admission policy requires that SWITC be the home of last resort. Admission only occurs after all other community facilities, options, and supports have been exhausted.[2] Most have been forced to live there after being judicially committed to IDHW while the rest have been placed there by their guardians so that they may receive a specialized form of treatment, known as "active treatment," which SWITC is required to provide.

Operated by the Idaho Department of Health and Welfare (IDHW), SWITC is Idaho's only state-run intermediate care facility for individuals with intellectual disabilities (ICF/IID). Formerly known as the Idaho State School and Hospital, it at one time provided care for over one thousand (1,000) individuals with disabilities.[3] Now, with approximately twenty-three (23) residents and an operating budget of over $11,000,000.00, SWITC has about $1,300 per resident per day by which to provide care and treatment.[4] Licensed and certified by IDHW's Bureau of Facility Standards, the facility must comply with state and federal regulations.[5] Such regulations require SWITC

[2] *Id*.

[3] Idaho Department of Health and Welfare, *State Begins Process to Sell Southwest Idaho Treatment Center*, (December 16, 2014, 5:01 PM), https://healthandwelfare.idaho.gov/AboutUs/Newsroom/tabid/130/ctl/ArticleView/mid/3061/articleId/1804/State-Begins-Process-to-Sell-Southwest-Idaho-Treatment-Center-Land.aspx.

[4] Idaho Department of Health and Welfare, *Facts, Figures, and Trends 2017-2018*, https://healthandwelfare.idaho.gov/Portals/0/AboutUs/Publications/FFT2017_2018.pdf (last visited May 30, 2018).

[5] The Bureau of Facility Standards is a separate department within the Idaho Department of Health and Welfare responsible for licensing and certifying health care providers such as ICF/IIDs, hospitals, ambulatory surgery centers, dialysis centers, home health agencies, hospice agencies, rural clinics, and

to develop and implement procedures to protect residents from all forms of abuse, neglect, and mistreatment; maintain specific numbers of competent, trained staff; ensure residents receive adequate and appropriate medical care; and provide active treatment to help each resident live with as much self-determination and independence as possible.[6]

In the summer of 2017, reports revealed that SWITC had failed to meet these requirements by all accounts. On June 27, 2017, DisAbility Rights Idaho (DRI) learned that SWITC and IDHW investigators were conducting a large-scale internal investigation into allegations of resident abuse and neglect by SWITC staff.[7] These allegations soon became the subject of media reports through the summer and fall of 2017 and into 2018. In total, over seventy (70) internal investigations were conducted.[8] Of those, investigators confirmed that over forty-nine (49) times, facility staff committed acts of physical abuse, psychological abuse, inappropriate and unnecessary sexual communications (defined as sexual abuse), and neglect against SWITC residents from January 1, 2017 through January 31, 2018.[9]

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nursing facilities are following state and federal regulatory requirements. The Bureau of Facility Standards also investigates complaints related to those facilities.

[6] *See* 42 C.F.R. §§483.400-480; IDAPA 16.03.11.100-800.

[7] In accordance with federal law, DRI has removed information such as names and dates, in order to protect the individual residents' privacy. In accordance with state privacy law provisions, DRI has also removed information such as names and dates of specific staff involved in these investigations. An un-redacted version of this report has been sent to individuals and officials who have the authority to obtain this information, e.g. SWITC, IDHW, and the IDHW Bureau of Facility Standards.

[8] During this period, there were four (4) additional investigations into allegations of abuse or neglect. However, those investigations pertained to a specific resident who had declined to give DRI consent to obtain and review their records. Consequently, individual internal investigations pertaining only to that resident were not reviewed nor are they incorporated within DRI's investigatory findings.

[9] Of the seventy (70) internal investigations reviewed, twenty-five (25) contained allegations of abuse or neglect that were substantiated. Within those twenty-five (25) investigations, the substantiated

Pursuant to its authority as Idaho's designated Protection and Advocacy System (P&A),[10] DRI conducted a secondary investigation into the internal investigations conducted by SWITC or IDHW investigators.[11] It is important to note that a secondary investigation is not a new investigation into the facts underlying every abuse or neglect allegation. Instead, the purpose behind a secondary investigation is to monitor the appropriateness, accuracy, and thoroughness of a primary investigation. In this case, DRI's purpose was to review the appropriateness, accuracy, and thoroughness of the investigations conducted by SWITC and IDHW investigators. In conducting this secondary investigation, DRI reviewed over five thousand (5,000) pages of records provided by SWITC and IDHW officials, including but not limited to the completed SWITC and IDHW investigations, facility policies, employee training records, and records pertaining to facility staffing. In addition, DRI also reviewed the investigations into resident abuse and neglect completed by Adult Protection and multiple licensing

allegations were as follows: five (5) allegations of sexual abuse; seven (7) allegations of physical abuse; eleven (11) allegations of psychological abuse; and twenty-six (26) allegations of neglect (forty-nine (49) substantiated allegations total)). DRI considers each allegation substantiated against an employee a substantiated allegation. So, for instance, if three (3) employees were found to have violated SWITC Policy 01.11 by engaging in "unnecessary sexual communication" with a SWITC resident (i.e. sexual abuse), then DRI would consider this as three (3) substantiated instances of sexual abuse. As detailed throughout this report, DRI believes this number should be much higher had SWITC and IDHW investigators actually identified and then thoroughly investigated all instances of abuse or neglect.

[10] DRI is authorized by federal statute to investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported to the system or if there is probable cause to believe the incidents occurred. *See* 42 U.S.C. §15043(a)(2)(B).

[11] DRI's investigation and report were funded through the Protection and Advocacy for Individuals with Intellectual and Disabilities (PADD) Program. DRI is a private, non-profit corporation, independent from state government or service providers. DRI receives funding from the U.S. Department of Health and Human Services (HHS) and the Administration on Intellectual and Developmental Disabilities (AIDD) to implement the DD Act. This report and its contents and conclusions are those of DRI and should not be construed as the official position or policy of, nor should any endorsements be inferred by, AIDD, HHS, or the U.S. Government.

surveys conducted by the IDHW Bureau of Facility Standards during 2017 and 2018. In total, DRI reviewed over twenty-thousand (20,000) pages of records pertaining to SWITC. SWITC and the IDHW were provided with an un-redacted advanced copy of this report and offered the opportunity to respond. Their response is included at the end of this report as Appendix A. DRI's reply to this response can be found in Appendix B. Based on its investigation, DRI has concluded that ***SWITC is not a safe place to call home.*** DRI's investigation has revealed that SWITC completely and totally failed to fulfill its obligations to protect residents from harm.

Since January 1, 2017, almost half of SWITC's residents were abused or neglected.[12] Residents were slapped, head-butted, thrown to the ground, and threatened with acts of physical violence if they did not comply with staff's orders. They were exposed to inappropriate sexual comments by staff, such as making sexual comments about a resident's mother or licking an animal's butthole. They were called derogatory names like "weirdo," "dummy," or "burping, unhygienic, disgusting sacks of shit." Others were ignored as they called for help after collapsing to the floor, or were allowed to harm themselves by repeatedly hitting their head on a hard surface in front of staff who watched and chose not to intervene. A few residents were even denied the assistance they needed for essential skills such as toileting – having been left to sit, eat, and sleep in soiled clothing that were covered in feces.

[12] It should also be noted that since January of 2017, multiple lawsuits and Notices of Tort Claim have been filed by employees and families of former residents against the State of Idaho, IDHW, and SWITC, alleging whistleblower, negligence, and other state law claims.

Worst of all, a resident died. The Canyon County Coroner's office reported that on August 20, 2017, a SWITC resident died after having his body in a position that prevented him from breathing.[13] Although SWITC staff documented that a staff member checked on him every thirty (30) minutes on the night of his death, video surveillance uncovered that not one SWITC staff person checked on him for almost six (6) hours.[14] Further, SWITC staff documented that he had received medication at 8:00 AM that morning, which video surveillance did not support. Again, not one SWITC staff person physically entered the resident's room until 11:29 AM, thus making it impossible to assert he had received his medications at 8:00 AM.[15]

Unfortunately, June of 2017 was not when SWITC and IDHW first discovered that something was amiss at the facility. Through its investigation, DRI discovered that many of the incidents described above occurred well before June of 2017. Instead of addressing the causes and factors that may have contributed to these conditions, IDHW chose to commit their time and resources to solicit the Idaho Legislature for the creation of a new facility: the Secure Treatment Facility.[16] IDHW proposed that the new facility be located in a housing unit at SWITC, staffed and administered by SWITC. To support their request for a new "secure facility," an IDHW Deputy Administrator publically characterized SWITC residents as "very dangerous," and claimed high levels

[13] Associated Press, *Police: SW Idaho Patient Died as Center Staff Skipped Checks*, The Spokesman Review, (December 5, 2017, 4:01 PM), http://www.spokesman.com/stories/2017/dec/05/police-sw-idaho-patient-died-as-center-staff-skipp/.

[14] *Id*.

[15] *Id*.

[16] I.C. §§66-1401 to 1407.

of workers compensation claims demonstrated the unsafe conditions faced by SWITC staff. [17] The Deputy Administrator also displayed an object he claimed residents used as a "weapon" in support of the creation of a "secure facility". DRI questions why residents at SWITC are now so much more "dangerous" than they were in the preceding decades of operation? DRI questions why Idaho needs a special, secure facility when other states are able to serve individuals with developmental disabilities in facilities that comply with federal ICF/IID rules. DRI questions how a resident who is supposed to be receiving specialized treatment and intense supervision has enough free unsupervised time to allegedly fashion a "weapon."

Through its investigative efforts this past year, DRI is now able to answer these questions. In short, the residents are not more "dangerous," Idaho does not need a secure facility, and if SWITC met its legal obligations to provide treatment and supervision, no resident would have the time to fashion a "weapon". Further, through its investigation and the findings of IDHW's Bureau of Facility Standards, DRI concludes that those who live at SWITC are the ones facing the "unsafe" and "dangerous" conditions. DRI believes that the responsibility for this situation lies with the SWITC Administration, personnel, and IDHW. Instead of looking inside and accepting responsibility for the abusive and neglectful acts of its staff, SWITC and IDHW chose to blame the residents. They chose to blame the very people who they are responsible under law to care for. They chose to blame Idaho's most vulnerable citizens.

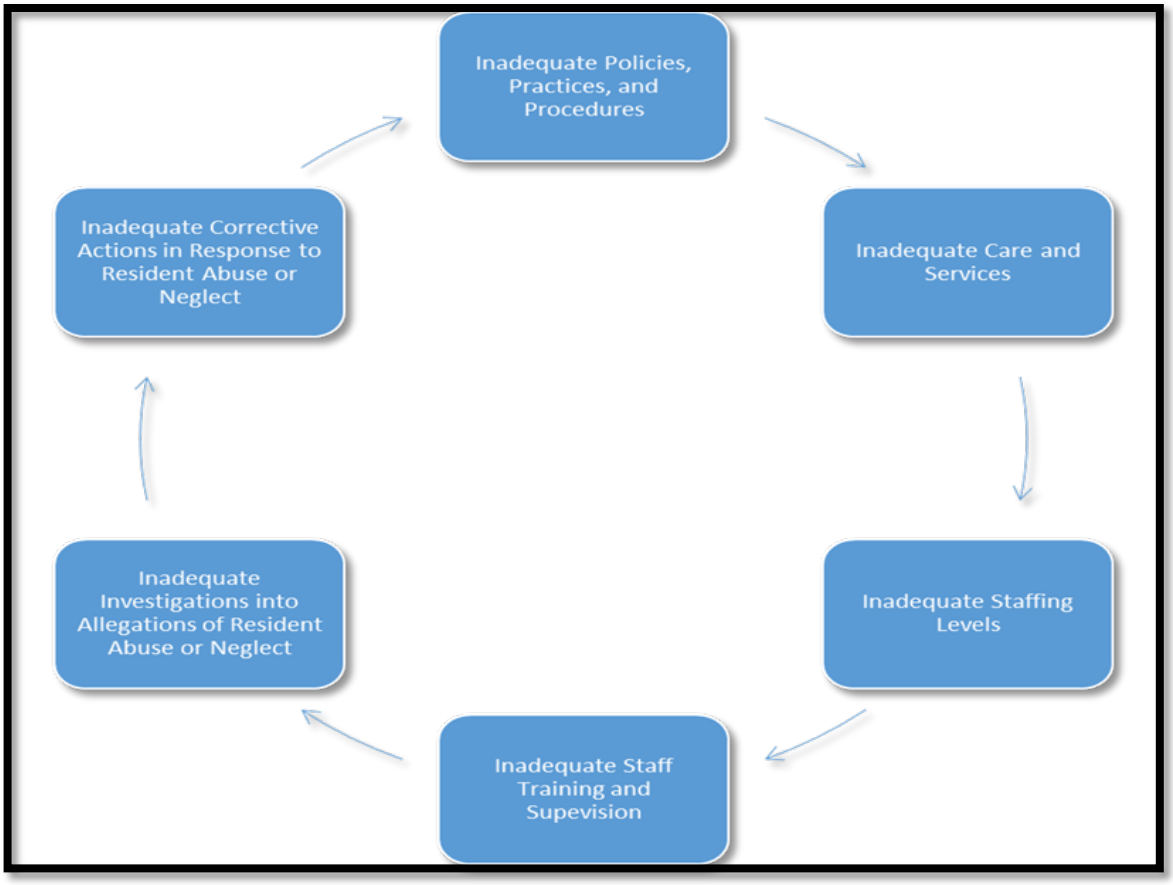
[17] *Idaho Secure Treatment Facility Act: Hearing on H222 Before the Senate Health & Welfare Committee*, 64th Legislature (1st Session 2017) (statement of Deputy Administrator of Division of Family and Community Services, Cameron Gilliland)(Monday, March 13, 2017, 2:00 P.M.) https://legislature.idaho.gov/sessioninfo/2017/standingcommittees/SHW/.

DRI has found that SWITC has consistently failed to offer the treatment, services, and protections that it is by law obligated to provide to those in its care. SWITC failed to implement proven evidence-based treatments and practices to reduce altercations and injuries. SWITC ignored or, in some cases, condoned staff for taking actions that were likely to result in altercations and injuries. SWITC failed to prioritize resident safety. SWITC failed to properly train its staff to protect those in its care. SWITC failed to employ sufficient numbers of people to complete its mission.

These failures are significant and consequential. It bears repeating that since the passage of the Secure Treatment Facility Act in 2017, almost **half** of the residents at SWITC have been victims of physical abuse, sexual abuse, psychological abuse, or neglect committed by SWITC staff, resulting in hospitalizations and even death. Additionally, the Bureau of Facility Standards inspected SWITC on no less than seven (7) occasions, resulting in hundreds of pages of documented deficiencies, including multiple instances where residents were placed in "immediate jeopardy," multiple instances where SWITC failed to meet required staffing levels, and multiple instances where SWITC failed to provide active treatment. These issues, combined with the facility's woefully inadequate response to acts of abuse and neglect, have created a **cycle of abuse, neglect, and injury**, affecting every person at the facility from the moment they are admitted until their discharge or, in some cases, death.

This cycle permeates through every level of facility operation, from resident care and treatment, to facility oversight and incident response. It begins before residents even step through the door, with inadequate policies, practices, and procedures that fail

to prioritize the health and safety of those who are required to live at SWITC above all else. It continues on to admission, with the facility's failure to conduct proper assessments in order to identify each individual's behavioral and other health needs. Without proper assessment, appropriate plans and programs cannot be developed. When such plans are developed, the administration has repeatedly failed to employ enough staff to implement the plans. Those who are employed to work directly with residents are not adequately trained or supervised in order to ensure such programs and plans are implemented as prescribed by professional staff. As the cycle continues, untrained and poorly supervised staff commit acts of abuse or neglect on residents, resulting in injuries to both residents and staff. If reported, such acts are poorly investigated. Once investigated, they are not adequately addressed. Corrective actions are not implemented, not suitable to address the issue at hand, and often fail to hold supervisory and other professional staff accountable. Despite repeated assurances by the facility's administration that such inadequacies have been corrected, the circumstances that gave rise to each level of this vicious cycle persist and the cycle continues.



The time has come for this cycle of abuse, neglect, and injury to end. DRI sincerely hopes that IDHW and SWITC's Administration will read these reports, acknowledge their inadequacies, and take responsibility for the conditions that currently exist at SWITC. SWITC Administrator Jamie Newton has previously stated that operating SWITC is "a balance between keeping staff and resident's safe."[18] As this report demonstrates, DRI believes that SWITC's approach to this "balance" has failed. The time has come to achieve this "balance" by prioritizing resident health and safety

[18] Emily Lowe, *Following Slew of Citations, SWITC, Now in Compliance, Beefs Up Staff Training*, The Spokesman Review (June 25, 2018, 8:32 AM), http://www.spokesman.com/stories/2018/jun/25/following-slew-of-citations-switc-now-in-complianc/.

and providing residents with the treatments and services they are entitled by law to receive. With the proper provision of required treatment, services, and protections, provided by adequately trained and supervised staff, it is entirely possible that the Secure Treatment Facility may never be used, that injuries to staff will dramatically decrease, and, most importantly, that residents at SWITC will never be subjected to acts of abuse or neglect again. Idaho's most vulnerable citizens deserve – and are entitled - to live in a home where they are safe, secure, and treated with respect. **Unless or until it immediately undertakes significant changes** to every aspect of its operation, **SWITC will never be a safe place to call home**.

II. Background

DRI is the designated Protection and Advocacy System (P&A) for the state of Idaho. Pursuant to the Developmental Disabilities Assistance Bill of Rights Act (DD Act), 42 U.S.C. §15001, et seq., and its implementing regulations, the P&A was created to protect the rights of individuals with disabilities and investigate instances of abuse and neglect in facilities. Through the DD Act, DRI has access to individuals with developmental disabilities, service providers (including facilities), and records necessary to conduct full investigations regarding incidents of abuse or neglect.[19]

On June 27, 2017, DRI received a report that a large-scale internal investigation was being conducted at SWITC regarding numerous allegations of abuse and neglect involving multiple staff and residents, including incidents of staff targeting certain residents and engaging in acts of physical abuse, psychological/verbal abuse, and

[19] 42 U.S.C. §15043; 45 C.F.R. §1326.27.

neglect. In total, SWITC administration and IDHW human resource personnel conducted over seventy (70) internal investigations[20] into resident abuse and neglect by staff. They confirmed over forty-nine (49) instances[21] where facility staff committed acts of abuse and neglect on residents from January 1, 2017 through January 31, 2018.

As Idaho's designated P&A, DRI initiated a secondary investigation to review the quality of these abuse and neglect investigations and the investigators' findings. (For a more detailed explanation of a secondary investigation, please review pages 7-8 of this report). As a part of its investigation, DRI also reviewed the investigations completed by the local state Adult Protection Services agency and multiple surveys conducted by the Bureau of Facility Standards during 2017 and 2018. In total, over twenty-thousand (20,000) pages worth of records were reviewed. DRI evaluated what type of staff behavior was or was not considered abuse or neglect, what changes or corrective actions were recommended and implemented by the facility, and whether or not such recommendations or changes were sufficient to ensure the safety of SWITC residents going forward.

In conducting this review, DRI enlisted the services of a professional consultant who has over twenty-five (25) years' experience in developmental disability facility management and administration, including as a former Deputy Administrator of a state department of developmental services and a former administrator of a state-run facility

[20] *See supra* text accompanying note 8.

[21] As detailed throughout this report, DRI believes this number should actually be much higher had SWITC and IDHW investigators actually identified and then thoroughly investigated all instances of abuse or neglect.

that provided ICF/IID level of care. A summary of DRI's observations, findings, and recommendations are set forth below.

III. Investigative Findings

A. From January 1, 2017 through January 31, 2018, SWITC administration and staff failed to protect residents from harm in violation of facility policy, state law, and federal law.

1. SWITC/IDHW investigators found residents were abused or neglected by SWITC staff on forty-nine (49) occasions, in violation of facility policy.

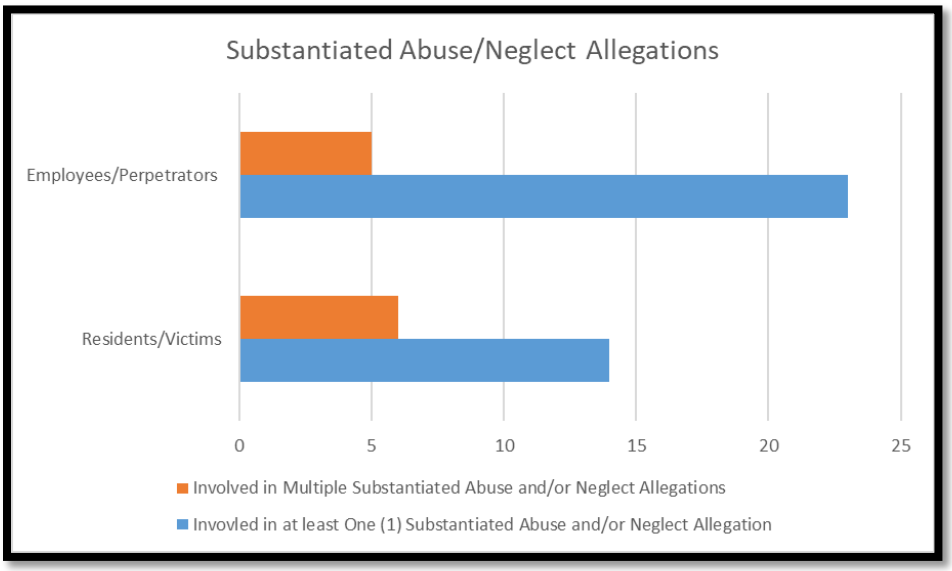
Investigations of alleged or suspected abuse, neglect, and mistreatment of residents at SWITC are governed by SWITC Policy 01.11.0. This policy states that it is SWITC's responsibility to "ensure individuals are free from abuse, neglect, and mistreatment."[22] The policy describes the actions, inactions, and conditions that may be considered abuse, neglect, or mistreatment by staff or other non-residents towards people who reside at SWITC. It also outlines the investigative process which must be followed by SWITC Administration in order to determine if abuse, neglect, or mistreatment occurred.[23]

For purposes of this report, DRI reviewed seventy (70) internal investigations into allegations of abuse and/or neglect committed by SWITC staff from January 1, 2017 through January 31, 2018.[24] These investigations were conducted by either

[22] SWITC, *Investigations of Alleged/Suspected Abuse, Neglect, and Mistreatment*, Policy 01.11.0, approved by Administrator Jamie L. Newton on 06/08/2017. (This policy was updated and approved by Administrator Jamie L. Newton on 04/13/2018).
[23] *Id.*
[24] *See supra* text accompanying note 8.

SWITC and/or IDHW human resources (IDHW) investigators. Of the seventy (70) investigations reviewed, findings were as follows:

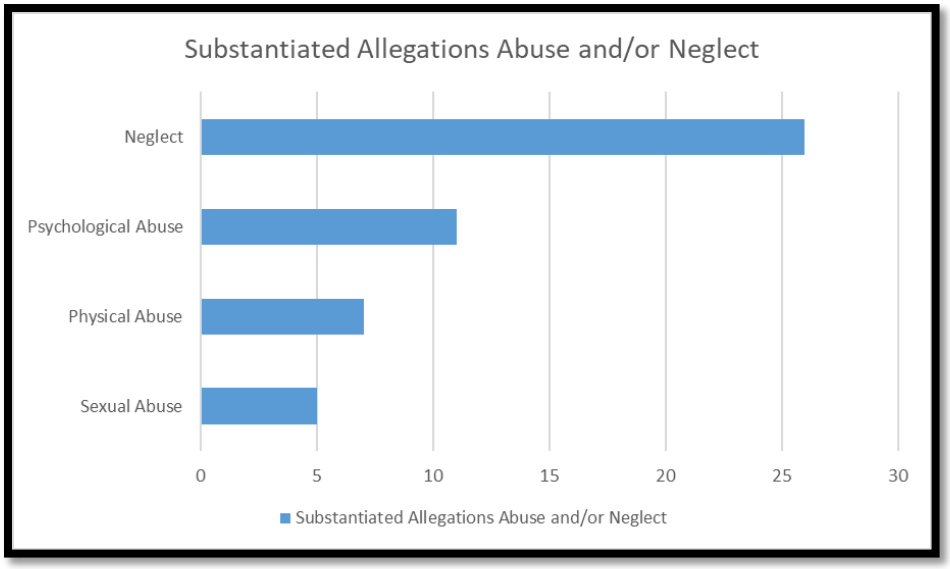
- **<u>Substantiated Allegations:</u>** In twenty-five (25) of the investigations, allegations of abuse and/or neglect were found to have occurred.[25] Fourteen (14) residents/victims were abused or neglected by twenty-three (23) staff/perpetrators. Six (6) of the residents/victims were abused or neglected multiple times. Five (5) of the staff were found to have committed multiple acts of abuse and/or neglect.



[25] Included within these twenty-five (25) investigations, were two (2) investigations in which the investigator substantiated abuse or neglect for one reason, but the Administrator or the Administrator on Duty disagreed with these findings, substantiating abuse or neglect for another reason. Additionally included within these investigations, were three (3) investigations where the investigator originally did not substantiate abuse or neglect, only to be overturned by the Administrator or Administrator on Duty. Of these, one (1) was "re-reviewed" by an IDHW investigator who overturned the Administrator on Duty finding of neglect for failure to provide medical treatment, concluding that the accused staff did in fact provide medical care. Not included in the above calculations were three (3) investigations in which the investigator(s) originally did substantiate the allegation(s) of abuse or neglect, only to later have their findings overturned by the SWITC Administrator. As detailed throughout this report, DRI believes this number should actually be much higher had SWITC and IDHW investigators actually identified and then thoroughly investigated all instances of abuse or neglect.

Of the twenty-five (25) investigations in which abuse or neglect was confirmed, the acts were as follows:

- **Five (5)** confirmed acts of **inappropriate, sexually oriented communications in front of or directed at clients** (then defined as **sexual abuse**).[26]
- **Seven (7)** confirmed acts of **physical abuse**.
- **Eleven (11)** confirmed acts of **psychological abuse**.
- **Twenty-six (26)** confirmed acts of **neglect**.



Some examples of the confirmed acts of abuse and neglect are as follows:

- ***Inappropriate, sexually-oriented communications*** (*then defined as **"Sexual Abuse"**)*:

[26] Investigations involved allegations of staff engaging in inappropriate, unnecessary sexually oriented communications in front of or directed at clients, which constituted sexual abuse per the previous version of Policy 01.11.0 approved on June 8, 2017. It should be noted that the updated version of Policy 01.11.0, approved on April 13, 2018, amended the definition of "sexual abuse" and removed the language that "any unnecessary sexual communication with an individual who resides at SWITC regardless of the individual's willingness to engage in that contact or communication." As a result, unnecessary sexual communications are no longer considered "sexual abuse." *See* SWITC, *Investigations of Alleged/Suspected Abuse, Neglect, and Mistreatment*, Policy 01.11.0, Approved by Administrator Jamie L. Newton on 04/13/18, pg. 3.

- Staff made multiple, sexually inappropriate comments directed to and in front multiple residents, made comments of a sexual nature about a resident's mother, and, later, made comments about licking an animal's butthole to another resident while looking at video footage of animals online.

- Staff taught a resident with limited communication abilities to use the gesture for masturbation as the sign or gesture to use if the resident was choking on food.

- ***Physical Abuse*:**

  - Staff bragged to co-workers about having to "[whoop] [a resident on] his ass when he got out of line."

  - Staff applied excessive pressure to a resident's wrist and elbow while performing a non-approved restraint method, causing an abrasion to the resident's wrist.

  - Staff head-butting a resident multiple times while attempting a restraint.

  - Staff threw a resident to the ground and then placed their thumb on a pressure point at the corner of a resident's jaw, causing the resident's jaw to dislocate.

  - Staff slapped a resident, to which a co-worker stated "Did you hit him? I love it!"

- ***Psychological Abuse*:**

  - Staff called a resident a "weirdo."

  - Staff told a resident "Jesus, you guys are annoying the crap out of me! Good God, you're both adults, you're over 30" after one resident asked the staff for help in response to being threatened by another resident.

  - Staff called a resident a "weirdo" and "dummy."

  - Staff called a resident a "smartass," then told the resident to "shut up!" while raising their fist, threatening to punch the resident if they did not comply.

- Staff told two residents ““I swear to God, you guys look like…burping, unhygienic, disgusting sacks of shit I’ve ever been around.”

- Staff told a resident “You get involved with staff, you’re going to get hurt. That’s how it ends.”

- ***Neglect*:**

  - Staff failed to intervene while observing a resident hit their head seven (7) times against a hard surface.

  - Staff ignored a resident who had cried for help after falling to the ground.

  - Multiple staff failed to provide required prescription medication to a resident who was experiencing seizure-like activity.

  - Multiple staff failed to provide assistance to a resident with their toileting needs, resulting in fecal matter being found all over the resident’s body, clothing, and bathroom.

  - Multiple instances where staff observed their co-workers committing acts of abuse or neglect and then failed to report such instances or intervene to protect residents from harm as required by facility policy.

  - Multiple instances where staff slept while on duty when they were supposed to provide enhanced, one on one (1:1) supervision for a resident, thus leaving the resident unattended and at risk of harm.

  - Staff failed to properly document the status of and treat a resident’s wound, that lead to an infection which required a multiple-day hospitalization.

  - Multiple staff failed to perform required bed checks on the night a resident died.

  - Staff allowed a resident, whose dietary restrictions include “nothing by mouth” due to silent aspiration concerns, to eat cookie dough, and placed the resident at risk of choking or even death.

2. Adult Protection investigators found residents were abused or neglected on nineteen (19) occasions, in violation of state law.

Pursuant to SWITC policy 01.11.0 and Idaho law, [27] SWITC staff are required to report allegations of abuse or neglect of a vulnerable adult to Adult Protection.[28] Adult Protection will then initiate an investigation into the reported allegations. In this case, Adult Protection initiated investigations into several reported incidents. The agency then substantiated as follows:

- Eleven (11) acts of abuse of a vulnerable adult.
- Eight (8) acts of neglect of a vulnerable adult.

These numbers are different from the numbers found by the facility's internal investigation because each agency used a different definition of "abuse" or "neglect." SWITC/IDHW relies upon the definitions outlined in SWITC policy 01.11.0, whereas Adult Protection relies upon the definitions of abuse and neglect defined in I.C. §§39-5302(1) and (8).[29] Such definitions are not synonymous. While SWITC may have substantiated abuse or neglect in one instance, Adult Protection may not have, and vice

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[27] *See* I.C. §39-5303.

[28] *See* Idaho Commission on Aging, *Idaho Adult Protection Services*, (July 2016), https://aging.idaho.gov/protection/ID%20AP%20PowerPoint%2020160711.pdf. (The Adult Protection program is administered by the Idaho Commission on Aging. Provision of services are implemented through contracting with each of the local Area Agencies on Aging.)

[29] *Compare* SWITC, *supra* note 22, at 2 ("ABUSE is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, pain or personal anguish. Abuse includes physical abuse, sexual abuse, and psychological (mental) abuse.") and SWITC, supra note 22, at 3 ("NEGLECT is the failure to provide goods and services necessary to avoid physical harm or mental anguish or the disregard of an individual whether purposeful or due to carelessness, inattentiveness, or omission by the perpetrator."), *with* I.C. §39-5302(1) ("'Abuse' means the intentional or negligent infliction of physical pain, injury, or mental injury.") *and* I.C. §39-5302(8) ("'Neglect' means failure of a caretaker to provide food, clothing, shelter or medical care reasonably necessary to sustain the life and health of a vulnerable adult, or the failure of a vulnerable adult to provide those services for himself.")

versa. Moreover, as discussed later in this report, this discrepancy may further be explained by the fact that SWITC did not consistently report all allegations of abuse or neglect to Adult Protection. Of those it did report, not all were reported within the specific timeframes outlined in I.C. §39-5303.

3. The Bureau of Facility Standards found multiple occurrences where SWITC failed to keep residents safe in violation of federal law.

As a Medicaid provider, SWITC must meet the health and safety requirements set forth in federal law.[30] These requirements or "conditions" address nine specific areas including the provider's governing body and management, *client protections*, facility staffing, active treatment services, client behavior and facility practices, health care services, the facility's physical environment, emergency preparedness, and dietetic services. In Idaho, the Bureau of Facility Standards is charged with licensing and certifying that SWITC complies with these federal regulatory requirements as well as additional state requirements through annual surveys or complaint investigations. Any violation of these "conditions" may result in penalties up to and including revocation or termination of a facility's license to operate as well as termination of the facility's ability to bill Medicaid for services provided.[31]

As reports of the widespread abuse and neglect began to surface, on July 10-19, 2017, the Bureau of Facility Standards conducted an annual survey of the facility. At

[30] *See* 42 C.F.R. §§483.400-800.

[31] Currently, Medicaid's federal match is $0.70 per every $1.00 spent, meaning that for every dollar spent on a Medicaid beneficiary, the federal government pays $0.70 and the state pays $0.30 from state general funds.

that time and since, the agency found SWITC in violation of federal regulations or "conditions" pertaining to client protections on four (4) separate occasions. Specifically, SWITC has been out of compliance with standards related to the protection of clients' rights (***including the right to be free from physical, verbal, sexual, or psychological abuse or punishment***); communications with clients, parents, and guardians; and staff treatment of clients (***including prohibiting staff from using physical, verbal, sexual, or psychological abuse or punishment***).[32]

i. July 2017 Survey

In July 2017, the Bureau of Facility Standards found that SWITC did not have policies and procedures that prevented and detected abuse, neglect, and mistreatment. Further, the agency found that the policies SWITC had were not sufficiently implemented and monitored to ensure individual rights were upheld.[33] The facility failed to protect client rights because it did not provide Guardians with the information needed to make informed decisions. At least (3) guardians were asked to consent to medication dosages for residents without being told that the medication dosage they were consenting to was actually *well above* the maximum amount considered safe for the resident.[34] The facility failed to obtain consent required to use restrictive interventions such as enhanced supervision or the use Benadryl as a PRN[35] to treat

[32] *See* 42 C.F.R. §483.420.

[33] Idaho Department of Health and Welfare, *Southwest Idaho Treatment Center – Nampa 07-19-17 Recertification/Relicensure + Complaint (Revised 09/11/17)(Updated 10-18-17)*, http://healthandwelfare.idaho.gov/Portals/0/Medical/LC7/071917SWITCR_C.pdf.

[34] *Id*. at 6-9.

[35] PRN is the abbreviation for "Pro Re Nata" meaning "as needed."

symptoms of anxiety.[36] Instead, the facility made the decision to implement these strategies on its own, in violation of federal rules.

In addition, surveyors found that SWITC gave residents unnecessary medication, including one (1) resident who had been given the psychotropic medication lorazepam on multiple occasions without following the resident's doctors orders for when the drug could be administered.[37] Residents were also denied opportunities to participate in activities out in the community in violation of federal requirements, including one (1) resident who had not been allowed to leave the SWITC campus for six (6) months.[38]

Moreover, in July 2017, Bureau of Facility Standards surveyors found SWITC failed in its obligation to communicate with guardians as required by law. For example, a guardian had not been invited to the resident's person-centered planning meeting, had not been receiving requested records in a timely manner, and would often voice concerns which would go unaddressed by the facility.[39] That same guardian was also not provided with prompt notification of significant events, including notification that the resident had been the victim of eleven (11) resident altercations including hair pulls, slaps, scratches, assaults, and attacks – delaying, hindering, or preventing the guardian's ability to advocate on behalf of the individual resident in order to help protect them from further harm.[40]

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[36] Idaho Department of Health and Welfare, *supra* note 33, at 11-14.
[37] *Id*. at 14-16.
[38] *Id*. at 16-19.
[39] *Id*. at 19-25.
[40] *Id*. at 25-28.

Surveyors found that SWITC's Administration had failed to take appropriate corrective action in response to abuse or neglect.[41] In two (2) neglect investigations, staff did not immediately report such incidents to the facility's Administrator as required by facility policy.[42] Although both investigations documented that the Administrator did not receive notification until two (2) to three (3) days after the incident occurred, the need for staff-retraining on Administrator notification was not identified as a corrective action.[43] In another case, surveyors discovered that a resident had a seizure while at a community dance off campus.[44] Although the resident had a prescription for Diastat[45] to be administered on a PRN basis, no direct care staff brought the medication on the outing. The resident was then transported back to the SWITC campus in order to receive treatment, placing the resident at further risk of harm while experiencing the seizure.[46] However, SWITC's Administration did not include a requirement that the resident's seizure medication be made available on future community outings a potential corrective action.[47] On August 24, 2017, the SWITC Administrator provided the Bureau of Facility Standards with written notice indicating that the issues identified in the July 2017 survey would be corrected on or before September 11, 2017.

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[41] *Id*. at 28-30.
[42] *Id*.
[43] *Id*.
[44] *Id*. at 29.
[45] Diastat is medication used to control seizures. *See* Valeant Pharmaceuticals North America LLC, *DiastatAcuDial*, (2017), http://www.diastat.com/.
[46] Idaho Department of Health and Welfare, *supra* note 33, at 29.
[47] *Id*.

ii. September 2017 Survey

After SWITC's Administration submitted two (2) detailed "plans of correction" [48] to the Bureau of Facility Standards, outlining the steps the facility would take to correct the issues identified in the July survey, the facility received additional deficiencies regarding client protections.[49] Among them were three (3) instances of "immediate jeopardy," indicating that an "immediate and serious threat to individual health and safety" had occurred. In September, surveyors discovered that the bathtub rooms on the Aspen and Birch housing units each had doors that would automatically lock upon closure.[50] The surveyors watched as an individual with known self-injurious behaviors, including hitting his head against objects, walked into the bathtub room. Although the resident's program plans required constant supervision when bathing due to his self-injurious behaviors, a staff shut the door behind the resident and placed a privacy screen in front of the door. The door then locked behind the resident, preventing staff from monitoring or immediately intervening should the individual engage in self-injurious behaviors. After this observation, surveyors also reviewed records and found two (2) other individuals with documented histories of seizures that were allowed to bath or shower in these locked bathtub rooms, without being visually monitored by staff

[48] SWITC first submitted a plan of correction to the July 19, 2017 survey on August 10, 2017, indicating that such corrective actions would be completed by August 21, 2017. On August 24, 2017, the facility submitted an updated plan of correction, indicating that corrective actions would be completed on September 11, 2017. *See* Idaho Department of Health and Welfare, *supra* note 33.

[49] Idaho Department of Health and Welfare, *Southwest Idaho Treatment Center – Nampa 09-20-17 Recertification/Relicensure + Complaint Follow-Up*, http://healthandwelfare.idaho.gov/Portals/0/Medical/LC7/092017SWITC_R_CFU.pdf.

[50] *Id*. at 2-8.

as required by their plans. As a result, residents were at risk of serious harm or death without any way for staff to immediately intervene.

Also during the September 2017 visit, surveyors found that individual behavior plans were not sufficiently developed nor were staff sufficiently trained to immediately intervene and respond when a resident-to-resident conflict arose.[51] During their observations on the Birch housing unit, surveyors personally witnessed one (1) resident physically assault another resident, repeatedly, for two (2) hours and twenty-two (22) minutes. [52] Although each incidence of assault took place in front of multiple staff, **not a single staff** intervened to protect either resident. [53] The surveyors then reviewed records for five (5) other residents known to have assaultive behaviors. [54] Although each had a "physical assault plan," not one plan included sufficient intervention strategies for staff to immediately intervene and protect the residents.[55] The surveyors found that SWITC placed such residents at risk of "serious harm, impairment or death due to the potential risk associated with ongoing incidents of physical abuse without staff intervention." [56] On September 29, 2017, the SWITC Administrator provided the Bureau of Facility Standards with written assurances that all issues identified during the September survey would be corrected on or before October 4, 2017.

[51] *Id*. at 8-13.
[52] *Id*.
[53] *Id*.
[54] *Id*.
[55] *Id*.
[56] *Id*.

iii. February 2, 2018 Survey

Five (5) months later, while investigating a complaint investigation on February 2, 2018, Bureau of Facility Standards surveyors once again found the facility had placed its residents in immediate jeopardy.[57] While observing on the Aspen housing unit, surveyors noticed that a resident who had been diagnosed with a severe form of epilepsy, (characterized by multiple types of seizures), was told by direct care staff to get in the shower in his bathroom.[58] Once in the bathroom, staff left the resident's bathroom and shut the door, walked to and stayed at the staff desk approximately fifteen (15) to thirty (30) feet away.[59] Although the staff claimed that the individual could shower alone, without supervision, surveyors noted that the resident's "Bathing Skills" program created by professional staff specifically required that "staff are to be with [the individual] at all times to due [sic] history of seizure disorder and instability."[60] After reviewing his records, surveyors found that the resident's seizure care program, bathing program, and behavior plan did not have sufficient intervention strategies or instructions to staff on how to monitor him while bathing/showering to ensure his safety.[61] Such incidents are in addition to the forty-nine (49) confirmed incidents of

[57] Idaho Department of Health and Welfare, *Southwest Idaho Treatment Center – Nampa 02-02-18 Complaint*, http://healthandwelfare.idaho.gov/Portals/0/Medical/LC8/020218SWITCC.pdf. Although the February 2018 surveys occurred after the scope of DRI's review of SWITC's internal investigations, the surveys reference individual records and investigations which occurred during the scope of DRI's investigation (January 1, 2017 through January 31, 2018). They also indicate that the facility continues to place residents at risk of harm, despite multiple assurances that safety issues have been corrected.
[58] *Id*.
[59] *Id*.
[60] *Id*.
[61] *Id*.

abuse or neglect internally investigated by SWITC - meaning they were not identified, reported, investigated or corrected by facility administration. SWITC was notified of this failure and provided the Bureau of Facility Standards with a corrective action plan that indicated the issues had been corrected by February 12, 2018.

iv. February 22, 2018 Survey

Twenty (20) days later, Bureau of Facility Standards surveyors returned to SWITC only to once again witness staff placing residents in "immediate jeopardy."[62] This time, regarding the use of physical restraints.[63] While performing observations, surveyors watched as two (2) staff physically restrained an individual whose behavior program specifically stated not to use any physical restraint methods. The reason for the prohibition was that the individual had fractures in his back, which would potentially worsen if restrained, placing him at risk of paralysis should further trauma or injuries occur.

In addition to this failure to keep residents safe, surveyors also noted other client protection failures. For instance, not only were guardians not promptly notified of significant events, (i.e. injuries), but records pertaining to three (3) separate residents indicated that their guardians did not receive notification *at all* when residents were victims of abuse or neglect. [64]

[62] Idaho Department of Health and Welfare, *Southwest Idaho Treatment Center – Nampa 02-22-18 Complaint*, http://healthandwelfare.idaho.gov/Portals/0/Medical/LC8/022218SWITCC.pdf. Deficiencies related to conditions other than client protections were also noted.
[63] *Id*. at 103-112.
[64] *Id*. at 11-19.

Once again, surveyors found evidence that the facility failed to ensure policies were sufficiently developed, implemented, and monitored to ensure individuals were not subjected to abuse, neglect, or mistreatment.[65] For instance, even though SWITC's policy regarding abuse, neglect, and mistreatment included the use of non-approved behavioral managing techniques as a form of mistreatment.[66] Surveyors noted in one abuse and neglect investigation that a resident suffered "bruises and scuffs" to his right and left cheeks, left side of his nose, shoulders, and the back of his neck as well as bruises to his upper right shoulder and right index finger after being restrained on the floor by multiple staff.[67] Despite the fact that the restraint performed – restraining the individual to the ground – was not an approved restraint, the facility's investigator failed to identify this as potential mistreatment, failed to conduct an investigation into this potential abuse, and failed to implement any corrective action. The investigator simply concluded facility policy had not been violated and abuse did not occur.[68]

Once again, Bureau of Facility Standards surveyors noted multiple issues surrounding the facility's compliance with Administrator reporting requirements.[69] For instance, the facility's Behavior and Incident Reporting policy requires that staff complete a SER (significant event report) and notify the Administrator for all resident-to-resident assaults (physical and psychological) as well as for all patterns of resident

[65] *Id*. at 19-29.
[66] *Id*. at 19-23.
[67] *Id*. at 22.
[68] *Id*. at 22-23.
[69] *Id*. at 29-37, 57-63.

head hits and significant injuries.[70] In spite of these notification requirements in the policy, surveyors documented at least seventeen (17) instances where resident to resident assaults, head hits, and significant injuries were not reported to the Administrator.[71] As such, they were not investigated nor addressed through any corrective actions by the Administrator at the time they occurred. In addition, the facility's policy on investigations of abuse, neglect, and mistreatment requires that the results of all investigations be reported to the Administrator within five (5) working days of the incident.[72] Yet, in one (1) case, surveyors found that the Administrator was not provided with the results of an investigation until forty-eight (48) days after it had been completed.[73]

Bureau of Facility Standards surveyors also found the facility failed to thoroughly conduct investigations and, once again, failed to appropriately respond to abuse and neglect investigations.[74] In one case, surveyors found that the facility's investigator did not interview all witnesses to an event being investigated.[75] In another case, surveyors noted that the facility's investigator failed to identify and then investigate evidence of improper restraint as potential abuse.[76] Upon reviewing the investigation into a resident's death, surveyors found several inadequacies such as: whether there were

[70] *Id.* at 30.
[71] *Id.* at 29-37.
[72] *Id.* at 58-59.
[73] *Id.* at 59.
[74] *Id.* at 37-57, 63-81.
[75] *Id.* at 40.
[76] *Id.* at 40-43.

enough staff on duty; whether the facility's Medication and Treatment Administration policy was implemented in accordance with Idaho Board of Nursing Rules; and whether staff failed to implement the facility's Suicide Prevention policy.[77] Since none of these issues were identified, let alone investigated by SWITC, Bureau of Facility Standards surveyors found that these life-threatening conditions to persisted. As a result, SWITC once again was found out of compliance with its federal regulations and once again, the SWITC Administrator submitted written assurances that these issues would be corrected.

During the investigation period, DRI observed that SWITC continuously violated its own policies, state law, and federal law. What is most troubling is that each time SWITC was confronted with its own failures, its Administration provided written assurances that things had changed. That failures or deficiencies had been corrected. Yet time and time again, those failures continued to appear. As a result, DRI is left to conclude that issues at SWITC have not been corrected and that SWITC is not safe place to call home.

B. From insufficient policies to inadequate incident response, SWITC has allowed a cycle of abuse, neglect, and injury to exist, placing residents at a continued risk of harm.

Unfortunately, concerns regarding the safety of SWITC residents do not end with the substantiated instances of abuse and neglect documented above. This report describes a series of inadequacies that exist at SWITC, which continue to place residents in harm's way. Such inadequacies have permeated through every level of

[77] *Id.* at 43-46.

facility operation from facility policies, to staff training and supervision and incident response. When combined, they have created a cycle of abuse, neglect, and injury that continues to this day.

1. SWITC's policies failed to prioritize the care, treatment, and safety of its residents.

As with all facilities, SWITC has a multitude of written policies, practices, and procedures which govern its daily operations as an ICF/IID. Policies are the primary way of communicating a facility's position regarding resident care. They are also created to ensure that the facility complies with its constitutional, statutory, and regulatory requirements. Policies, practices, and procedures are the first documents reviewed by newly hired staff. Policies are relied upon by current staff and are among the first documents provided to residents, family members, and guardians upon an individual's admission. They set the tone for how a facility is run and provide guidance for all staff from administration to direct care workers on how they are expected to perform. They also provide guidance to all residents on what services, treatment, and care they can expect to receive. A facility that equips its staff with comprehensive, detailed policies that prioritize resident health and safety will likely have staff who are well-informed of their respective duties and obligations to provide residents with the best care possible. For those facilities whose policies lack thoroughness and a clear commitment to the care and treatment of its residents, the opposite is true.

During its investigation into the abuse and neglect of residents that occurred at the facility in 2017, DRI requested and reviewed with the assistance of its consultant several of the facility's policies and procedures. Upon review, DRI observed that many

of the facility's policies seemed to miss the message that its residents came first. Instead of indicating a clear commitment to its residents, SWITC failed to send a message that the chief purpose and focus of its operation was to provide for the care, treatment, and safety of its residents.

A prime example of the facility's failure to prioritize resident care, treatment, and safety is found within Policy 01.11.0: "Investigations of Alleged/Suspected Abuse, Neglect, and Mistreatment." The policy describes the actions, inactions, or conditions that may be considered abuse, neglect or mistreatment as well as the investigatory process for determining if such abuse, neglect, or mistreatment occurred.

What the policy does not do, however, is indicate that the facility has a zero tolerance approach to resident abuse, neglect, or mistreatment. To begin with, the policy's definition of the terms "abuse" and "neglect" are very narrow and contrary to state law. Under I.C. §66-412, every individual with developmental disability admitted to a facility is entitled to certain rights. One of those rights includes the right to "be free from mental and physical abuse ***including that which arises from acts of negligence***."[78] The law specifically names SWITC as a facility within the state that must ensure this right.[79] Despite this statutory mandate, SWITC's administration created a policy that only protects people who live at SWITC from "*willful*" acts of abuse, neglect or mistreatment, disregarding abuse, neglect, or mistreatment that may

[78] I.C. §66-412(3)(a)(emphasis added).

[79] I.C. §66-402(8). "'Facility' means the southwest Idaho treatment center…."

occur from an act of negligence.[80] While this may align with federal guidance,[81] it completely disregards state law and provides investigators with the ability to ignore abuse rising from the negligent acts of staff.

Even more problematic is that the term "willful" is not defined within the policy nor by federal guidance. Without a definition of the word "willful," each investigator is left to guess as to its interpretation and application. Multiple interpretations and applications of a crucial term can lead to inconsistent conclusions and an inconsistent message to staff and resident as to what is and is not considered abuse. As a result, during DRI's investigatory timeframe, multiple acts of abuse were not substantiated because the investigators interpreted the meaning of "willful" differently. For example, in two (2) abuse investigations, the investigator ultimately concluded that abuse did not occur as "the policy indicates that intent to harm or punish must be present for abuse to occur."[82] As emphasized above, the policy does not require "intent" by staff. It prohibits willful acts of abuse, neglect, or mistreatment by staff. In another case, staff retaliated against a resident by pulling the resident's hair after the resident had struck the staff in the face. Although the staff admitted to pulling the resident's hair – something SWITC policy specifically lists as an example of physical abuse – the

[80] SWITC, *Investigations of Alleged/Suspected Abuse, Neglect, and Mistreatment*, Policy 01.11.0, Approved by Administrator Jamie L. Newton on 06/08/2017, pg. 2, as well as the updated version approved on 04/13/18, pg. 2. ("Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting harm, pain or personal anguish.")

[81] CMS, *State Operations Manual, Appendix J – Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities*, (Rev. 178, 04-13-18), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_j_intermcare.pdf. (Defining "abuse" as "the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, pain or personal anguish.")

[82] (Emphasis added).

investigator ultimately concluded that the staff didn't possess the required intent to harm or punish in order to "meet the policy abuse definition as 'willful infliction of injury.'"[83] Similarly, in an investigation into whether or not a staff member abused a resident during a restraint, the investigator ultimately concluded that abuse did not occur as the staff's "intent" was not to harm the resident or cause the resident distress.

It should be noted that even the Idaho criminal statutes do not require a showing of intent in their definition of the "willfully." According to I.C. §18-101(1), the word "willfully" "...implies simply a purpose or willingness to commit the act or omission. *It does not require any intent to violate or injure another*...."[84] By requiring a showing of intent, SWITC investigators and the Administrator have on their own accord raised the standard for what constitutes abuse, allowing such acts to go unacknowledged, unsubstantiated, unpunished, and uncorrected. Consequently, staff are sent a message that it is ok for to hit, bruise, or pull the hair of residents as long as they did not "intend" to harm the resident.

Policy 01.11.0 recently underwent some significant changes, including changes to the definitions of abuse, neglect, and mistreatment. Unfortunately, the definitions were not broadened to protect residents from the recent influx of substantiated abuse, neglect, and mistreatment. Instead, they were narrowed to allow for more acts by staff to not fall within the policy definition. To illustrate, the definition of "sexual abuse" was changed as follows:

[83] (Emphasis added).
[84] I.C. §18-101(1)(emphasis added).

Previous Version of Policy 01.11.0, approved by Administrator Jamie L. Newton on 06/08/2017:	**Updated Version of Policy 01.11.0, approved by Administrator Jamie L. Newton on 04/13/2018:**
"**Sexual abuse** includes any incident where a client is coerced or manipulated to participate in any form of sexual contact *or any unnecessary sexual communication with an individual who resides at SWITC regardless of the individual's willingness to engage in that contact or communication*."	"**Sexual abuse** includes any incident where a client is coerced or manipulated to participate in any form of sexual activity or sexual assault against a client."

As demonstrated above, the phrase in italics regarding unnecessary sexual communication was removed. In 2017, SWITC/IDHW investigators substantiated at least two (2) incidents unnecessary sexual communication as sexual abuse. In one incident, staff made sexually inappropriate statements about a resident's mother to the resident and later made comments about licking a guinea pig's butthole to second resident while looking at video footage of guinea pigs online. In the other, staff told a resident that the gesture they should use when choking on food was actually a gesture symbolizing masturbation. Instead of putting forth a policy that prevents these grossly inappropriate communications from happening again, SWITC has now chosen to eliminate them as prohibited acts. Upon DRI's review, the use of such language is not prohibited within any other definition of abuse, including the newly defined "verbal abuse."[85] Consequently, there appears to be nothing in SWITC policy that protects

[85] SWITC, *Investigations of Alleged/Suspected Abuse, Neglect, and Mistreatment*, Policy 01.11.0, Approved by Administrator Jamie L. Newton on 04/13/18, pg. 3. "Verbal abuse refers to any use of insulting, demeaning, disrespectful language (oral, written, or gestured) directed towards and in the presence of a client. Examples of verbal abuse may include but are not limited to: ridiculing or making fun of a client; and inappropriate screaming, yelling, cursing, or use of profane language against a client."

residents from unnecessary or unwanted sexual communications from staff going forward.

Moreover, the definitions found in Policy 01.11.0 are not in line with the recently created rules governing the Secure Treatment Facility, which will not only be located on the SWITC campus within one of SWITC's residence halls, but also managed and staffed by the same administrator and staff who are currently working at SWITC. For comparison purposes, see the definition of "physical abuse" as follows:

SWITC Definition of Physical Abuse from Policy 01.11.0 (last updated 04/13/2018)	**Secure Treatment Facility Definition of Physical Abuse Docket No. 16-0315-1801 (Temporary Rules)(April 2018 version) IDAPA 16.03.15.010.01**
"**Physical abuse** is any action intended to cause physical harm or pain, trauma or bodily harm." Examples of physical abuse may include but are not limited to: • hitting, slapping, punching, kicking, and/or striking a person physically or with an object; • pinching of skin; • twisting of limbs or other body parts; • pulling of hair; • use of any restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment."	"**Physical abuse** is any action that causes physical harm or pain, trauma, or bodily harm such as hitting, slapping, punching, kicking, and pinching. It includes the use of excessive force or improper technique when placing a person in restraints, the use of restraints that are not specified in the facility's policies and procedures or ordered by the physician and consented to by the legal guardian in the person's Individual Treatment Plan (ITP) and restraint of any form imposed as a means of coercion, punishment, convenience, or retaliation by staff. All injuries sustained by the person during restraint or injuries suspected to be sustained during restraint must be investigated for potential abuse."

Considering the Secure Facility will be housed on SWITC's campus, managed by the SWITC Administrator, and staffed by employees who also work at SWITC, it would

make sense that the facilities' practices, policies, and procedures governing abuse, neglect and mistreatment be the same – if for nothing else, consistency. Without such uniformity, one set of definitions governs one side of a door while another set of definitions governs the other. Using the physical abuse definition as an example, a scenario may exist where an injury resulting from a restraint may be investigated as potential abuse at the Secure Facility, while the same exact injury incurring only a few feet away in SWITC would not be identified as abuse at all.

Furthermore, the current policy notably omits any indication that acts of abuse or neglect committed by staff will result in termination. Even committing acts such as participating in cover-ups of abuse or neglect or retaliating against an individual for reporting or cooperating in an abuse or neglect investigation will not automatically result in termination.[86] If SWITC were serious about protecting residents, it would have let staff know they would lose their job if they ever abused, neglected, or mistreated a resident.

SWITC's policy on abuse, neglect, and mistreatment was also recently revised to expand the facility's "exceptions" to placing staff on administrative leave. Previously, the policy required all staff accused of abuse, neglect, or mistreatment be placed in

[86] SWITC, *Investigations of Alleged/Suspected Abuse, Neglect, and Mistreatment*, Policy 01.11.0, Approved by Administrator Jamie L. Newton on 06/08/2017, pg. 2. "Individuals will be subject to immediate disciplinary action up to and including dismissal for: attempting to cover-up a potential act of abuse, neglect, or mistreatment; participating in a cover-up of a potential act of abuse, neglect, or mistreatment; retaliating against an individual for reporting or cooperating in an investigation; attempting to retaliate against an individual for reporting or cooperating in an investigation; disclosing information about a reported allegation to people other than the AOD, Administrative Director or investigative team." *See also* SWITC, *Investigations of Alleged/Suspected Abuse, Neglect, and Mistreatment*, Policy 01.11.0, Approved by Administrator Jamie L. Newton on 04/13/2018, pg. 2.

administrative leave during the pendency of the investigation to ensure the safety of the residents with few exceptions. Now, those exceptions include:

- When a client is accusing multiple staff or all staff on shift at the same time. In this case the [Administrator on Duty] should ensure that someone is supervising the accused staff and that they do not go anywhere alone with clients. The [Administrator on Duty] should let the staff and the supervisor know that they should remain where the cameras can see them as much as possible and that these arrangements need to remain in place until the investigation has been completed.

- When the accusation involves the staff not following a very specific client plan. For example, the staff is accused of not following a client's pureed diet. The [Administrator on Duty] can have them continue to work, but should inform the supervisor and the staff that they cannot work with anyone else with a specialized diet until the investigation has been completed.

- The [Administrator on Duty], in consultation with the [Administrator], may choose to do a pre-investigation for those allegations that seem impossible or implausible or when there is a client who we have identified as consistently making false accusations. For example, when a client gets upset at staff they begin yelling that staff is raping them. In this instance, the other staff present along with any client witnesses should be interviewed and if applicable, video of the incident reviewed. During this time, the staff may be reassigned to work in a different area and given instructions similar to the instructions under the first bullet point in this section. This report will be filed separately from the other investigation reports, unless, during the pre-investigation, it is determined that the allegation is possible or plausible or a new allegation surfaces. In that case, a full investigation will be completed. [87]

Expanding the reasons why an accused staff should not be placed on administrative leave sends the message that an employee's ability to work is prioritized above those who the facility is obligated by law to keep safe: its residents. DRI is concerned that such "exceptions" appear to be yet another example of the facility's

[87] SWITC, *Investigations of Alleged/Suspected Abuse, Neglect, and Mistreatment*, Policy 01.11.0, Approved by Administrator Jamie L. Newton on 04/13/2018, pg. 5-6.

failure to take a zero tolerance stance as to resident abuse or neglect. Instead of placing the safety of the residents above the employment rights of their staff, the facility has actually made it easier for staff accused of abuse or neglect to remain at work. This increases the safety risks of the residents by allowing accused staff to remain working with residents until that the abuse or neglect allegation is substantiated – instead of taking the prudent step of placing the staff on leave until a thorough investigation concludes the abuse or neglect did not occur. The expanded exception also appears to prioritize certain types of allegations above others: i.e. failure to follow a client's specific diet plan is not as serious or as harmful as punching a client – when in fact, failure to follow a specific diet could very easily result in serious harm or even death.

Moreover, allowing the Administrator on Duty to "pre-investigate" certain allegations sets a dangerous precedent in essentially allowing for that individual to pre-screen allegations depending on the type of allegation made and the victim involved. Consider the language regarding residents who "have been identified as consistently making false accusations." What if, for instance, those accusations are considered false or were found to be unsubstantiated because the investigator did not conduct a thorough investigation? Now, the victim is allowed to be forever scrutinized anytime they make an accusation simply because those investigating their accusations did not do as they were required. Meanwhile the accused staff are allowed to continue working with other residents unless or until the allegation is determined to be "possible" or a new allegation surfaces.

Further evidence of SWITC's failure to prioritize resident safety can be found by examining the "On-The-Job Training Checklist" the facility was using for new staff training.[88] The second and third page of the checklist outline the general information the trainer is to give to new staff, with specific categories numbered "1" through "21." Information regarding "Client Abuse" didn't even make the top 5 of the categories listed. Instead, it is listed at number 8 on the list, below topics such as "1. Smoking Policy;" "2. Phone and Internet Use;" "3. Calling In;" "4. Calling in Late;" "5. Absences Over Three Days;" "6. Dress Code;" and "7. Greeting Visitors, Giving Info." Once again, indicating that resident safety is not a priority of the facility.

Even more telling is how the facility has chosen to inform residents of their legal rights as a resident of a facility. As an ICF/IID, SWITC is required to inform each resident, parent (if resident is a minor), or legal guardian, of the resident's rights while living in the facility as well as the rules of the facility.[89] Upon admission, SWITC provides each resident with a form entitled "Rights and Responsibilities" which "apply to you as an individual that lives at [SWITC] and as a citizen of the United States."[90] The form is comprised of the facility's Mission Statement, an explanatory paragraph, and two columns: one detailing the resident's rights with the other detailing the resident's responsibilities. Many of the areas detailed in the two columns do not correspond with

[88] SWITC, Form #1337, last updated on 12/08/17. This form was provided by SWITC to DRI on January 19, 2018, in response to a request for documents pertaining to employee training. It was described as "a more detailed summary of what is covered with each new employee during their first days on the job." On October 17, 2018, SWITC/IDHW informed DRI that this form is no longer used for training staff.
[89] 42 C.F.R. §483.420(a)(1); IDAPA 16.03.11.200
[90] SWITC, Policy 01.01 Form #4057 (dated 7/1/11).

each other, sending a conflicting message that a resident's right is dependent upon their good behavior. In other words, if a resident does not act appropriately, staff can take away their rights, including constitutional rights such as free speech. To illustrate, see the listing of the rights and responsibilities regarding "respect" as follows:

Your Rights	Your Responsibilities
You have the right to: • Be protected from neglect and from physical, sexual, or psychological abuse. • Be treated with respect by others. • Have time to be alone and to have privacy when your personal needs are being cared for. • Respectfully say "no" and ask people to change the things they do for you or expect of you. • Have all information contained in your personal records kept confidential.	*You have the responsibility to:* • Treat other people and their property with respect. (This means no name calling; putting down other people's personal beliefs; using other people's things without permission; breaking other people's things; acting mean and harassing people; using physical violence. It also means things like being quiet between 10pm and 6am when most people are sleeping; telling people politely (no yelling, swearing) when you want to refuse a request or ask that something be changed; saying things like please and thank you, and sharing the time on the phone when others also want to use it). • Respect other people's right to privacy. (This means do not look in other's records, or listen to their conversations; do not go in their rooms or touch their personal things without approval from them.) • **If you do take responsibility:** People will also treat you and your property with respect and you'll have more friends. • **If you do not take responsibility:** Law enforcement may get involved. You can get a ticket or a fine that can cost

	money. You may not get to live where you want to. You might not make any friends. Other people may not want to be around you. Other people may not treat you like you want them to. You may lose some of your privileges and rights.

When read as written above, these columns imply that in order to have the rights listed in the left column, including the right to be protected from neglect and physical, sexual, or emotional abuse, you ***must*** comply with the responsibilities in the right column. What is notably missing, however, is a statement that such rights ***are guaranteed*** by state and federal laws,[91] exist at all times, and cannot be denied or taken away - no matter what. While a facility is certainly entitled to inform residents of the rules of their facility, doing so alongside a listing of a resident's rights sends a message that the rights are nothing more than mere privileges which must be earned and can be taken away based solely how you behave.

Another example of SWITC's failure to demonstrate a commitment to prioritizing resident care and treatment through its own policies can be found in the written guidance (or lack thereof) it provides on active treatment. As an ICF/IID, SWITC is obligated by law to provide each and every resident with active treatment.[92] Active treatment is a continuous program that includes specialized training, treatment, and health services to help each person achieve two important goals: (1) live with as much

[91] 42 C.F.R. §483.420; I.C. §§66-412, 66-413; and IDAPA 16.03.11.200.
[92] 42 C.F.R. §483.440(a); IDAPA 16.03.11.400.

independence and self-determination as possible and (2) not lose or regress skills or functions that they already possess.[93] Active treatment is the hallmark of an ICF/IID. It is what sets ICF/IID apart from other care facilities such as nursing homes or psychiatric hospitals as it must be provided in order for a facility to be licensed as a Medicaid provider and must be required by an individual with a developmental disability in order for them to be admitted to the facility.[94]

Yet, none of SWITC's internal policies, including its policy on Admissions,[95] provide any specific details about active treatment. Federal law requires that in order to provide active treatment, each individual admitted to an ICF/IID receive a comprehensive functional assessment that identifies specific developmental, behavior, social, health and other needs. The results of this assessment are then used to develop an individual program plan which must be monitored and revised by the facility, as appropriate, to meet the changing needs of the individual. While each step of this process is outlined in detail within the federal ICF/IID regulations, they are barely mentioned in SWITC's Admissions policy. In fact, the only reference to the development of an individual program plan – a requirement that spans almost two pages worth of federal regulations – is limited to one sentence on the last page of the policy: listed as an event that the Treatment Team is responsible for developing within thirty (30) days of an individual's admission.[96] It does not mention the requirement that a

[93] *Id.*
[94] 42 C.F.R. 483.440(b)(1); IDAPA 16.03.11.400.
[95] SWITC Policy 01.01, *Admission to Southwest Idaho Treatment Center*, (approved by Sue Broetje on 04/1/13).
[96] *Id.* at 5.

comprehensive functional assessment be completed nor does it provide any guidance as to how often such plans are to be reviewed and under what circumstances they are to be revised. Without specifically detailing in writing how the facility will provide active treatment, how can the facility guarantee that it is meeting its primary obligation (and the main purpose of living in an ICF/IID) of ensuring that each resident receives such services? What message is being sent to the residents and staff when the key essential component of an ICF/IID is absent from facility policies?

SWITC's policies are the primary source of communicating its philosophical approach to resident care, treatment, and safety. As such, they unfortunately serve as the beginning of SWITC's perpetual cycle of abuse and neglect. Not only do SWITC's policies fail to send the message that its residents come first, they actually convey the opposite. If a facility does not take the time to incorporate resident-centered values and principles within its written policies, practices, and procedures, proper needs assessments may not be timely completed. Comprehensive treatment programs and plans may not be developed. Staff training and supervision requirements may go undefined. Worst of all, staff will operate without the expectation that resident abuse or neglect will not be tolerated. Hence, a cycle of inadequacies is born, negatively affecting the care, treatment, and safety of those the facility is required to serve and protect.

2. SWITC failed to ensure that residents receive the care and services they are entitled to under state and federal law.

SWITC is obligated by both federal and state law to provide its residents with

"active treatment services."[97] In fact, the need for such services is a requirement for admission to an ICF/IID. Active treatment is a:

> "program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services….directed toward…[t]he acquisition of behaviors necessary for the individual to function with as much self-determination and independence as possible…"[98]

Active treatment must be continuously, aggressively, and consistently implemented to meet the federal regulatory standard.[99] Prior to administering active treatment, a facility must assess the individual's current developmental, behavioral, social, health, and nutritional needs upon admission in order to create and implement an individual program plan to meet any identified needs.[100] Once implemented, the plan must be monitored, reviewed, and revised as necessary.[101]

To implement their active treatment program, each SWITC resident is entitled by law to receive necessary professional program services.[102] Such services may include speech therapy, occupational therapy, physical therapy, counseling, etc. According to Centers for Medicaid and Medicare Services, the effectiveness of active treatment "is ***dependent*** upon a facility's assembly of a competent team of professional program staff" including but not limited to, speech-language pathologists, mental health counselors, physical therapists, occupational therapists, dietitians, teachers, and other

[97] 42 C.F.R. §483.440(a); IDAPA 16.03.11.400.
[98] *Id.*
[99] *Id.*
[100] 42 C.F.R. §483.440(b)-(d); I.C. §66-413; IDAPA 16.03.11.400.
[101] 42 C.F.R. §483.440(d); IDAPA 16.03.11.400.
[102] 42 C.F.R. §483.430(b)(1); IDAPA 16.03.11.300.

medical staff.[103] This means that if a resident's assessment identifies specific communication needs, a speech language evaluation may be required. If a resident's assessment identifies specific motor needs such balance, strength, or other ambulatory issues, a physical therapy evaluation may be necessary. If such evaluations result in specific therapy recommendations, those recommendations must be incorporated within the individual's plan and provided.

Despite such statutory and regulatory mandates, SWITC failed to provide such active treatment services in multiple instances.[104] As documented by the Bureau of Facility Standards in their July 2017 survey of the facility, behavior assessments failed to contain current, comprehensive, consistent information by which appropriate programs and plans could be developed.[105] In multiple cases, assessments had not been updated for years. Plans or programs that had been developed failed to address identified needs, failed to implement replacement behavior training, or were not even implemented to begin with.[106] While on campus, surveyors observed residents for a total of nine (9) hours and thirty-five (35) minutes, during which surveyors noted five (5) residents were not participating in any skill-building or meaningful activity that their programs would require. Instead, the residents were watching television, sleeping, or

[103] CMS, *State Operations Manual, Appendix J – Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities*, (Rev. 178, 04-13-18), 76, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_j_intermcare.pdf (emphasis added).
[104] Idaho Department of Health and Welfare, *supra* note 33 at 46-57.
[105] *Id*. at 57-77.
[106] *Id*. at 77-93.

spending time in their room, i.e. doing nothing.[107] The facility also failed to revise one individual's programs, despite accumulating seven (7) months of data demonstrating that the individual was failing to progress towards his program objectives.[108] Even more concerning, the facility failed to get necessary consent and approval from residents or their guardians prior to using restrictive interventions in resident plans such as the use of physical restraints, outing restrictions, and increased supervision.[109]

In addition, the Bureau of Facility Standards documented multiple instances of residents not being provided with the professional program services needed in order to address their needs.[110] One individual's assessment from 2016 had recommended speech language, physical therapy, and occupational therapy evaluations – yet, nine (9) months had passed and no such evaluations had been conducted.[111] Another individual had been discharged from a hospital with specific instructions to have physical therapy, occupational therapy, and speech language evaluations and treatment provided.[112] Yet, in the four (4) months since his discharge, he had only received a speech language evaluation, not any of the required treatment the evaluation had recommended.[113]

Although SWITC claimed such deficiencies had been corrected, the facility continued to be cited for deficiencies surrounding its provision of active treatment

[107] *Id*. at 47-57.
[108] *Id*. at 96-101.
[109] *Id*. at 101-110.
[110] *Id*. at 38-42.
[111] *Id*.
[112] *Id*.
[113] *Id*.

services in surveys conducted in October of 2017 and February of 2018. In October, the Bureau of Facility Standards found that three (3) individuals had functional behavior assessments which lacked the information necessary to make decisions regarding appropriate behavioral interventions.[114] In February, that number increased to four (4).[115] The February survey also uncovered that one individual's comprehensive functional assessment failed to include an evaluation of his sensorimotor needs– a violation the facility had previously been cited for in 2016.[116] Sensorimotor skills involve the process of receiving sensory messages through systems such as vision, hearing, smell, taste, and touch, in order to producing an appropriate motor or movement in response.[117] This individual had an individual program plan dated January 22, 2017, which documented that he was "very unstable when walking," "fell frequently," and was a "HIGH RISK for potential falls" to the point where he had to wear a helmet and have the floors and walls in his bedroom padded to protect him from injuries due to falls.[118] Yet, despite such clear evidence of sensorimotor issues, no evaluations related to these needs had been performed.[119] As a result, no recommendations could be

[114] Idaho Department of Health and Welfare, *Southwest Idaho Treatment Center – Nampa 10-12-17 Recertification/Relicensure +Complaint Follow-Up (2nd)*, 1-4, http://healthandwelfare.idaho.gov/Portals/0/Medical/LC7/101217SWITC_R_CFU2nd.pdf.

[115] Idaho Department of Health and Welfare, *supra* note 62, at 83-90.

[116] Idaho Department of Health and Welfare, *supra* note 62, at 91-94. *See also* Idaho Department of Health and Welfare, *Southwest Idaho Treatment Center – Nampa 06-10-16 Recertification/Relicensure*, 1-3, http://healthandwelfare.idaho.gov/Portals/0/Medical/LC6/061016SWITC_R.pdf?ver=2016-07-06-122804-693.

[117] North Shore Pediatric Therapy, *Sensorimotor Skills*, https://nspt4kids.com/healthtopics-and-conditions-database/sensorimotor-skills/ (last visited August 1, 2018).

[118] Idaho Department of Health and Welfare, *supra* note 62, at 91-94.

[119] *Id*.

incorporated within his plan of care to help prevent further falls or injuries due to falls from occurring.

Moreover, DRI was recently informed that various therapeutic/recreational opportunities have become increasingly limited at the facility. For instance, it is DRI's understanding that residents no longer have access to a sensory room, which had been used as a therapeutic calming technique for many individuals. It is also DRI's understanding that the facility's gym and pool, which provided residents with exercise/recreational opportunities, have been closed for almost two (2) years.

Without the provision of a "continuous and active treatment program," residents at SWITC may never have the opportunity to acquire the skills necessary to function with as much self-determination and independence as possible, thereby creating the second step in SWITC's cycle of abuse and neglect. According to Administrator Jamie Newton, "most" of SWITC's residents "have serious behavioral histories," and reside at SWITC "because they are dangerous to others or themselves."[120] If such statements are indeed true, then it is even more imperative that SWITC fulfill its obligation to provide active treatment services starting with complete, comprehensive assessments and evaluations which identify each resident's specific needs so that appropriate and effective treatment plans can be created to address them. Rather than continuing to blame residents for their behaviors, SWITC and IDHW should instead examine their own failures to meet their constitutional, federal, and state responsibilities. Without current, appropriate assessments to identify each resident's need, addressed through a

[120] Lowe, *supra* note 18.

comprehensive, individualized, and implemented plan that meets the residents' needs, those "serious" and "dangerous" behaviors will continue to go untreated, possibly increasing and worsening as time goes on. As a result, residents will not achieve the skills they need to manage such behaviors so they can someday live independently and staff will not have the tools or strategies they need to address such behaviors appropriately. Combine this with the fact that the facility repeatedly leaves shifts short-staffed, employing staff who are poorly trained and unsupervised, it is not difficult to imagine how situations of resident abuse and neglect can arise.

3. SWITC repeatedly failed to provide the amount of direct staff required to serve the needs of its residents.

Pursuant to federal and state law, SWITC is required to employ a specific number of direct care staff to ensure individual program plans are implemented and that residents are safe.[121] Such requirements set forth the minimum number of direct care staff that must be present and on duty for all shifts over a twenty-four (24) hour period in each housing unit at a facility.[122] The requirements, known as staffing "ratios," vary depending on the age of the resident, the severity of the resident's disability, and number of residents residing in each housing unit.

Despite these requirements, Bureau of Facility Standards surveyors found that the facility failed to meet its required, minimum staff to resident ratios for the first seven (7) months of 2017 (January through July). In response, the SWITC Administrator indicated that by October 4, 2017, the facility would "[reassess] staffing

[121] 42 C.F.R. §483.430(d)(1); IDAPA 16.03.11.300.
[122] 42 C.F.R. §483.430(d)(2)-(3).

minimum requirements to ensure appropriate levels of staffing have been determined" and that the facility would hire additional staff, monitor staffing schedules on a daily basis, and provide monthly reviews of staffing minimums to the Administrator.[123]

Even with these assurances, staffing issues have remained. With the assistance of its consultant, DRI reviewed SWITC's work schedules for the months of September, October, and November of 2017 and found that the facility still failed to meet minimum staffing requirements in each of these months. Such problems persisted into 2018, when the Bureau of Facility Standards discovered that eighteen (18) shifts had been worked below ratio from December 1, 2017 through February 19, 2018.[124] **In total, SWITC had failed to meet minimum staffing requirements in thirteen (13) straight months.** All the while continuing to admit new residents to the facility and continuing to bill Medicaid for providing services to such residents – services that it was not capable of adequately providing without having the minimum number of required staff.

Federal law requires minimum staffing ratios because not having enough staff places everyone in the facility at risk. Such risk includes:

> [a] chaotic environment, client-to-client abuse, self-abuse by clients, clients sitting unengaged for long periods of time with little to no staff presence, clients not given the opportunity to assist in activities of daily living [i.e. cleaning,

[123] Idaho Department of Health and Welfare, *supra* note 49, at 9.

[124] Idaho Department of Health and Welfare, *Southwest Idaho Treatment Center – Nampa 04-25-18 Complaint Follow-up + Complaint*, http://healthandwelfare.idaho.gov/Portals/0/Medical/LC8/042518SWITCFU_C.pdf. Although the facility did have shifts that were worked below the minimum rations, BFS ultimately concluded that there was not sufficient evidence to determine that resident needs were not being met. DRI would like to point out that by this time, the facility had been staffed below minimum required staffing ratios **for over a year** despite assurances by the facility that it would hire additional staff to meet such minimum requirements in order to maintain its license to operate as a Medicaid provider.

> preparing meals, managing money, eating, bathing, putting on clothes, or using the bathroom] or participate in the rhythms of life due to the need to "get things done" (such as assisting with [meal] preparation), or programs not being carried out due to inadequate on-duty staffing.[125]

After not meeting staffing requirements for over a year, every one of those risks identified above have unfortunately become reality at SWITC. In February of 2018, Bureau of Facility Standards surveyors observed that residents were subject to "ongoing verbal, physical, and psychological abuse" from other residents.[126] Residents were telling other residents to "shut the fuck up," I'm going to kill you," "your ass is mine fucker," and "come on and hit me you bitch."[127] They threatened to hurt other residents, raising closed fists, lunging after, and following other residents into their room, threatening to "get" the other resident. In some cases, residents would follow through with such threats, throwing objects at or even physically hitting other residents, sometimes multiple times, until staff intervened. Surveyors noted one particular resident was the victim of ten (10) psychological assaults and eleven (11) physical assaults from other residents, over a span of only three (3) months. The main perpetrator? A resident who had been the victim of multiple assaults and threatening behaviors as well, including seven (7) threatening behaviors in the month of November 2017 alone. Such findings came after the facility's administration had publicly assured that all deficiencies it had been cited for, including those related to client protections, had been corrected.

[125] CMS, *supra* note 103, at 23.
[126] Idaho Department of Health and Welfare, *supra* note 62, at 63-81.
[127] *Id*.

Residents also harmed themselves, hitting their heads repeatedly against hard surfaces or hitting objects such as walls or windows with their hands. Moreover, individuals residing at SWITC were also subjected to staggering numbers of abuse and neglect from facility staff. When not subjected to harm from themselves or others, residents are left to essentially entertain themselves, sitting for hours watching television, sleeping, or spending time alone in their rooms with little to no interaction or supervision from staff.[128] In fact, in four (4) of the internal abuse and neglect investigations DRI reviewed, investigators were told by staff that they were "short [staffed]" or "short of time" and, as a result, could not comply with resident supervision requirements or implement treatment plans correctly.

Not providing enough staff on each shift has had a significant impact on the services and treatment that residents receive at SWITC. As such, it serves as the third component in the cycle of abuse and neglect that permeates this facility. Even if SWITC had been provided proper needs assessments and developed appropriate plans and programs – such steps are meaningless without a sufficient number of trained staff to implement those plans and programs on a daily basis. Programs that are not consistently implemented leave residents confused. Needs go unaddressed, behaviors increase or worsen over time, resulting in an unsafe environment due to client-to-client abuse, self-abuse, or even abuse at the hands of staff. If a unit is short staffed to begin with, such abuses may not be immediately observed. If they are observed, staff may not be able to immediately intervene, especially in situations where assistance or "back-

[128] Idaho Department of Health and Welfare, *supra* note 33, at 47-57.

up" is needed. To make matters worse, those responding as "back up" are often staff pulled from other units, unfamiliar with and untrained as to the particular behaviors, plans, and interventions belonging to the residents on the unit they are responding to. Inappropriate or unapproved restraint methods are then used, escalating situations, and placing both the resident and staff at further risk of harm. As a result, residents at SWITC face the possibility of being injured each and every day simply because the facility cannot provide its required minimum number of direct care staff.

4. SWITC repeatedly failed to ensure that direct care staff received appropriate training and supervision.

SWITC is not only required to employ sufficient numbers of staff, but also to ensure that their staff are appropriately trained and supervised. Pursuant to federal and state standards, the facility must provide each employee with initial and continuing training to enable the employee to perform his or her duties effectively, efficiently, and competently.[129] As a result, staff must not only be able to demonstrate the skills and techniques necessary to administer interventions when necessary in order to manage inappropriate resident behavior, but also must be able to implement the individual program plans for reach resident for whom they are responsible.[130]

DRI's review of seventy (70) abuse and neglect investigations uncovered multiple instances where staff were either not trained at all or if they were trained, the training was inadequate. For instance, the facility's policy regarding investigations of abuse or neglect requires staff to immediately report any witnessed or suspected incidents of

[129] 42 C.F.R. §483.430(e)(1); IDAPA 16.03.11.300.
[130] 42 C.F.R. §483.430(e)(3)-(4).

abuse or neglect to the Administrator or Administrator on Duty.[131] SWITC provided DRI with multiple documents indicating that the facility and its staff supervisors had conducted several trainings on this policy and its reporting requirements from February of 2016 through November of 2017. Yet, in at least twenty-one (21) investigations, staff failed to follow the policy's reporting mandates by either not reporting timely or not reporting at all. Such instances were as follows:

Incidents That Went Unreported:

- A staff's supervisor disclosed in an investigation regarding potential neglect that there had been previous incidents where a staff had fallen asleep on the job, while working as an assigned one-on-one care provider for a resident with enhanced supervision needs. Yet, there was no evidence that any of the previous incidents had been reported as neglect or investigated.

- Two staff, (one of whom was a nurse), were present when a resident reported to a third staff that he was almost hit by another resident. The third staff responded by saying "Jesus, you guys are annoying the crap out of me...Good god. You're both adults, you're over 30." None of the staff intervened as the resident was about to be punched, nor did the two staff report the third staff's comments as potential abuse or neglect.

- Three staff failed to report potential abuse or neglect after a fourth staff admitted that he had to "whoop" a resident's ass the day before, by taking the resident down into the resident's night stand, which had to be thrown away after the incident. Not only did the staff fail to report such statements as evidence of abuse, but one of the staff even asked if "justice was served," and then chuckled when the abusive staff responded.

- One staff failed to report potential abuse/neglect after another staff admitted to provoking a resident into a behavior so the police would take the resident to jail to avoid having to take the resident back to their housing unit themselves.

[131]SWITC Policy 01.11.0 entitled "*Investigations of Alleged/Suspected Abuse, Neglect, and Mistreatment*," requires that "any staff member" must "immediately" intervene, if necessary, to protect the individual, and call the Administrator or Administrator on Duty to report an allegation of abuse, neglect, or mistreatment if abuse, neglect, or mistreatment is witnessed or suspected, or if a suspicious injury is discovered.

- Two staff failed to report derogatory statements that another staff made to a resident about the resident's attire, stating "...it's not cool to....[run] around like fucking Captain America," justifying his/her comments by saying "I'm telling you this because I'm trying to give you sound advice, because you are going to be in the fast food industry because that's probably your best chance at a career pathway....If you dress up like Captain America or Thor...you need to understand that they're going to knock your fucking teeth in..."

- One staff supervisor failed to report derogatory comments that another staff made to a resident, saying "You fuck up every conversation. I'm not fucking helping you because you totally interrupted me."

- One staff failed to intervene or report derogatory statements made by another staff to a resident who had aimed a toy pistol at him, arguing with the resident as follows: "No. Answer my question. Why did you tell me that? Because you just had to open your fucking mouth...should have kept your mouth shut. You just have to argue, no matter what. You just have to have some stupid fucking words even though it doesn't make sense, right? You take that out again and I'm going to destroy it."

- Four staff fail to report an incident as potential abuse after they observed another staff pick up a resident's hat and throw it at the resident, hitting the resident in the face.

- One staff failed to intervene or report as abuse an incident he/she observed where a staff told a resident "Come here, smartass!," getting in the resident's face and saying "What are you going to do...Shut up! One more time and you get this!" (raising fist in the air, gesturing that "this" would be a punch in the face.)

- One staff failed to report an incident of abuse after a staff admitted to them that they had "no patience" for a former resident, who was a minor at the time the incident occurred. The staff admitted that the resident had punched them once, so in response, the staff had grabbed the resident's arms and yelled in the resident's face.

- One staff failed to report two incidents of potential sexual abuse after witnessing another staff state to resident that they had sex with the resident's mother earlier that morning and, later, made comments about licking a guinea pig's butthole to another resident while looking at video footage of guinea pigs online.

- Four staff failed to report sexually inappropriate comments as abuse after observing another staff tell a resident that the gesture they should use when choking on food was actually a gesture symbolizing masturbation.

- At least two staff failed to report a derogatory comment as abuse when a staff called another resident a “weirdo.”

- Three staff failed to report potential abuse after another staff admitted to them that they had slapped/smacked another resident on the butt and slapped the resident across the face with their right hand.

Incidents That Were Not Timely Reported:

- Staff waited twenty-nine (29) days before reporting as potential abuse an incident where another staff admitted to provoking a resident into a behavior so the police would take the resident to jail to avoid having to take the resident back to their housing unit themselves.

- Staff waited four (4) days before reporting as potential abuse an incident where another staff told a resident to “stop being a dick.”

- Staff waited almost forty-three (43) hours before reporting as potential abuse an incident where another staff failed to intervene while observing a resident hit their head on a counter seven (7) times.

- Staff waited almost twenty-four (24) hours before reporting as potential neglect evidence of a resident wearing the same clothes for three (3) days and observations of fecal matter smeared on countertops in the resident’s bathroom, indicating that other staff had not been assisting resident with personal care needs.

- Staff waited six (6) days before reporting as potential neglect suspicions that a resident’s wound infection resulted from a nurse’s instructions that direct care staff wrap wound with a towel, indicating a failure to provide appropriate medical care to the resident.

- Staff waits approximately two (2) hours after receiving a report that a resident had been pushed by staff before reporting the incident as potential abuse, during which time the accused staff was not immediately separated from other residents, but allowed to work on another housing unit.

- Staff waited approximately fourteen (14) days before reporting as potential abuse an incident where a staff sat on top of a resident in a facility van in

order to stop the resident from having a behavior while on an outing in the community.

As another example, consider SWITC's own policy on behavioral restraints, which requires all staff to be trained on the approved physical restraint techniques not only initially upon hire but annually thereafter.[132] Despite this requirement, eleven (11) investigations uncovered evidence of staff attempting to perform physical restraints without having been trained on such techniques or using physical restraint techniques that have not been approved for use by the facility. In one (1) incident, a resident was pinned up against the wall, then slid down and held down on the ground by multiple staff – a non-approved restraint method - even though there were enough staff on hand to attempt an approved CPI-Team hold[133] at the time. When interviewed, the staff involved in restraining the individual admitted that the restraint was "not what they teach in CPI" and that "CPI wasn't attempted as it wasn't really an option." After the incident had occurred, the resident's eye was so swollen, he couldn't see out of it. In another incident, a staff held a resident's head against a door while performing a non-approved restraint, cutting the resident's face above the eyebrow which started to bleed and required a trip to the emergency room for stitches. Another resident suffered facial injuries after staff threw the resident to the ground and put their thumb in a pressure point at the corner of the resident's jaw, causing it to dislocate. Keep in mind

[132] SWITC, *Behavioral Restraint*, Policy 01.07.0, approved by Administrator Jamie L. Newton on 05/01/16 (later updated and approved on 01/17/18).

[133] "CPI" refers to Nonviolent Crisis Intervention restraints such as the CPI Transport Position, Team Control, Children's Control, etc. taught in the Nonviolent Crisis Intervention training program. According to SWITC's *Behavioral Restraint* Policy 01.07.0, last updated and approved by Administrator Jamie L. Newton on 01/17/18, "[t]he only physical restraints approved for general use are those specified in the Participant Workbook for the Nonviolent Crisis Intervention training program."

that SWITC is not a correctional institution – it is a highly specialized treatment facility. Its residents are not inmates. They are individuals with developmental disabilities. Individuals whose physical and mental impairments are so severe, they require a higher level of care than what can be provided in the community. They reside at SWITC to receive such care and treatment, not to be subjected to unnecessary, inappropriate restraints.

Moreover, in ten (10) investigations, it was discovered that staff were either not trained on individual program plans or failed to follow them. In one of the most egregious examples, a staff offered cookie dough to a resident who had a feeding tube due to significant aspiration issues, despite clear documentation throughout the resident's programming files that the resident was to have **nothing** by mouth (abbreviated as "NPO"). Although the resident did eat the cookie dough by mouth, thankfully, they did not suffer any serious harm. When asked if they knew the consequences of feeding the resident by mouth, the staff admitted that they did not and did not even know what "NPO" meant. Staff further explained that despite having worked at the facility for four (4) months at this point, they had not received any training on resident programs and that anything they had learned, they "had to figure out" for themselves.

In another example, staff blocked a resident from leaving a building, even though the resident's programs specifically stated "[d]o NOT physically block [the resident] from leaving unless imminent danger is present." As a result, the resident became upset and struck the staff in the face. In retaliation, staff then pushed the

resident up against the wall and pulled the resident's hair. While interviewed, the staff admitted that they were "uncertain of [the resident's] programs…and did not know what was in [the resident's] behavior or assault programs." The investigator assigned to the incident then concluded that the staff's "[f]ailure to follow [the resident's] programs…resulted in significant behaviors that may have been avoided had the programs been followed."

As demonstrated above, substandard staff training has and continues to place residents at risk of serious injury or death. By not reporting or delaying the reporting of potential abuse or neglect, abusive/neglectful staff were allowed to remain in direct contact with residents of the facility, subjecting residents to an unacceptable risk for further harm. By not ensuring that all staff are trained on or implementing proper restraint methods, multiple residents were subjected to un-approved, improper physical restraints, resulting in black eyes, dislocated jaws, cuts, and bruises. By not ensuring staff were trained to properly implement resident program plans, residents were left without proper supervision, proper medical care, and were subjected to restraints that often times resulted in injuries - injuries that could have been avoided had the staff simply implemented what was already identified and outlined by professional staff in the residents' plans. Each of these scenarios ends with only one unacceptable and inhumane result: staff abusing or neglecting residents. Therefore, the cycle continues.

5. SWITC failed to adequately and appropriately identify and investigate allegations of resident abuse or neglect.

i. The investigations conducted by SWITC/IDHW investigators were not thorough and resulted in inconsistent conclusions,

including some that were unsupported by the evidence collected.

Pursuant to federal regulations, SWITC is obligated to "thoroughly" investigate all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source.[134] Federal guidance specifies that, at a minimum, a thorough investigation includes:

- The collection of all interviews, statements, physical evidence and any pertinent maps, pictures or diagrams;
- Review of all information related to the allegation;
- Resolution of any discrepancies;
- Summary of conclusions; and
- Recommendations for action both to safeguard all the clients during the investigation and after the completion of the report.[135]

Additionally, SWITC Policy 01.11.0 sets forth several requirements necessary to complete a "thorough investigation," including that every witness be interviewed, relevant individuals, paperwork, and environment checks be reviewed, and that each investigation must answer "who, what, when, and where related to an event through interviews, record review and observation."[136]

Despite such mandates, DRI uncovered multiple instances where SWITC/IDHW investigators failed to conduct thorough investigations. Specific examples include failing to interview all witnesses to an event and failing to identify and then resolve apparent discrepancies between witness testimony, documentary, and/or video evidence. In fact, DRI uncovered nine (9) investigations in which all witnesses to the event were not

[134] 42 C.F.R. §483.420(d)(3).

[135] CMS, *State Operations Manual, Appendix J – Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities*, (Rev. 178, 04-13-18), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_j_intermcare.pdf. ("Staff failure to implement facility safeguards, once client to client aggression is identified, may also constitute neglect.")

[136] SWITC, *supra* note 22, at 4.

interviewed. While DRI acknowledges that in two (2) of those investigations, SWITC/IDHW investigators refrained from interviewing the accused staff, per the request of the Nampa Police Department, they maintained the ability to interview other witnesses and the victims themselves. However, the most frequent – and significant – example involved investigators' failure to identify, report and investigate all potential violations of the abuse and neglect or other facility policies, despite having such violations clearly documented in the evidence that was collected. Investigators focused only on the specific allegation raised by the complainant and ignored evidence of contributory or ancillary issues that indicated a violation of policy or additional abusive or neglectful acts had occurred. Examples include:

- Fifteen (15) times in which the SWITC staff failed to identify, report, or investigate evidence of the Administrator or Administrator on Duty failing to timely report allegations of abuse or neglect to Adult Protection or Child Protection, in violation of Policy 01.11.0 and state and federal law.[137]

- Five (5) times in which the investigator(s) failed to identify, report, or investigate evidence of staff failing to report suspected abuse or neglect or failing to report per the requirements outlined within Policy 01.11.0. One (1) case involved a staff

[137] Pursuant to federal and state law, not only must SWITC staff thoroughly investigate all allegations of abuse and neglect, but report them to the appropriate state investigative agencies. *See* 42 C.F.R. §483.420(d)(2); I.C. §§39-5303, 16-1605. Such laws require that if a SWITC staff "has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected or exploited" he or she shall immediately report such information to Adult Protection, whereas reports of abuse, abandonment, or neglect of a child under the age of eighteen (18) shall be reported within twenty-four (24) hours to law enforcement or the Department (IDHW Child and Family Services – the same division that is responsible for overseeing SWITC). Failure to comply with these requirements not only can subject the facility to licensing issues, but can also result in criminal prosecutions as a misdemeanor offense. SWITC's own Policy 01.11.0 mandates that the Administrator or Administrator on Duty report such allegations to Adult Protection or Child Protection, depending on the age of the victim. *See* SWITC, *Investigations of Alleged/Suspected Abuse, Neglect, and Mistreatment*, *Policy 01.11.0*, Approved by Administrator Jamie L. Newton on 06/08/2017, pg.5. See also pg. 7 of the updated version of Policy 01.11.0, approved on April 13, 2018 by Administrator Jamie L. Newton, which requires the same. Despite these mandates, DRI discovered that SWITC staff failed to abide by these requirements in fifteen (16) of the seventy (70) investigations reviewed, either by reporting past the required timeframes or by failing to report at all.

sharing details regarding an abuse allegation via Facebook Messenger. Another involved two (2) staff disclosing during interviews that they overheard a resident make statements that a staff member had touched them in an inappropriate sexual manner, yet neither staff reported the statement as potential abuse.

- Four (4) times in which the investigator(s) failed to identify, report, or investigate additional allegations of abuse or neglect reported by the victim or documented in the evidence itself.[138]

- Five (5) times in which the investigator(s) failed to identify, report, or investigate evidence regarding the inappropriate use of a restraint.

- Four (4) times in which the investigator(s) failed to identify, report, investigate, or address evidence of inadequate staffing ratios or statements by staff that they were "short [staffed]" or "short of time" and, as a result, could not comply with resident supervision requirements.

- Three (3) times in which the investigator(s) failed to identify, report, investigate, or address evidence of staff failing to receive training on facility policies, practices, or procedures including, but not limited to, policies regarding abuse and neglect, client programming/plans, and behavior interventions.

- Two (2) times in which the investigator(s) failed to identify or investigate evidence of staff potentially violating the facility's policy on Technology Acceptable Use, HIPAA, and other related policies by disclosing information via

[138] Such additional allegations included: victims disclosing additional abuse allegations from previous dates including allegations that staff had pulled the resident's hair and tied the resident to their bed; documentation that staff had verbally threatened a resident for not completing programs threatening that if the resident didn't comply with staff demands that the resident will not be able to go on outings, would not receive positive reinforcement from staff such as high-fives or smiles, and that the resident's family would be disappointed in the resident; documentation that multiple staff overheard a co-worker making demeaning comments to a resident but did not report them as potential abuse telling the resident it's not "cool" to "[run] around like fucking Captain America…" and "I'm tell you this, because I am trying to give you sound advice, because you are probably going to be in the fast food industry because that's probably your best chance at a career pathway," "if you dress up like Captain America or Thor…they're going to knock your fucking teeth in…"; and documentation of a staff's failure to follow a client's programs (i.e. handing a resident a lighter when the resident's plan specifically stated not to allow the resident to handle lighters) which lead to the use of a restraint (in order to get the lighter back from the resident).

their social media account(s) and using their personal phone to photograph resident rooms.

- One (1) time in which the investigator(s) failed to identify, report, or investigate evidence of a staff using their cellphone while driving, a clear violation of the Community Activities Policy 01.18.0, which specifically prohibits "use of a cellular telephone while driving" as well as evidence of staff placing residents in the car at risk of harm.

- One (1) time in which the investigators failed to identify or investigate evidence of staff not following the protocols set forth in Suicide Prevention Policy 01.10.00, as also identified by the Bureau of Facility Standards in their February 22, 2018 survey.

- One (1) time in which the investigator(s) failed to identify or investigate concerns regarding whether or not night shift staff were performing bed checks as required.

Such failures to identify, report, and investigate potential policy violations are particularly significant in that it suggests the incidents of abuse or neglect are actually much higher than what has been reported/investigated. As listed above, **DRI has identified at least forty (40) more occasions in which staff either directly or indirectly put residents at risk of injury or death**. Yet none of those occasions were ever identified, reported, or investigated by SWITC or IDHW investigators, denying residents the opportunity for these dangerous practices by staff to be corrected. When such evidence is ignored, patterns and trends go unidentified and unaddressed, allowing for circumstances of abuse or neglect to continue in perpetuity. It also affects the integrity of the entire investigative process. If an investigation is not thorough to begin with, it influences the findings and conclusions made by the

investigator as well as the recommendations or corrective actions, if any, made by the Administrator.

In fact, DRI's investigation also uncovered that conclusions reached by the investigators were inconsistent, resulting in findings that were unsupported by the evidence presented. For instance, on at least three (3) different occasions, the investigator(s) misapplied the definitions of abuse or neglect found in Policy 01.11.0, concluding that abuse or neglect did not occur, when the evidence collected suggested otherwise. In one investigation, investigators concluded that although a staff person had held a resident's head against a door during a restraint, causing the resident to hit their head on the door and resulting in a laceration to the resident's eyebrow, the injury was "minor." As such, it was not substantiated as physical abuse per Policy 01.11.0. However, whether or not an injury is "minor" is not the standard by which physical abuse is determined per Policy 01.11.0. Instead, the policy advised that physical abuse is "any physical action to another which is of an intensity that a member of the general public would perceive to be painful."[139] Having one's head pushing into a door, causing injury to the face, could certainly be considered painful regardless if the injury was "minor."

In another investigation, the investigator did not substantiate an allegation of neglect, concluding "this case does not appear to rise to the level of gross neglect." However, whether or not an allegation rises "to the level of gross neglect" is not the

[139] SWITC, *supra* note 22, at 2. It should be noted that this particular language was struck from the definition of physical abuse in the revised version of this policy, approved by Administrator Jamie L. Newton on April 13, 2018.

standard by which neglect is determined per policy 01.11.0.[140] In fact, the term "gross neglect" is not found within the definition of "neglect" nor is it given as an example of "neglect" pursuant to Policy 01.11.0.

In a third investigation, two (2) residents were found walking off campus towards an interstate overpass without permission or supervision. Although it is unknown how long the residents were unsupervised before they left their unit, video/audio surveillance established that they were spotted within five (5) minutes of leaving their residence hall by two (2) staff members who happened to be outside, walking nearby at the time. Policy 01.11.0 defines neglect as the "failure to provide goods and services necessary to avoid physical harm or mental anguish or the disregard of an individual whether purposeful or due to the carelessness, inattentiveness, or omission by the perpetrator."[141] While certainly arguable that not supervising residents to the point where they are out of the unit and heading towards the interstate overpass qualifies as neglect per this definition, the investigator did not substantiate neglect in this case. Instead, the investigator referenced SWITC Policy 01.13.00, which appears to suggest that leaving a client unsupervised only constitutes potential neglect if it exceeds fifteen (15) minutes.[142] Such an analysis ignores the fact that the definition of neglect found in 01.11.0 contains no time restrictions. It also does not consider the fact that

[140] SWITC, *supra* note 22, at 3.

[141] SWITC, *supra* note 22, at 3. It should be noted that the language "…or the disregard of an individual whether purposeful or due to carelessness, inattentiveness, or omission by the perpetrator" was removed from the definition of neglect in the revised version of this policy, approved by Administrator Jamie L. Newton on April 13, 2018.

[142] SWITC, *Behavior and Incident Reporting*, Policy 01.13.00, Approved by Administrator Jamie L. Newton on 08/01/17.

the residents may have continued to go unaccounted for had they not been fortuitously spotted by two facility staff who coincidently were taking a walk outside at the exact moment the residents were leaving the facility grounds. Moreover, there is no indication that the investigator even reviewed the residents' treatment plans to determine if they had any enhanced supervision requirements (i.e. one on one or line of sight) which would have required staff to observe them continually, at all times. Nor was there any inquiry as to how the two (2) residents were able to leave their housing unit without the housing staff's knowledge in the first place.

In other investigations, investigators applied the correct definition of abuse or neglect but came to conclusions unsupported by the evidence presented. For instance, in one (1) investigation, it was reported that staff might have failed to provide a resident with medical attention in a timely manner after the resident experienced seizure-like activity during a community outing. The resident, who had a documented history of seizure-like activity, had a prescription for Diastat[143] to be administered on a PRN basis. Yet, no direct care staff brought the medication on the outing, requiring the resident to be transported back to the SWITC campus in order to receive treatment. The investigator ultimately concluded that neglect was not substantiated.[144] This was despite the investigator's own findings that there was no clear direction for staff during the event; not enough staff were in the facility van in order to transport residents back to the facility after the incident occurred; that the staff's decision to separate the

[143] *See supra* text accompanying note 45.

[144] This finding was eventually overturned by the Administrator, who substantiated a finding of neglect.

residents and transport some back to the facility in the van made staffing ratios inadequate for the return; and that the staff did not have the individual's seizure medication on hand at the outing, even though she had been diagnosed with a seizure disorder, and then did not call 911 upon observing her suffering from seizure-like activity for several minutes.

In another example, it was reported that a staff member failed to provide necessary medical care, resulting in a resident developing an infection that required hospitalization. The investigator ultimately found that the staff did provide medical care and so neglect was not substantiated despite evidence of the staff documenting the wound was "resolved" when it fact it was not. In addition, evidence collected demonstrated that the same staff had failed to follow physician orders to keep the wound clean, covered, and monitored for signs of infection for four (4) days, which ultimately led to the individual developing an infection that required a six (6) day hospitalization to resolve. In the meantime, the resident endured significant pain which could have been alleviated had physician orders simply been followed by staff who continue to work at SWITC.

In an investigation into potential abuse, a resident reported that his face had been slammed to the ground, causing injury to his eye during a restraint. Upon investigation, staff admitted that the resident had been pinned up against the wall, and then slid down and held down on the ground by multiple staff – a non-approved restraint method - even though there were enough staff on hand to attempt an

approved CPI-Team hold[145] at the time. After the incident had occurred, the resident's eye was so swollen, he couldn't see out of it.[146] In the end, the investigator did not substantiate abuse, noting the resident had been attacking staff and claiming that staff had witnessed the resident banging his own head onto the floor, which probably caused the injury to his eye. However, the evidence provided included an admission by the main staff perpetrator "taking [the resident] to the ground" which was corroborated by another witness who reported seeing the staff "in a compromising position…on top of [the resident]." Moreover, none of the nine (9) individuals interviewed for this investigation stated that the resident's eye injury occurred as a result of him hitting his own head on the ground.

Furthermore, when investigating an allegation of psychological abuse, it was alleged that a staff approached a resident, who is legally blind and known to be on a restrictive diet, in order to say "Can you smell the donuts? You can't have a donut. Your mom says you can't have none of that good stuff." The staff later apologized to the resident. Psychological abuse is defined as the use of "any insulting, demeaning, disrespectfully oral, written or gestured language directed toward and in the presence of a resident at SWITC" as well as "ridiculing…or making fun (verbally or by gesture) of

[145] *See supra* text accompanying note 133.

[146] The resident had originally alleged that his face had been slammed to the ground by unknown staff. The investigator concluded that none of the other witnesses supported the resident's allegation that the staff slammed his face to the floor, causing the injury. Instead, the investigator concluded that staff witnessed the resident banging his own head on the floor. However, DRI's review of the witness testimony shows that none of the witnesses interviewed reported that the resident's eye injury occurred as a result of the resident hitting his head on the ground.

a client."[147] Despite video evidence capturing the staff going out of her way to initiate this statement to the resident, knowing he did not see the donuts, may not have smelled the donuts, and could not have the donuts, the investigator ultimately concluded that psychological abuse did not occur because the statement did not meet the definition of abuse. The investigator explained that the statement was not delivered in a disrespectful or demeaning way and was not used to taunt or tease the resident.

In one of the most troubling cases, a staff member admitted to head-butting a resident multiple times while restraining a resident during a behavior. Despite this admission, the investigator ultimately did not substantiate abuse, finding that the purpose of the head-butt was "defensive to avoid serious injury to the face or head." While this conclusion was ultimately overturned by the Administrator, it certainly calls into question the thoroughness of the investigations being conducted by the facility's own investigators.

Had SWITC and IDHW investigators fulfilled their statutory obligations to thoroughly investigate abuse and neglect, the number of instances investigated and substantiated would have been much, much higher. In addition to the forty-nine (49) allegations of abuse or neglect that were substantiated, DRI believes an additional forty (40) instances of abuse or neglect were left unidentified, un-reported, and uninvestigated. There were also least seven (7) incidents where the investigator concluded that abuse or neglect did not occur, despite evidence to the contrary. As a

[147] Policy 01.11.0 was updated as of April 13, 2018. The updated version created an additional category of abuse known as "verbal abuse" separate and apart from psychological abuse. Per the updated policy, verbal abuse is defined as "any use of insulting, demeaning, disrespectful language (oral, written, or gestured) directed towards and in the presence of the client.

result, DRI estimates at least ninety-six (96) instances of abuse or neglect occurred at SWITC from January 1, 2017 to January 31, 2018.

ii. SWITC/IDHW HR investigators acted inappropriately by allowing staff to re-create missing or incomplete documentation after the fact and encouraging residents to sign non-disclosure agreements during investigation interviews.

In its review, DRI observed SWITC and IDHW HR investigators engaging in inappropriate investigatory practices. In three (3) cases, a SWITC investigator discovered that required forms or documents such as Behavior and Incident Reporting forms (commonly referred to as "BIRFs") were incomplete or missing in regards to an incident. To remedy the situation, the investigator would have staff complete the documentation during or after the interview.[148] In one case, the staff backdated the form to the date of the incident without any notation that the form had been completed after the fact. The investigator then relied upon this re-created form to support their conclusion that abuse was not substantiated, noting that her "[r]eview of the Behavior and Incident Reporting Form …supports the testimony of the staff."

Although DRI acknowledges the importance of completing such forms so that behaviors and interventions may be documented and tracked, having an investigator counsel staff/witnesses to re-create or edit such documents after the fact is completely inappropriate and contrary to every rule of investigation. In most cases, these documents serve as a primary source of evidence regarding an incident of abuse or

[148] When the same issue presented itself in two investigations assigned to IDHW investigators, the IDHW investigators simply noted the missing documentation in their investigation files. The IDHW investigators did not instruct staff to then re-create such documents.

neglect. Allowing forms to be re-created after the fact is akin to manufacturing evidence after a crime has occurred and calls into question the validity of all of this investigator's findings and conclusions. It further sends a message to staff that it is ok to not follow policy as the facility will help you correct your mistake, even if it is at the expense of a resident.

If required documentation is missing, the proper practice should be to simply note the missing documentation in the investigation file. It should not be to allow staff to re-create the documentation after the fact and then rely upon such documentation as a key piece of evidence to support an investigatory conclusion. This practice would allow the Administrator to then address such matters with staff and their supervisors upon their review of the investigatory report. However, in this case, the Administrator did not even recognize nor correct the investigator's inappropriate actions.

Another example of inappropriate investigatory techniques centered on the investigator's use of confidentiality (i.e. non-disclosure) forms. In the investigations that DRI reviewed, SWITC and IDHW investigators began each interview by presenting the witness (including residents) with a copy of the "Letter of Confidentiality" often referred to as "the confidentiality form." Required by SWITC Policy 01.11.0, the letter informs the individual that they are "**expected not to discuss this matter with any other persons (SWITC staff or people outside of SWITC) other than the members of the Investigation Team, the [Administrator], or Human Resources**" during the investigation or in the future. While this may be appropriate for SWITC employees, it is not appropriate for residents. The form's bold language explicitly implies that residents

are to keep suspected abuse or neglect secret and only within the facility, i.e., permitted to disclosures to investigators, the Administrator, or human resources.

Such secretive overtones were further ingrained through comments investigators made while explaining the form during resident interviews. The investigator would inform the resident that "the investigations are confidential and that [the resident] cannot talk to anyone about it." In one particular case, the investigator asked two (2) residents if they "remembered the rule of investigations?" One resident confirmed that he did, stating "[y]ou don't talk to anyone." The other resident said "yes" and that "you can't tell anyone, even in your family." In another case, the investigator explained to the resident that keeping things confidential "means don't tell anybody." The investigator then asked, "Can you keep a secret?" At no time did the investigators advise the residents of their statutory right to communicate with anyone they choose, nor did investigators advise residents that they were free to discuss such matters with other investigative agencies such as the police, Adult Protection, Bureau of Facility Standards surveyors, or even the DRI. [149] In fact, when one resident informed an investigator that a DRI employee was assisting them, the investigator reminded the resident "what this form says is that you and I will keep our conversation between us."

After such explanations, residents would then be asked if they wanted to sign the form. In some cases, the resident would sign. In others, they would not. In one case in which the resident declined to sign the form, the investigator took it upon

[149] I.C. §66-412(c) which states that every developmentally disabled person has the right to "communicate by sealed mail, telephone, or otherwise with persons inside or outside of the facility…"

themselves to sign the form on the resident's behalf, indicating that they were signing "for" the resident even though the resident had declined to sign. In another case, the witness refused to sign the form, but then told the investigator that she could sign it for him. The investigator then signed the form, indicating she was doing so "with his permission."

This practice has a very chilling effect, both on and off SWITC's campus. Rather than encouraging residents to come forward, share their concerns, and report suspected abuse or neglect, residents are essentially instructed to keep such information to themselves. As evidenced by some of the resident's responses above, residents understand this to mean that incidents of abuse or neglect should not be shared with "anyone" including "family." Silencing residents from discussing such matters not only violates their constitutional and statutory right to freely communicate, but may also serve to prevent such individuals from seeking the assistance they need to ensure their allegation is appropriately responded to by the facility. As a result, residents may not feel as though they can share this information with counselors, advocacy agencies, or even their guardians who have a statutory obligation to ensure the resident's health and safety needs are met. This practice also fails to prepare residents for life out in the community. SWITC's primary purpose is to "maximize the individual's [resident] independence." Independence cannot be maximized by teaching residents to remain silent when victimized. If residents are consistently taught to keep quiet about abuse within a facility, how will they respond to such actions when they are living out in the community?

6. The corrective actions recommended by the SWITC Administrator failed to prioritize and ensure the safety of SWITC residents going forward.

i. The corrective actions were not fully implemented, and, overall, failed to prevent the reoccurrence of abuse and neglect within the facility.

Not only were the investigations into abuse or neglect inadequate, so were the facility's responses. DRI's investigation uncovered that the corrective actions recommended by the Administrator were oftentimes inconsistent, not fully implemented, or insufficient to address the abuse or neglect identified in the investigations. As a result, issues would resurface within weeks or months after such corrective actions were alleged to have been implemented.

For instance, an investigation completed in early 2017 revealed that staff had failed to report suspected abuse or neglect per the procedures outlined in policy 01.11.0. In response, SWITC's Administrator personally sent an email to all supervisors, instructing them "to train staff that regardless of the staff's demeanor or how things are said all statements such as the one reported [calling a resident a "dick"] should be reported as abuse." Despite this mandate, failure to report suspected abuse/neglect was later substantiated by SWITC/IDHW investigators as neglect in five (5) more investigations during the summer of 2017.[150] In one of those investigations, two staff were present when a resident reported to a third staff that he was almost hit by another resident. Instead of offering assistance, the third staff responded by saying

[150] Again, DRI believes this number should actually be much higher had SWITC and IDHW investigators actually identified and then thoroughly investigated all instances of abuse or neglect.

"Jesus, you guys are annoying the crap out of me....Good god. You're both adults, you're over 30." No staff intervened as the resident was about to be punched, nor did the two staff report the third staff's comments as potential abuse or neglect. Another staff failed to intervene or report as abuse an incident they observed where a co-worker told a resident "Come here, smartass!," and then got in the resident's face to say "What are you going to do ...shut up! One more time and you get this!" (raising a fist in the air, gesturing that "this" would be a punch in the face).

Even the staff supervisors themselves didn't seem to get Administrator's message. In another case a staff supervisor overheard but failed to report derogatory comments that another staff made to a resident such as: "You fuck up every conversation. I'm not fucking helping you because you totally interrupted me." Clearly, the Administrator's email regarding staff demeanor was not taken seriously and no follow-up was taken by the Administrator to ensure that her message had been properly communicated.

Another issue that resurfaced after corrective actions were to have been implemented involved staff's use of non-approved physical restraint methods. At SWITC, the use of physical restraint methods are governed by Behavior Restraint Policy 01.07. According to the policy, the only physical restraint methods approved for use are those taught in Nonviolent Crisis Intervention training program and include the use of Crisis Prevention Institute (CPI) techniques.[151] Staff are to be trained in these

[151] See SWITC*, Behavioral Restraint*, Policy 01.07.0, approved by Administrator Jamie L. Newton on 05/01/16 (later updated and approved on 01/17/18); *See also supra* text accompanying note 133.

techniques prior to using them, both initially upon hire and annually thereafter. An investigation completed in June of 2017 revealed that staff were using restraints not taught in the training in violation of SWITC policy. Direct care staff's explanation was that they did not believe CPI "was practical." In response, SWITC's Administrator emailed the facility's CPI instructors asking them to "…reiterate with all your staff in all of your classes that CPI is designed to work on people of all functional abilities and even people with typical development." Was this an effective response? DRI would argue in the negative as at least eight (8) more abuse incidents and investigations involved the use of non-approved physical restraints after this email was sent. In each of those investigations, the corrective response issued by the facility Administrator centered around the need for "reminders" or "re-training" on the use of approved restraints, including re-training on CPI. Once again, the facility Administrator's email was not taken seriously and the Administrator did not follow-up to ensure her message had been properly communicated.

ii. The corrective actions failed to hold supervisory and other professional staff accountable for their role in the continuous cycle of abuse and neglect.

Also inadequate was the facility's failure to hold supervisory or professional accountable for the pervasive abuse and neglect that had spread throughout the facility. While reviewing the investigations conducted by SWITC and IDHW investigators, DRI observed that the investigators consistently apportioned the blame for "bad acts" on the facility's direct care staff – staff whose position only requires "some knowledge of personal hygiene and first aid" and experience "following written

and oral instructions; reading and writing English."[152] Absent were investigations, findings, or corrective actions which held staff supervisors and other facility leadership accountable for identified failures to train, supervise, or ensure staffing ratios were met for all shifts. Instead, the primary focus of these investigations was limited to determine if the specific direct care staff involved committed the act of abuse or neglect. Once a determination was made as to whether or not abuse or neglect was substantiated, the Administrator would decide if any corrective actions were to be implemented. With *few* exceptions, the corrective action usually focused on the particular direct care staff implicated in the investigation or to the programs or plans of the particular victim/resident. For instance, the implicated staff would either be terminated, required to be retrained in a certain area, meet with their supervisor, etc., or, the particular victim/resident would have their plans reviewed and revised. In other investigations, the corrective action would be "systemic" in nature, such as the requirement that all staff be re-trained on a certain topic or that policies or procedures be changed and then re-trained to staff, etc. While this may appear as an adequate response, such actions were then not implemented or, if they were implemented, they were insufficient to prevent similar acts of abuse or neglect from occurring again.

In only four (4) of the seventy (70) investigations reviewed was a supervisor or other professional staff held accountable or considered at fault for the substantiated abuse or neglect. While abuse or neglect was substantiated in each of these four (4)

[152] Idaho Department of Health and Welfare Division of Human Resources, *Job Descriptions – Psychiatric Technician Trainee*, last revised May 21, 2008.

investigations, only two (2) resulted in the termination of supervisory or professional staff. In the other two (2) investigations, “treatment teams” (consisting of CS Managers, Clinicians, etc.) as opposed to individual direct care staff were held accountable for the neglect. While this resulted in updates to policies, reviews of client records for possible changes, and staff training, it did not result in any specific corrective actions for any individual supervisors or professional staff. The remaining sixty-six (66) investigations focus solely on the direct care staff involved, attributing little to no blame or responsibility on those in charge of supervising the direct care staff implicated therein, even though many of the implicated direct care staff were supervised by the same individual.

Failing to hold supervisors or other professional staff accountable is problematic for two (2) reasons. First, charting the locations of where the alleged abuse or/neglect occurred uncovered a trend in that the majority of both the reported and substantiated abuse and neglect occurred in one (1) housing unit, during one (1) particular shift. A logical inference could be made that such a high concentration of alleged and substantiated acts of abuse or neglect signals a problem that extends far beyond the ranks of the unit’s direct care staff, at the very least warranting a review of the supervision being provided to those staff. If for nothing else, to trigger an inquiry of whether the supervision being provided (if any) is adequate or if any changes, etc. need to be made in order to avoid future instances of abuse and neglect from occurring again.

Second, failing to attempt to hold such supervisor or professional staff accountable, ignores the fact that in many of the investigation interviews, direct care staff disclosed several concerns regarding supervisory staff. Such concerns included the lack of training on resident programs and plans, lack of training on facility policies and procedures, questions and concerns regarding the use of approved restraints, the adequacy or appropriateness of client plans, as well as concerns regarding the lack of adequate staffing levels at the facility – all of which fall directly under the responsibility of supervisory or professional staff at the facility such as Psych Tech Seniors, CS Managers, Clinicians, etc.[153]

During interviews, staff would comment that they felt "on their own, as far as support goes," that "professional staff are up in their 'guilded [sic] tower'" while "psych techs are left on their own without support," and that "you do not see professional staff until something happens." Another staff stated "[new staff] are working impossible situations…[t]here is stuff going on there that is wrong. You have clinicians out there writing programs for clients they have never worked with. It has been a running joke, they are cutting and pasting their plans. More often than not you will pull it up and it

[153] Idaho Department of Health and Welfare Division of Human Resources, *Job Descriptions – Psychiatric Technician, Senior*, last revised on July 14, 2016. (Psychiatric Technician Seniors are primarily responsible for "providing direct supervision to psychiatric technicians [direct care staff]."); IDHW Div. of Human Res., *Job Descriptions – Client Services Manager*, last revised on December 19, 2012, (CS Managers are primarily responsible for supervision and resource management including: recommending hires and ensuring/conducting initial orientations, developing and monitoring staff work schedules and ensuring adequate staffing levels; ensuring/conducting staff training in implementation of client training and behavioral management plans; ensure staff understand, know how to access, and implement facility and department policy and procedure; and provide ongoing staff observations and training, as needed.); IDHW Div. of Human Res., *Job Descriptions – Clinician*, last revised on May 22, 2008, (Clinicians are primarily responsible for assessments, therapy/rehabilitation, and consultation/education, including designing, implementing, and directing multifaceted clinical therapies and rehabilitation programs.).

has another client's name on the top of it." Even more concerning were staff comments regarding the facility's use of video and audio surveillance in the resident housing units. When a newly hired staff noticed the cameras and asked, "Can they hear everything we say?," other staff responded yes, but "[t]hey don't ever check them…" Another staff replied that if they had been checked, "I would have been in the unemployment line." Although such comments clearly indicate a complete lack of oversight by supervisory and professional staff, such allegations were not even investigated as the facility's focus throughout the abuse and neglect investigations continued to be on requiring direct care staff to be disciplined and/or trained - not to require the same of those who were responsible for supervising such staff.

Not only were supervisory and professional staff not held accountable, some were actually promoted. In fact, the supervisor who was responsible for overseeing the housing unit with the highest rate of reported and substantiated acts of abuse and neglect was eventually promoted to a position overseeing quality assurance for the entire facility. In addition to conducting investigations regarding resident abuse or neglect, the individual will now primarily be responsible for evaluating the "quality of client programming" and reviewing and commenting on "new and revised facility policies and procedures related to client training."[154]

SWITC's own job descriptions make it clear that supervisors and other professional staff are responsible not only for supervising direct care staff, but also for

[154] Idaho Department of Health and Welfare Division of Human Resources, *Job Descriptions – Developmental Disabilities Quality Commitment Supervisor, SWITC*, last revised on August 11, 2011.

ensuring that staffing ratios are met and that client plans and programs are appropriately developed and implemented. Yet, after thirteen (13) months of documented resident abuse and neglect, after hundreds of pages of documented deficiencies regarding staffing ratios and client plans and programs – those same supervisory and professional staff remain without so much as a question being raised as to their performance. Once again, SWITC has failed to attribute blame where it belongs: not on its residents, not just on its direct care staff, but on those who are truly responsible for training, supervision and oversight of the facility. Until such staff are finally held accountable for the acts and omissions of those they are charged with training and supervising, no amount of change can ever be effectuated to keep those who reside at SWITC safe.

iii. The corrective actions failed to incorporate any trauma-informed care principles to ensure residents were provided with appropriate information, resources, and services needed to cope with the effects of being subjected to abuse or neglect.

DRI's review uncovered that in all of the remedial actions undertaken as a result of substantiated abuse and neglect incidents, the focus was exclusively on the staff involved. Staff were either terminated, placed on leave or re-trained to expeditiously return to work. Not once did the SWITC Administrator vocalize or initiate any changes or actions to assist those who were victims of the abuse or neglect: SWITC's residents. Not once did the Administrator recommend or initiate any actions which included any sort of follow-up or debriefing with the victim/resident or the resident's treatment team to ensure the resident was provided with the appropriate information and resources, including counseling, to cope with any trauma or trauma-related effects caused by the

abuse or neglect they suffered at the hands of direct care staff. Although the Administrator would notify guardians of the results of every investigation, not once did the Administrator share this information directly with the residents themselves. Not once did the Administrator answer any questions or concerns the resident may have had about the investigatory process. Not once did the Administrator notify or involve the residents in developing or implementing any changes at the facility that would make them feel safer in their home. Not once did the Administrator recommend or initiate any training to ensure residents understood what constitutes abuse or neglect and are aware of the process of how to report any abuse or neglect so allegations would be timely identified and reported in the future.

Ultimately, the corrective actions recommended by the Administrator failed to take into account the most important part of SWITC, the reason why SWITC even exists: its residents. The trauma resulting from abuse or neglect can last long after the abuse or neglect occurred. By failing to even acknowledge the affects this may have caused, SWITC has once again missed the opportunity to ensure its residents feel safe and respected their own home.

iv. None of the staff involved in the substantiated instances of abuse or neglect were ever criminally charged, prosecuted, or placed on the Medicaid Provider Exclusion List, thus exposing countless numbers of vulnerable children and adults to potential risk of harm by known abusers.

While the IDHW reported[155] that "disciplinary actions up to and including termination" were taken against "all of the employees who were found to have engaged in…abuse and/or neglect," such consequences represent the bare minimum of actions that could have been taken against these employees. If Adult Protection substantiates an allegation of abuse or neglect of a vulnerable adult, Idaho law obligates the agency to share its findings with law enforcement as well as with the IDHW Bureau of Facility Standards.[156] Once received, law enforcement then initiates its own investigation into the allegations. If law enforcement determines that the elements of a crime have been established, it then forwards the case on to the county prosecutor, who has the discretion to commence criminal proceedings against the alleged perpetrator. Unfortunately, none of the staff involved in the substantiated instances of abuse or neglect were ever criminally charged.

Had those staff been charged and convicted, IDHW administrative rules would ***require*** that their names be placed on the Idaho Medicaid Provider Exclusion List.[157] Placement on this list prevents the individual from working as a service provider for any and all Medicaid participants. Absent a criminal conviction, IDHW still ***has the discretion*** to exclude such persons for at least one year "where there has been findings by a governmental agency against such person or entity of endangering the

[155] Nicole Blanchard, *6 State Employees Punished Over Abuse of Nampa Treatment Center Residents*, Idaho Statesman, (August 8, 2017, 11:34 AM), https://www.idahostatesman.com/news/local/community/canyon-county/article166045907.html.
[156] I.C. §§39-5304(5); 39-5310(1).
[157] *See* IDAPA 16.05.07.240.

health or safety of a patient, or of patient abuse, neglect, or exploitation."[158] Despite multiple substantiated allegations of resident and abuse and neglect, IDHW has not yet exercised this discretion. As a result, those staff are free to continue to work directly with individuals with disabilities – adults, children, and the elderly – placing countless numbers of vulnerable individuals at future risk of harm.

IV. Conclusion

A person's home should be a sacred place in which they feel safe, secure, and protected. It should not be a place where residents are slapped, head-butted or thrown to the ground. It should not be a place where cries for help are ignored, where essential needs are not met. It should not be an environment where residents are demeaned, insulted, taunted, and verbally abused. This is especially true at SWITC – a facility which is obligated by law to protect and provide care and treatment for those who reside within its walls. A facility required by law to treat all those who live there with dignity. SWITC has failed to meet these obligations not once, not a handful of times, but repeatedly.

The Director of IDHW, Russell Barron, has stated that the abuse and neglect investigations at SWITC during the summer of 2017 "…revealed the problem to be limited."[159] As this report demonstrates, that statement could not be further from the truth. DRI's investigation and hundreds of pages of surveys conducted by the Department's own Bureau of Facility Standards this past year have revealed that

[158] IDAPA 16.05.07.250.01.

[159] Blanchard, *supra* note 155.

SWITC's problems go far beyond isolated incidents of resident abuse and neglect perpetrated by only a few direct care staff. Instead, systemic inadequacies permeate through every level of operation from resident care and treatment, to facility oversight, all the way though incident response. When combined, these inadequacies have created a cycle of hazardous living conditions for residents of SWITC – which the facility's administration has failed to acknowledge, let alone address.

SWITC is the ***only*** ICF/IID licensed and operated by the State of Idaho. With an annual budget of now over ***$11 million dollars*** to provide for the care, treatment, and safety of only twenty (20)-some residents, it is inconceivable that SWITC's residents are forced to live in a home where they are offered such substandard care and treatment. A home where they are subjected to acts of physical and psychological abuse and neglect on a regular, recurring basis.

The time has come for this revolving cycle to end. The State of Idaho can and should do better to protect the health and safety of its most vulnerable residents. Not only because it is obligated to do so under federal and state law, but also because it is morally unconscionable not to. Unless or until significant, comprehensive changes are made to every aspect of SWITC's operations, SWITC will never be a safe place to call home. Residents will continue to remain at risk of serious, life-threatening, physical and psychological harm and neglect.

The time has come for SWITC to commit to the safety and well-being of its residents. To prioritize this commitment in its policies. To provide residents the care and services they are required by law to receive. To staff its facility with the required

number employees in order to serve the needs of its residents. To ensure that its staff are adequately trained and supervised from their first day of employment and everyday thereafter. To adequately and appropriately identify and investigate allegations of resident abuse or neglect. To address any instances of abuse or neglect with corrective actions that are actually implemented, appropriate, and meet the needs of its residents. To take measures to ensure its residents and other vulnerable children and adults are protected from abusive or neglectful staff in the future.

If SWITC and the IDHW are unwilling to immediately institute these changes, then perhaps the time has come for the State of Idaho to explore the possibility of closing the facility. DRI urges stakeholders, lawmakers, and members of the public to consider whether operating a state-run facility that continually fails to comply with federal and state regulations, that continually fails to meet the needs of its residents, that continually subjects its residents to abuse and neglect, is what is best for Idaho. Instead, perhaps the time has come for Idaho to invest SWITC's $11 million dollar budget in developing, promoting, and providing a range of community-based housing and supportive service options. Perhaps then, the State can ensure that all of its residents, including those with intensive physical, emotional, and behavioral needs, are able to have a safe place to call home.

V. Recommendations

1. SWITC should contract with an independent consultant with experience in the field of dually diagnosed individuals (developmental disabilities and mental illness) and in the management of remedial actions within an ICF/IID setting to:

(i) review all facility policies, practices, and procedures to ensure resident care, treatment, and safety are clearly identified as the faculty's top priority;

(ii) develop and train all staff including direct care staff, supervisors, professional staff, and Administration on the provision of active treatment so that residents receive the specialized treatment they are entitled and required by law to receive;

(iii) develop and train on a Quality Assurance monitoring and tracking system to identify patterns and trends in abuse, neglect, and mistreatment investigations and corrective actions incorporating incidents recorded in Significant Event Reports (SERs);

(iv) assist with developing and implementing a program that immediately eliminates staff's use of non-approved restraint methods and to develop and implement a meaningful process to reduce and/or eventually eliminate the use of physical restraints at SWITC;

(v) evaluate the performance of SWITC staff supervisors, professional staff, and Administration as well as their contribution to the current cycle of abuse and neglect;

2. SWITC and IDHW should immediately contract with an independent outside consultant with expertise investigating incidents of abuse and neglect in facilities, including ICF/IIDs to train the SWITC and IDHW investigators as well as the SWITC Administrator on how to thoroughly conduct an abuse and neglect investigation. Thereafter, all staff assigned to investigate incidents at SWITC, including but not limited to the Administrator and Quality Assurance staff (DD QC Supervisor) should be required to complete a certified investigator-training program prior to investigating any incidents of abuse or neglect.

3. SWITC and IDHW should immediately contract with an independent outside consultant with expertise in creating trauma-informed environments, staff, and care principles to advise SWITC on how to implement trauma-informed care and person-

centered principles throughout the facility, i.e. administration, supervision, investigation, policies, physical facility, direct care staff, resident treatment, and debriefing.

SWITC/IDHW has informed DRI that SWITC has employed a social worker who provided trauma based therapy to some residents. However, this is far short of the needed transformation to a facility based on trauma informed care principles. According to the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration, "A program, organization, or system that is trauma-informed: 1. Realizes the widespread impact of trauma and understands potential paths for recovery; 2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; 3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and 4. Seeks to actively resist re-traumatization. A trauma-informed approach can be implemented in any type of service setting or organization **and is distinct from trauma-specific interventions or treatments** that are designed specifically to address the consequences of trauma and to facilitate healing."[160] Using this approach has been demonstrated to reduce confrontations, reduce staff and resident injuries, improve recovery and shorten institutional stays dramatically, even with the most challenging residents. It requires commitment and expertise at every level of the facility.[161]

[160] U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration, *Trauma-Informed Approach and Trauma-Specific Interventions*, (April 27, 2018), https://www.samhsa.gov/nctic/trauma-interventions (emphasis added).

[161] *See* IDAPA 16.03.15.011.26 (temporary administrative rules governing the Secure Treatment Facility, to be administered by the SWITC facility administrator and staffed by SWITC employees, defining trauma-informed care as a "*system of care that incorporates key trauma principles into the facility's culture and each person's treatment interventions and supports*.")(emphasis added).

4. SWITC should immediately amend Policy 01.11.0 to:

(i) develop and implement a "Zero Tolerance" position as to resident abuse, neglect, and mistreatment that includes amended definitions of abuse and neglect to comply with the CMS State Operations Manual Appendix J – Guidance to Surveyors: ICF/IID and Idaho Secure Treatment Facility definitions of abuse and neglect and training to staff and investigators that intent to harm is not an element of abuse that must be established in order to substantiate an allegation of abuse, in accordance with I.C. §18-101(1);

(ii) incorporate and requires all investigators to meet performance standards for conducting abuse and neglect investigations, pursuant to the CMS Conditions of Participation requirements for "thorough investigations." Such standards should include:

1. A review of the individual's current person-centered service plan, behavior support plans, and supervision requirements;
2. A review of the circumstances leading up to and following the incident;
3. Interviews with all witnesses to the incident, including but not limited to all residents who witnessed the incident and the resident/victim themselves;
4. A review of all available video/audio evidence, etc.;

(iii) require investigator(s) to identify any other ancillary and/or related issues and investigative findings to be addressed by the Administrator and/or AOD in their review of the investigation. For example: lack of active treatment, staff failure to engage in purposeful activities with residents, use of unapproved restrictive interventions, etc.;

(iii) clearly communicate to staff who commit acts of abuse, neglect, or mistreatment that they will face termination;

(iv) require the Administrator to ensure all suspected incidents of abuse, neglect, or mistreatment are identified, reported, properly investigated and corrected when substantiated; and

(v) require the Administrator/AOD meet with the alleged victim and their guardian, where applicable, immediately upon the conclusion of the investigation, in order to inform them of the conclusions reached, any corrective actions implemented, and to offer/provide any additional services such as counseling, etc. which the victim may feel is necessary as a result of the abuse or neglect.

5. All SWITC personnel should immediately comply with statutory requirements to report observed or suspected abuse, neglect or exploitation to Adult or Child Protection pursuant to facility policy and state and federal law. Those who do not follow this requirement should be subject to discipline up to and including termination. Failure to follow this requirement should also be reported to the appropriate authorities.

6. SWITC and IDHW investigators should immediately cease from using or incorporating the use of non-disclosure forms (referred to as a "Letter of Confidentiality") when interviewing residents during an abuse and neglect investigation. Investigators immediately cease from telling or talking to residents about "keeping secrets." Investigators affirmatively inform residents of their right to communicate with others, including their right to communicate with law enforcement, friends, family, guardians, and the protection and advocacy system pursuant to I.C. §66-412(3)(c).

7. SWITC and IDHW investigators should immediately cease the practice of allowing or encouraging staff to alter, falsify, modify, or re-create documents and develop a policy that prohibits such actions. SWITC should develop a policy that prohibits staff from altering, falsifying, modifying, or re-creating documents. The policy should apply to all staff, including investigators, and should outline that any staff found to be in violation of this policy will be subjected to discipline including termination.

8. SWITC's Administrator should ensure that any re-training recommended as a corrective action is actually completed and is effective.

9. SWITC and IDHW should assist in preventing staff with substantiated incidents of abuse or neglect against a resident from working as a care provider in any facility or community setting by doing as follows:

> (i) ensuring that any correspondence or Notices of Contemplated Action provided to the staff accurately reflect the circumstances for which the staff was terminated or chose to resign: i.e. “your personnel record will reflect you chose to resign while under investigation for abuse” or “your personnel record will reflect that you were terminated while under investigation for abuse,” etc.; and
>
> (ii) reporting substantiated acts of abuse or neglect by staff to the IDHW/Medicaid Fraud Unit for consideration of placement on the Medicaid provider exclusion list pursuant to IDAPA 16.05.07.250.

10. IDHW/Medicaid Fraud Unit should exercise its discretion to place any staff involved in substantiated instances of abuse or neglect on the Medicaid Provider Exclusion list pursuant to IDAPA 16.05.07.250 to ensure the safety of other Medicaid recipients including children and adults with disabilities.

11. SWITC should immediately provide training to SWITC residents and their guardians, where applicable, on how to identify and report abuse and neglect. Such trainings should then be provided upon admission and annually thereafter.

12. SWITC should immediately develop and then implement a comprehensive policy that defines and outlines the protections that exist for individuals residing at the facility.

13. SWITC should review each and every resident’s treatment plan to ensure they are current, effective, and being implemented as recommended. Any identified inadequacies should be immediately corrected.

14. SWITC should provide each resident with an evaluation as to their communication needs, including but not limited to any assistive technology needs, and then implement any recommendations.

15. SWITC's Administration should ensure that all new staff are properly trained prior to working directly with residents. Such a training must place a focus on resident care and safety, include detailed information on mandatory reporting requirements, facility policies including policies related to abuse, neglect, and mistreatment, policies related to behavioral intervention and the use of restraints, and the expectation that staff know the programs of the residents they are working with. Staff should also be required to sign training acknowledgment forms, signifying the date that the staff received the training and that the staff understand the subjects covered within the training.

16. SWITC should not accept any new admissions unless or until minimum, required staffing levels are met. During periods when minimum, required staffing levels are not met, SWITC should discharge residents to community placements to ensure those residing in the facility have access to an adequate, required number of staff to provide for their care and safety.

17. SWITC should request a formal, written opinion from the Idaho Board of Nursing as to whether its Medication and Treatment Administration Policies 300.03 and 300.04 comply with the Idaho Board of Nursing Rules and current standards of practice/care principles as referenced by the Bureau of Facility Standards in their February 2018 survey of the facility.

18. SWITC should consistently use the THERAP electronic report and tracking system to its fullest potential. SWITC should also ensure that its supervisory, professional, and Administration staff are reviewing entries made within the system on a regular basis to ensure residents are receiving their required standard of care.

19. The legislature should pass legislation requiring that administrators of ICF/IIDs and the Secure Treatment Facility obtain a license. This would be similar to the licensure requirements of administrators of residential assisted living facilities found in I.C. §§39-3321 and 54-4201 and nursing facilities found in I.C. §§54-1601 through 54-1616. This would serve the public interest just as requiring licensure of nursing home administrators does.[162]

[162] *See* Idaho Board of Nursing Home Administrators, *Licensing Freedom Act Report*, (May 19, 2018), https://ibol.idaho.gov/IBOL/NHA/Documents/NHA%20EO.pdf. ("The Idaho Board of Nursing Home Administrators' mission is to help protect the health, safety and welfare of the public through the licensure and regulation of nursing home administrators in Idaho. Board member representation is diverse to include healthcare professionals, advocacy groups, nursing home administrators, and the public at large. Meetings are announced and open to the public. The nursing home population is a vulnerable group of individuals that include those in post-acute care, the elderly, developmentally disabled, and those with chronic illness. The nursing home administrator is the gate-keeper to quality of care. Under oath, they certify that they will abide by the laws and rules governing the practice of nursing home administration in Idaho. It is essential to the well-being of each patient/resident for this board to monitor the integrity and competence of nursing home administrators. Duties of the board include but are not limited to validation of licensure upon entry to the state, oversight for the administrator in training program, investigation into the culpability when negative incidents occur at the nursing home, and validation of continuing education credits in maintaining a current skill set. This board works in tandem with other agencies to ensure that each resident/patient who enters a nursing home has an opportunity for equal treatment, compassion, and person-centered care in an environment of safety and quality. Competent oversight is a critical component in meeting the needs of each resident/patient.")

IDAHO DEPARTMENT OF HEALTH AND WELFARE'S RESPONSE TO 2018 DISABILITY RIGHTS IDAHO REPORT

IDAHO DEPARTMENT OF HEALTH & WELFARE
FAMILY & COMMUNITY SERVICES

APPENDIX A

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APPENDIX A

Overview

At its core, the report produced by DisAbility Rights Idaho (DRI) shows some of the significant challenges the Southwest Idaho Treatment Center (SWITC) faces. Much of the report focused on events that occurred over a year ago, and many of the events reported were not accurate in context or description. However, SWITC acknowledges that, after receiving an internal report of possible abuse and neglect by SWITC employees, we conducted a very thorough investigation at SWTIC last summer, leading to employee dismissals, changes in practice, and a significant review of facility training, standards, and client active treatment plan review and management. SWITC took a very active role in making improvements identified during both the investigation as well as a subsequent survey which identified findings shared in the DRI report. All of the information about the investigation and survey findings were provided by SWITC to DRI last year and in March of 2018. Although the report reiterated the findings that were provided during the investigations and surveys, it failed to report on any changes and improvements made at SWITC. Since DRI did not attempt to contact anyone at SWITC or the Department of Health and Welfare to discuss context for the information or understand what changes had been implemented at SWITC, the report is based solely on conclusions drawn by DRI based on a limited and outdated information.

The report has some serious methodological flaws. Much of the information contained in the report is outdated and based on a partial investigation by DRI with limited sources. The difficult history and challenging behavior of residents at SWITC are ignored and the report's conclusion and recommendations suffer. At times, context of the facility's efforts as well as the context and facts surrounding investigations are ignored or grossly misrepresented. Some conclusions are drawn missing significant existing facts, and facility and administrator efforts are misconstrued. Much of the language is misleading, exaggerating findings and implying unsupported conclusions.

Finally, while some of the report's recommendations are worth considering, others suffer from the limited investigation and lack of expertise. Many of the recommendations made by DRI were already implemented by SWITC prior to receiving the report while others potentially violate employee due process or Intermediate Care Facility regulations. These recommendations could have been improved if DRI had met with the facility to understand steps already taken to address issues during survey and understood the rules and regulations governing the facility.

Analysis

At the time of its publication, much of the information contained in the report is already outdated. This would be excusable if the report acknowledged this limitation but many of the conclusions drawn in the report are written as if they represent the current state of SWITC. The report focuses on calendar year 2017 with some attention to a February 2018 licensure survey. Many changes were made at SWITC in 2017 and 2018 and they are not indicated by the report. Confusion as to the dating of information causes many problems throughout the report. Section

B.4. cites records provided by SWITC to DRI in March 2018 regarding new training. The section refers to this training, then criticizes the SWITC training's ineffectiveness in preventing the events in June 2017. It is unreasonable and confusing to criticize the training for events that happened before it was implemented. SWITC implemented extensive new training for employees in January 2018.

The report draws most of its information from internal investigations conducted by the Department of Health and Welfare ("Department"), licensure surveys and newspaper reports to build its conclusions. DRI has the right to access all SWITC records and staff, but failed to interview SWITC staff or administration, or to even seek feedback on its efforts prior to sending a draft of the report. The lack of investigation means that significant facts have been missed and false conclusions are listed in the report. For example, efforts SWITC has made around trauma-informed services are completely missed, and the institution and administrator are falsely characterized as doing nothing in Section 6iii. In reality, much has been accomplished around trauma-informed services and a more reasoned conclusion should have been made.

Furthermore, the report fails to include any information regarding the context related to clients at SWITC. There is no mention of the history or behavior of clients; instead, the report claims that any issues clients have are the result of failings of the institution. The report quotes Department officials describing the level of behaviors at SWITC but discounts these without examining client behaviors. DRI has the right to access client records at SWITC as well as the right to speak to the clients themselves. A review of some client histories shows significant issues for each client, including assaultive behavior for most clients prior to coming to SWITC. Several of the cases of abuse and neglect occur as staff at SWITC attempt to protect themselves from an attack or react from fear of severe injury or disfigurement. In at least four of these cases, the report concludes (contrary to what SWITC investigators found) that abuse occurred when staff were attempting to protect themselves and clients received either no injury or a minor injury (not requiring medical treatment). Certainly, there are issues at SWITC. Abuse and neglect cannot be blamed on clients; however, to ignore the context of client behaviors and history weakens the report, its conclusions, and recommendations.

Many of SWITC's investigations are included in the report. Unfortunately, the report does not provide context or evidence to support its conclusions. This leaves the reader unsure, and at times the reader is even misled about the actual facts of the cases. The veracity of the conclusions cannot be judged without more information. The report is lacking appropriate context and often explains only part of the story. It is important to be able to weigh all the relevant facts of these investigations to fairly judge the report's assertions and conclusions. One example in the report discusses an inappropriate restraint used on a client when the treatment plan only allowed for a limited restraint. What is not clarified is that the client was attempting to assault another client and staff intervened by getting on either side of the aggressive client and leading him out of the room as he continued to yell profanities at the other client. They did not restrain him, but rather led him out of the room, preventing other more serious issues from arising. It is important to note that in this example, the client received no injury and the assault on the other client was prevented. It is examples like this that

are irresponsible in the report, exaggerating the situation without context of what was happening during a particular instance.

The report builds conclusions on spurious evidence and uses unsupported conclusions to make SWITC's record appear much worse than it is. An example is Section III.A.1., which is titled SWITC/IDHW investigators found residents were abused or neglected by SWITC staff on forty-nine (49) occasions, in violation of facility policy. The report builds on the 27 substantiated incidents of abuse and neglect discovered by SWITC and the Department and then labels issues found by the multiple licensure surveys as abuse or neglect. There is no listing of the additional 22 events, only a summary of what was found by each survey. What DRI is counting as abuse and neglect is unclear. The report implies that the following are neglect or abuse: one-to-one staffing without getting permission from a guardian; use of over-the-counter dosages of Benadryl for a client without a guardian's permission; and not addressing demands from a guardian that were considered to be unreasonable. It is important to note that facility surveyors found these issues and cited the facility for them but did not characterize them as abuse or neglect.

On page 69, the report indicates that DRI identified at least 40 more incidents in which staff either directly or indirectly put residents at risk of injury or death that SWITC did not find. According to their report, this would bring the total to 96 incidents of abuse or neglect. DRI should have reported these incidents to SWITC and reporting authorities as DRI identified them, as required by Idaho Law, so the incidents could be properly investigated in a timely fashion and ensure clients are safe.

While some of the conclusions developed in the report are correct, some are weakened by a tendency to include unrelated items in evidence. On pages 59-61, the report claims that better training is needed around abuse reports and lists examples that would have been corrected with better training. However, under the title Incidents That Went Unreported, 13 of the 14 incidents were from the singular June investigations where a group of employees purposely hid abusive behavior from supervisors and administration. It is unclear how training could have impacted this intentional, deceitful behavior.

As the report maintains that abuse and neglect are an ongoing cycle at SWITC, it should show this cycle occurring at both ends of the year in question—both before and after changes were implemented. The report characterizes the issues as ongoing and seemingly uniform without addressing the significant and uncharacteristic nature of the abuse and neglect that was found in June 2017. The events were more significant both in severity and in frequency than is more commonly seen at the facility. The events are not treated as the aberration they are regarding severity, frequency, and deceit. Instead the events of that narrow period are quoted and spread throughout the report to prove or reinforce wide-ranging conclusions across the year. Not acknowledging these events as the aberration they were, weakens the conclusions of the report significantly.

The report also contains misinterpretation and misses the context and facts of specific cases. For example, on page 36 of the report, a review of the three investigations involves staff preventing client elopement and assaults on staff or other clients. Claims that staff redirecting or blocking assaults caused a client to fall support the narrative and conclusions of the report. However, the report disregards witnesses and video recordings that contradict DRI's conclusion that staff efforts constituted abuse.

The report exaggerates issues and misses crucial facts that would give a clearer description of SWITC. One example of this is regarding the staffing of the facility. Federal regulations call for a minimum staffing of one 1 staff on each of the four units for each shift. The report does not mention these guidelines, which SWITC has always met, but instead relies on the facility's own minimum staffing levels as to how many staff are needed. As SWITC missed its own selected staffing level, it was citable by survey and this was quoted by the report. In addition, the report implies that if a shift was low at any time during the month the facility failed for the whole month. "In total SWITC had failed to meet minimum staffing requirements for 13 months." This implies that SWITC was low for every shift or perhaps the majority of the time for the 13 months -- which is untrue. The report then quotes federal guidance listing dangers of going below staffing ratios, again without quoting the federal ratio requirements. The report also fails to address the fact that SWITC routinely meets its policy staffing ratio. Since the facility revised its staffing methodology in December 2017 surveyors have not cited SWITC for this issue.

The report only gives part of the story regarding reports made to Adult Protection. Examples are given on pages 67-69 where the report claims there were 15 occasions in which allegations of abuse or neglect were not reported in a timely fashion to Adult Protection or Child Protection. What the report fails to note is that Adult Protection does not respond to calls outside normal business hours. Any report to Adult Protection outside business hours would consist of leaving a voice message. An additional call with Adult Protection would be required to finish the report the next business day. Given the uselessness of reporting on evenings and weekends, SWITC staff reported allegations the next business day in seven of the 15 cases. In three cases, SWITC policy directed the facility not to report to Child Protection (which has since been corrected). All of the remaining five allegations were reported to Adult Protection within five days. Although this may not meet the arguable language of "immediately," SWITC's practice has neither been questioned by licensure and certification or Adult Protection nor is there proof that it impacted any of these cases.

On page 69, the report implies that the 15 cases, along with some possible HIPAA violations and other questionable conclusions about other investigations are part of "forty (40) more occasions in which staff either directly or indirectly put residents at risk of injury or death." Such conclusions don't seem justified.

As the report notes, none of the staff involved in substantiated instances of abuse or neglect were charged, nor were they placed on the Medicaid provider exclusion list. SWITC administration referred the abuse cases that might be considered criminal to law enforcement and to Adult Protection, as required. SWITC cooperated with all law enforcement

investigations. The filing of charges and prosecution are at the discretion of city and county prosecutors. The Canyon County Prosecutor's Office declined to file charges against any of the individuals involved. As the report notes, the Department has discretion to place someone on an exclusion list due to a finding that the person endangered the health or safety of a patient, or patient abuse, neglect, or exploitation. This seems like a simple matter, but the Department also must observe the due process rights of employees and no mechanism in the investigatory process provides this due process. The Department is currently developing policy to provide due process through the human resources policy and procedures. This will enable placement on the exclusion list. Employees accused of abuse will be able to confront the referral to the exclusion list as part of the termination of employment.

Conclusions as those listed above that miss context and crucial facts are throughout the sections of the report that we were able to analyze. Given the 100 pages in the report, the volume of documentation required for investigations (some are 200 pages long), and the short timeframe, it is impossible to entirely and thoroughly review the report to reveal all the missed facts, inaccuracies, and unfounded conclusions.

Report Recommendations

The recommendations regarding improving services and investigations are appreciated. Some of the recommendations will be explored further in efforts to continue to improve SWITC. While SWITC has held that abuse, neglect, and mistreatment are completely unacceptable and has routinely dismissed staff who engage in such conduct, reinforcing and more clearly communicating our zero-tolerance position around abuse, neglect, and mistreatment is appropriate. We appreciate the perspective and suggestion regarding revising confidentiality expectations discussed with clients involved in an investigation, as we concur that clients may and perhaps should talk with family, guardians, and advocates. The idea of a certification for investigators is intriguing and the facility will pursue looking for a recognized certifying agency to provide this training. It should be noted that SWITC investigators attended a 2-day training in August 2018 put on by Labor Relation Alternatives, Inc., called Conducting Serious Incident Investigations. Topics covered include the fundamental principles of investigation including the role of speed, thoroughness, and objectivity in conducting investigations, collecting and preserving physical evidence, interviewing witnesses and obtaining statements, collecting other documentary evidence, and reconciling conflicting testimonial evidence.

However, many of the recommended changes have already been implemented at SWITC. While training to prevent abuse and neglect has always occurred, it has been increased and revamped to place increased emphasizes on the fact that abuse, neglect, and mistreatment are not tolerated. Staff are very aware that they can be terminated for abuse, neglect, or mistreatment. Abuse is routinely reported, and reporting is emphasized repeatedly in training. A Licensed Clinical Social Worker with training in trauma-informed services met with clients regarding any abuse or trauma they have experienced. Treatment plans were reviewed extensively as a result of licensure or complaint surveys in 2017, and the reviews continue through SWITC's new Board Certified Behavioral Analyst. Communication needs are being addressed with the hiring of a

Speech and Language Pathologist in March 2018. Staff are receiving extensive new employee and ongoing training to include, Trauma-Informed Therapy training by the end of 2018 and Routine Based Treatment Training.

Some of the recommendations made by DRI will be difficult to implement. The recommendation that SWITC not accept new admissions based on staff numbers is difficult to implement when there is no alternative placement for many clients. Likewise, discharging clients to the community due to lack of staff is unlikely when there are no community providers willing to take these clients, and a concern for community safety. Additionally, such a discharge is likely to violate licensing regulations.

Conclusion

The issues at SWITC have been significant and the facility and its staff are working hard to address them. This report highlights some of the concerns, misses some serious contributors to the issues, and recommends solutions that could help. Unfortunately, the report also makes mistakes and exaggerates the issues when it could have made a significant contribution to solving issues at SWITC without courting the controversy and confusion that these mistakes invite.

DISABILITY RIGHTS IDAHO

Protection & Advocacy for Individuals with Disabilities

Reply to SWITC/IDHW's Response to No Safe Place to Call Home
A Report on the Cycle of Abuse, Neglect, and Injury at the Southwest Idaho Treatment Center, Issued by DRI on October 29, 2018

On October 1, 2018, DRI provided SWITC/IDHW with an advance, unredacted copy of its investigation report, ***No Safe Place to Call Home A Report on the Cycle of Abuse, Neglect, and Injury at the Southwest Idaho Treatment Center*** for their review. DRI also provided SWITC/IDHW with the opportunity to provide comment regarding the report's factual accuracy and a response that would be published along with the report.

On October 19, 2018, SWITC/IDHW, through its counsel, provided DRI with a formal written response, attached hereto as Appendix A.[1] The response acknowledged "[a]t its core, the report produced by DisAbility Rights Idaho (DRI) shows some of the significant challenges the Southwest Idaho Treatment Center (SWITC) faces." The response then goes on to assert that "[m]uch of the report focused on events that occurred over a year ago, and many of the events reported were not accurate in context or description." It also asserts that DRI's report "failed to report on any changes and improvements made at SWITC."

DRI's reply to the matters raised in SWITC/IDHW's October 19, 2018 response are as follows:

1. ***"Although the report reiterated the findings that were provided during investigations and surveys, it failed to report on any changes and improvements made at SWITC. Since DRI did not attempt to contact anyone at SWITC or the Department of Health and Welfare to discuss the context for the information or understand what changes had been implemented at SWITC, the report is based solely on conclusions drawn by DRI based on a [sic] limited and outdated information." (Appendix A, pg. 2).***

DRI made multiple requests for information regarding the "changes" made at SWITC in response to the abuse and neglect investigations initiated in the summer of 2017. Those attempts and SWITC/IDHW's responses are as follows:

On October 12, 2017, DRI requested a list of any systemic issues identified by the IDHW investigators during their investigations well as a list of each and every recommendation that has been or will be made to the SWITC facility Administrator or any IDHW personnel to address each and every substantiated allegation of abuse, neglect or

[1] Although DRI received a formal written response from SWITC's legal counsel, the response is entitled "Idaho Department of Health and Welfare's Response to 2018 Disability Rights Idaho Report." As such, DRI will refer to SWITC and IDHW interchangeably in this document as "SWITC/IDHW."

violation of internal policy. Also requested was a list of each and every recommendation that has or will be made to address any identified systemic issues identified by IDHW investigators.

On October 18, 2017, the lead investigator for IDHW responded that these "lists" "do not exist, and therefore will not be provided." The investigator then referred DRI to the investigation materials themselves for information about employee discipline, training, or other actions taken in response to the investigation findings.

On November 20, 2017, DRI renewed its request to the lead IDHW investigator for a list of each and every recommendation made regarding improvements or changes to be made at SWITC as a result of the individual investigations themselves and in response to any systemic issues identified by the IDHW investigators. On December 7, 2017, the lead investigator once again responded "the 'list' you requested for 'each and every recommendation that has been made to either SWITC Administrator or IDHW personnel to address such issue' does not exist and therefore, cannot be produced." Again, DRI was informed "much of the information you seeking is available in the information you have been provided," referring DRI to the investigation materials themselves for information about employee discipline, training, or other actions taken in response to the investigation findings. The IDHW investigator then stated "the SWITC Abuse, Neglect, and Mistreatment section of the Policy and Procedure Manual is currently being revised. We can forward you a copy of the revised portion of the manual when it is completed along with the older version so you can compare and see what changes have been made."

On January 9, 2017, DRI submitted to SWITC a detailed request for records pertaining to policies practices and procedures regarding employee training as well as policies, practices, and procedures regarding employee training specific to alleged/suspected abuse, neglect and mistreatment. DRI also requested information and records pertaining to SWITC quality assurance activities, after being informed that the facility had added a QA position to help with regular quality assurance activities to ensure [resident] plans were up to date and followed.

On January 19, 2017, SWITC, through its Administrator, provided a "summary from one of the Board Certified Behavioral Analyst BCBAs on the training that was done with the Clinicians and Developmental Specialist Seniors. My records indicate that I met with the CS Manager for Birch [housing unit] on 8/8/17 to provide training in the policies and procedures related to her role. I have attached a listing of the systematic training on ICF/IID regulations that have happened so far. I have also attached a more detailed summary of what is covered with each new employee during their first days on the job. We are continuing to develop this even further and are working on a 12 day classroom/hands on training that we hope to roll March 1st." As to trainings related to abuse, neglect, and mistreatment, SWITC responded that "[w]e don't utilize a specific curriculum other than our policy. The training goes over definitions of abuse and expectations around reporting and how it is investigated. This is done with new employees before they can work with clients by themselves. Their supervisor

is responsible for the training, though I personally trained several groups of new employees on 7/18/17, 8/8/17 and 11/13/17." As to the quality assurance piece, SWITC responded that "[a]t this time we are still developing our Quality Assurance program, but have started with a review that ensures that all of the corrections we made as a result of our surveys this year are being done and maintained. We are also having QA starting to do mock surveys to ensure that we catch issues related to regulation compliance proactively and correct them prior to our official survey. I have attached the forms they use for those reviews."

On March 2, 2018, DRI requested "a list of all of the changes that the facility had made or is in the process of making as a result of [IDHW HR's] investigations from the summer/fall of 2017." On March 5, 2018, SWITC, through its attorney, replied "[a]s we have previously told you, the list you are requesting does not exist and therefore, cannot be produced. The SWITC Abuse, Neglect, and Mistreatment section of the Policy and Procedure Manual is currently being revised; we will forward you a copy of the revised portions along with the older versions for comparison." It should be noted that the revised version of SWITC's Abuse, Neglect, and Mistreatment policy is referenced extensively throughout DRI's report.

DRI is certainly encouraged to hear that SWITC has implemented changes at its facility in order to improve conditions. However, if there are changes other than the employee disciplinary actions outlined in individual investigations and the trainings or changes described above by SWITC/IDHW representatives, DRI was not made aware of them.

Of the changes DRI was made aware of, i.e. changes in policy, such changes appear to be for the benefit of the facility and staff, rather than the residents themselves. For instance, although the Abuse, Neglect, and Mistreatment policy has been amended twice since February of 2017, none of those amendments included a statement that the facility has a zero tolerance approach to abuse or neglect. Instead, the changes made to the policy included removing sexual communication as a specific form of abuse and adding exceptions to the requirement that accused staff be placed on administrative leave once an allegation of abuse or neglect of a resident has been reported. In addition, the Behavioral Restraint Policy (SWITC Policy 01.07.0) was changed in January of 2018 to add two additional forms of "approved restraints." Instead of putting forth efforts to eliminate the use of physical restraints at the facility (and in spite of numerous, documented instances of staff inappropriately restraining residents), the facility chose to increase the types of restraints that could be used.

2. ***"Much of the information contained in the report is outdated and based on a partial investigation by DRI with limited sources." (Appendix A, pg. 2).***

From the outset, DRI's report explains that its investigation was narrowed to reviewing SWITC/IDHW HR internal investigations into acts of abuse and neglect committed against SWITC residents from January 1, 2017 through January 31, 2018. In response to this

comment, DRI inserted additional language into its report, clarifying that its investigation was a "secondary" in nature as well as detailing the voluminous amount of review that was incorporated within its investigation. DRI is unsure as to what SWITC/IDHW characterizes as a "partial investigation." However, its "limited sources" included a review of over twenty thousand (20,000) pages of records provided by SWITC/IDHW, IDHW's Bureau of Facility Standards, and Adult Protection as well as the use of a professional consultant with over twenty-five (25) years of experience in developmental disability facility management and administration.

3. ***"The difficult and challenging behavior of residents at SWITC are ignored and the report's conclusions and recommendations suffer." (Appendix A, pg. 2).***

DRI acknowledges that residents may have had behavioral issues prior to residing at SWITC. However, SWITC/IDHW makes it appear as though the residents were newly admitted to the facility and, therefore, an inference should be drawn that the facility was unable to address these behaviors in the short period since the resident's admission. Readers should be aware that of the thirty-seven (37) residents total who resided at SWITC from January 1, 2017 through January 31, 2018, twenty-four (24) were admitted prior to January 1, 2017. An additional eight (8) residents were then admitted after January 1, 2017. Of those admitted in 2017, half were residents who had resided at SWITC for years prior to being re-admitted in 2017. During all of this time, SWITC had been required to not only identify such behaviors but also address them through the active treatment process, which DRI discusses in detail on pages 45 through 52 of its report. If SWITC failed in those requirements, such a failure is attributable only to SWITC, not to the residents themselves.

Moreover, the behaviors exhibited by residents at SWITC are no different than the behaviors presented by residents at other ICF/IIDs and similar facilities throughout the United States. Yet, other facilities have been able to successfully provide care and treatment for such individuals and cope with these behaviors in a more productive way, perhaps through their implementation of trauma informed care principles. Using resident behaviors as a justification for staff who violate policy, merely creates an atmosphere that increases the likelihood of altercations and injuries.

4. ***"Many of the recommendations made by DRI were already implemented by SWITC prior to receiving the report while others potentially violate employee due process or Intermediate Care Facility regulations." (Appendix A, pg. 2).***

DRI is certainly encouraged to hear that SWITC has implemented changes at its facility in order to improve conditions. DRI will keep this in mind as it continues to monitor conditions at the facility as well as future survey results from the Bureau of Facility Standards. As to any recommendations SWITC/IDHW argues will "violate employee due process or Intermediate Care Facility regulations," DRI would continue to extend its invitation

to meet with SWITC and IDHW representatives in order to discuss their concerns regarding DRI's recommendations so that solutions may be reached to ensure resident safety is prioritized first and foremost.

5. ***"B.4 cites records provided by SWITC to DRI in March 2018 regarding new training. The section refers to this training, then criticizes the SWITC training's ineffectiveness in preventing the events in June of 2017. It is unreasonable and confusing to criticize the training for events that happened before it was implemented. SWITC implemented extensive new training for employees in January 2018." (Appendix A, pg. 3).***

DRI's only statements regarding employee training within section B.4 were as follows: "SWITC provided DRI with multiple documents indicating that the facility has conducted several trainings on this policy and its reporting requirements since February of 2016. SWITC has also indicated that training on this policy is incorporated into new employee orientations before staff can work with residents by themselves."

In order to clarify, DRI has removed the second sentence from its report, as apparently new staff had not been trained on the facility's Abuse, Neglect, and Mistreatment policy prior to working with residents by themselves. Instead, training on this policy during new employee orientations did not occur until 2018.

6. ***"The report draws most of its information from internal investigations conducted by the Department of Health and Welfare ("Department"), licensure surveys and newspaper reports to build its conclusions. DRI has the right to access all SWITC records and staff, but failed to interview SWITC staff or administration, or to even seek feedback on its efforts prior to sending a draft of the report." (Appendix A, pg. 3).***

Again, as DRI's report has now clearly outlined from the outset, DRI investigation was narrowed to reviewing SWITC/IDHW HR internal investigations into acts of abuse and neglect committed against SWITC residents from January 1, 2017 through January 31, 2018. In response to this and other similar comments, DRI inserted additional language into its report, clarifying that its investigation was a "secondary" in nature. The report now also details the voluminous amount of review incorporated within its investigation, including a review of over twenty thousand (20,000) pages of records. As for seeking feedback on SWITC's efforts, DRI made multiple records requests as to SWITC's efforts (outlined under answer number 1 above) and provided SWITC/IDHW with an advanced, unredacted copy of this report in order to provide DRI with comment as to any factual errors and a formal written response.

7. ***"For example, efforts SWITC has made around trauma-informed services are completely missed, and the institution and administrator are falsely characterized as doing nothing in Section 6(iii). In reality, much has been accomplished around trauma-informed services and a more reasoned conclusion***

should have been made." (Appendix A, pg. 3).

DRI's statement that "corrective actions failed to incorporate any trauma-informed care principles to ensure residents were provided with appropriate information, resources, and services needed to cope with the effects of being subjected to abuse or neglect" remains unchanged. DRI reviewed seventy (70) internal investigations into abuse and neglect. At the end of each investigation was an "Administrative Investigation Review" section, which outlined the Administrator's recommendations, if any, to be taken in response to the investigation. None of those recommendations included any trauma-informed care principles to support the residents. SWITC now claims "much as been accomplished around trauma-informed services," stating "[a] Licensed Clinical Social Worker with training in trauma-informed services met with clients regarding any abuse or trauma they have experienced." (Appendix A, pg. 6). Regardless, simply employing a social worker to provide trauma-based therapy to some residents falls far short of what is needed to create a facility based on trauma informed care principles. Please see DRI's statement on this, included within recommendation number 3, found on page 91 of its report.

8. *"Furthermore, the report fails to include any information regarding the context related to clients at SWITC… " (Appendix, pg. 3).*

Please see DRI's response under number 3, listed above.

9. *"Many of SWITC's investigations are included in the report. Unfortunately, the report does not provide context or evidence to support its conclusions. This leaves the reader unsure, and at times the reader is even mislead about the actual facts of the cases." (Appendix A, pg. 3).*

DRI provided SWITC/IDHW with an advanced, unredacted version of this report, with detailed citations as to each and every investigation it referenced. All evidence to support DRI's conclusions come directly from the facts and evidence provided in the investigations themselves, authored by SWITC and IDHW staff.

10. *"The report builds conclusions on spurious evidence and uses unsupported conclusions to make SWITC's record appear much worse than it is. An example is Section III.A.1., which it titled SWITC/IDHW investigators found residents were abused or neglected by SWITC staff on forty-nine (49) occasions, in violation of facility policy." (Appendix A, pg. 4).*

DRI provided SWITC/IDHW with an advanced, unredacted version of this report, with detailed citations as to each and every investigation it referenced, including each and every investigation it was relying on to support its statement that abuse or neglect was substantiated on forty-nine (49) occasions. Furthermore, both the unredacted copy received by SWITC/IDHW and the redacted version of the report published to the public contain an explanation as to what DRI is counting as abuse or neglect (see pages 6-7 and 16-20 of the

redacted report). DRI would direct SWITC/IDHW to pages 16-21 of its advanced, unredacted copy for more specific details.

As those pages explain, DRI reviewed seventy (70) internal investigations into resident abuse and neglect conducted by SWITC and/or IDHW human resources investigators. Of the seventy (70) internal investigations reviewed, twenty-five (25) contained allegations of abuse or neglect that were substantiated. Within those twenty-five (25) investigations, the substantiated allegations were as follows: five (5) allegations of sexual abuse; seven (7) allegations of physical abuse; eleven (11) allegations of psychological abuse; and twenty-six (26) allegations of neglect (i.e. forty-nine (49) substantiated allegations total)). DRI considers each allegation substantiated against an employee a substantiated allegation. So, for instance, if three (3) employees were found to have violated SWITC Policy 01.11 by engaging in "unnecessary sexual communication" with a SWITC resident (i.e. sexual abuse), then DRI would consider this as three (3) substantiated instances of sexual abuse. Again, as detailed throughout this report, DRI believes this number should be much higher had SWITC and IDHW investigators actually identified and then thoroughly investigated all instances of abuse or neglect.

Moreover, it should be noted that the numbers referenced above come directly from the seventy (70) internal investigations that SWITC/IDHW staff provided to DRI, not from any Bureau of Facility Standards survey results. DRI provided references to each and every investigation from which these substantiated instances can be derived in the advanced, unredacted copy of this report it provided to SWITC/IDHW on October 1, 2018.

11. ***"On page 69 [of the report provided to SWITC/IDHW], the report indicates that DRI identified at least 40 more incidents in which staff either directly or indirectly put residents at risk of injury or death that SWITC did not find. According to their report, this would bring the total to 96 incidents of abuse or neglect. DRI should have reported these incidents to SWITC and reporting authorities as DRI identified them, as required by Idaho Law, so the incidents could be properly investigated in a timely fashion and ensure clients are safe." (Appendix A, page 4).***

The additional incidents identified by DRI in its report came directly from the investigatory records authored and provided by SWITC/IDHW staff. If you were to read the documentation that accompanied the internal investigations, including witness statements, forms, etc. you would note that such evidence contained reports of or eluded to additional issues. The investigators ignored such additional issues and focused solely on the allegation originally complained of when conducting their investigations. In DRI's review, we found no indication that those additional issues, although documented, were ever investigated. These instances appear in SWITC/IDHW's own investigatory records, which DRI specifically referenced in the unredacted version of this report, provided to SWITC/IDHW.

Such records had been reviewed by the SWITC/IDHW investigators as well as the

facility's Administrator or administrator on duty prior to being provided to DRI. DRI's purpose in conducting a secondary investigation in this matter was to review the quality of the internal investigations conducted by SWITC/IDHW investigators and identify any flaws in their investigative process. Through its secondary investigation and as outlined in this report, DRI did in fact identify forty (40) additional incidents where SWITC/IDHW investigators failed to identify, report, and investigate all potential violations of the abuse and neglect or other facility policies, despite having such violations documented in their investigatory files. As explained in our report, such failures are a contributing factor in SWITC's cycle of abuse and neglect.

12. ***"While some of the conclusions developed in the report are correct, some are weakened by a tendency to include unrelated items in evidence. On pages 59-61 [of the report provided to SWITC/IDHW], the report claims that better training is needed around abuse reports and lists examples that would have been corrected with better training. However, under the title Incidents that Went Unreported, 13 of the 14 incidents were from singular June investigations where a group of employees purposefully hid abusive behavior from supervisors and administration. It is unclear how training could have impacted this intentional, deceitful behavior." (Appendix A, pg. 4).***

As cited in our report, the facility's failure to provide appropriate training and supervision training was not isolated to just the Abuse, Neglect, and Mistreatment policy, but other policies and procedures as well. Such failures were also not isolated to the month of June 2017, but months prior to and after. While DRI acknowledges that many of the incidents were discovered in June, our report makes clear that acts of abuse and neglect occurred throughout the entire investigatory period (January 1, 2017 through January 31, 2018). Although, SWITC/IDHW has focused on one example in its response, our report details over five (5) pages of discussion as to the facility's failure to provide appropriate training and supervision. When employees are able to hide pervasive levels of abuse and neglect, it is reasonable to question whether their training and supervision is adequate.

13. ***"As the report maintains that abuse and neglect are on ongoing cycle at SWITC, it should show this cycle occurring at both ends of the year in question – both before and after changes were implemented…" (Appendix A, pg. 4).***

DRI's investigation was narrowed to reviewing SWITC/IDHW HR internal investigations into acts of abuse and neglect committed against SWITC residents from January 1, 2017 through January 31, 2018. Such investigations included incidents occurring in February of 2017 through January of 2018, i.e. "at both ends of the year in question."

While DRI acknowledges that many of the incidents were discovered in June, our report makes clear that acts of abuse and neglect occurred throughout the entire investigatory period (January 1, 2017 through January 31, 2018). What is concerning to DRI is that once abuse and neglect was brought to the attention of the facility Administrator and

IDHW, there appeared to be no indication that they reviewed such incidents in a systemic fashion in order to determine how the level of abuse and neglect appeared to magnify in June. Instead, they maintain that such abuse and neglect was "an aberration" without attempts to identify the underlying causes.

14. ***"The report also contains misinterpretation and misses the context and facts of specific cases. For example, on page 36 of the report, a review of the three investigations involves staff preventing client elopement and assaults on staff or other clients. Claims that staff redirecting or blocking assaults cause a client to fall support the narrative and conclusions of the report. However, the report disregards witnesses and video recordings that contradict DRI's conclusions that staff efforts constituted abuse." (Appendix A, pg. 5).***

DRI would like to reiterate that the section referenced in SWITC/IDHW's comments in regards to three examples where acts of abuse were not substantiated because the investigator concluded that the accused staff did not act "intentionally." As discussed in detail within this section of the report, DRI takes issue with any conclusions based on whether or not an employee "intended" to harm a resident as such a finding contradicts Idaho Code §66-412. It also supports DRI's finding that by not defining the term "willful" in its abuse and neglect policy, SWITC has left the term to be inconsistently applied by those interpreting it: investigators and the facility Administrator.

15. ***"The report exaggerates issues and misses crucial facts that would give a clearer description of SWITC. One example of this is regarding the staffing of the facility……" (Appendix A, pg. 5).***

In the paragraph that follows this statement, SWITC/IDHW admits that it "missed its own selected staffing level." As stated in our report, Bureau of Facility Standards surveyors found that the facility failed to meet its required, minimum staff to resident ratios for the first seven (7) months of 2017 (January through July). In response, the SWITC Administrator indicated that **by October 4, 2017**, the facility would "[reassess] staffing minimum requirements to ensure appropriate levels of staffing have been determined" and that the facility would hire additional staff, monitor staffing schedules on a daily basis, and provide monthly reviews of staffing minimums to the Administrator. Yet, despite this assurance, staffing issues remained. With the assistance of its consultant, DRI reviewed SWITC's work schedules for the months of September, October, and November of 2017 and found that the facility still failed to meet minimum staffing requirements in each of these months. This conclusion was based on documents authored and provided by SWITC.

As our report further states, such staffing problems persisted into 2018, when the Bureau of Facility Standards discovered that eighteen (18) shifts has been worked below ratio from December 1, 2017 through February 19, 2018. This can be found by reviewing a letter from Nicole Wisenor of the Bureau of Facility Standards to Administrator Jamie Newton dated May 23, 2018, included as an attachment to the February 22, 2018 Bureau of Facility

Standards survey.[2]

The letter also states that during an interview on February 21, 2018, "the Administrator stated that she was aware shifts were worked below ratio and the facility was in [sic] process of recruiting and retaining employees through new staff orientation training." In that letter, the Bureau of Facility Standards found that "the facility did have shifts that were worked below the minimum ratio." As a result, DRI is unsure as to what is "untrue" about its conclusion that SWITC failed to provide the amount of direct care staff required to serve the needs of its residents.

16. ***"However, many of the recommended changes have already been implemented at SWITC… Communication needs are being addressed with the hiring of a Speech and Language Pathologist in March of 2018." (Appendix A, pg. 6-7).***

DRI is encouraged to learn that SWITC has hired a Speech and Language Pathologist in order to address residents' communication needs. However, DRI hopes that such communication needs were addressed prior to March of 2018, as the facility had been cited for failing to provide professional program services, such as speech therapy, in July of 2017.[3] In response, the facility's Administrator indicated that corrective actions to "ensure that all individuals have had any assessment the team has identified as needs," would be taken by September 11, 2017 and October 4, 2017.[4]

[2] Idaho Department of Health and Welfare, *Southwest Idaho Treatment Center – Nampa 04-25-18 Complaint Follow-up + Complaint*, http://healthandwelfare.idaho.gov/Portals/0/Medical/LC8/042518SWITCFU_C.pdf.

[3] Idaho Department of Health and Welfare, *Southwest Idaho Treatment Center – Nampa 07-19-17 Recertification/Relicensure + Complaint (Revised 09/11/17)(Updated 10-18-17)*, http://healthandwelfare.idaho.gov/Portals/0/Medical/LC7/071917SWITCR_C.pdf.

[4] SWITC first submitted a plan of correction to the deficiencies cited in the July 19, 2017 survey on August 10, 2017, indicating that such corrective actions would be completed by August 21, 2017. On August 24, 2017, the facility submitted an updated plan of correction, indicating that corrective actions would be completed on September 11, 2017. After immediate jeopardy was discovered at the facility in September of 2017, the facility then had to submit an updated plan of correction, addressing the identified immediate jeopardy as well as the deficiencies cited in the July 19, 2017 survey. This updated plan of correction indicated that all corrective actions were to be completed by October 4, 2017.