



DO NO HARM

*Multiple Incidents of
Abuse and Neglect at the
Psychiatric Institute of Washington*

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ABOUT DISABILITY RIGHTS DC

Since 1996, Disability Rights DC at University Legal Services, Inc. (“Disability Rights DC”), a private, non-profit legal service agency, has been the federally mandated protection and advocacy (P&A) program for individuals with disabilities in the District of Columbia. Additionally, Disability Rights DC provides legal advocacy to protect the civil rights of District residents with disabilities.

Disability Rights DC staff¹ directly serves hundreds of individual clients annually, with thousands more benefiting from the results of investigations, institutional reform litigation, outreach, education, and group advocacy efforts. Disability Rights DC staff address client issues relating to, among other things, abuse and neglect, community integration, accessible housing, financial exploitation, access to health care services, discharge planning, special education, and the improper use of seclusion, restraint and medication.

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I. EXECUTIVE SUMMARY

The patients at The Psychiatric Institute of Washington (“PIW”) have a right to be safe. As the federally mandated Protection and Advocacy program for the District, Disability Rights DC (“DRDC”) has the authority to conduct investigations into allegations of abuse and neglect at the District’s psychiatric institutions, as well as the authority to obtain medical records, incident and investigation reports, and videotape footage.² Alarming, for years, Disability Rights DC’s investigations into allegations of abuse and neglect at PIW have revealed evidence of serious and disturbing abuse and neglect at PIW.

In June of 2021, DRDC released a report, *A Disturbing Death: Abuse and Neglect at the Psychiatric Institute of Washington*, which described videotape footage of nursing neglect surrounding the death of a patient, as well as many incidents of serious abuse and neglect.³ Allegations of abuse and neglect made by PIW patients and other stakeholders have increased since the release of the report. Numerous patients have reported to Disability Rights DC that they did not feel safe at PIW, that PIW is understaffed, that there are sometimes no Registered Nurses on the units, and that they have been threatened by other patients and do not feel staff intervene to protect them. Patients have also reported incidents of staff abuse. Patients have told Disability Rights DC that they were admitted to PIW for treatment, but their stay left them traumatized, or even physically injured. DRDC’s investigations and review of videotape footage have revealed disturbing staff conduct and/or significant abuse or neglect. DRDC’s investigation findings include:

- Videotape footage showing multiple staff persons using unauthorized physical restraint techniques, which caused a patient to fall to the ground and likely resulted in head and arm injuries. *See infra* at 21.
- Videotape footage of a male staff person who dragged a crying, frightened female patient across the floor twice, then pushed her into the room and held the door closed so that she could not leave. The patient reported she thought the staff was going to sexually assault her after he pushed her in the room. *See infra* at 21-22.
- Videotape footage of a chaotic adolescent unit where multiple patients engaged in physical altercations and staff did not adequately intervene, culminating in a frightening scene in which seven DC Metropolitan Police officers arrived on the unit and arrested one youth. During this incident an adolescent patient was stabbed in the cheek and sustained a laceration and facial fracture. *See infra* at 7, 9-10.
- Several other incidents on the adolescent unit where multiple assaults occurred, the police were called, and youths were arrested. *See infra* at 13-14.
- An incident where a patient was struck in the face and sustained nasal fractures and a laceration. *See infra* at 29.

- Incidents where staff administered drugs as restraints in violation of DC law. See *infra* at 28.
- Multiple allegations of staff abuse including staff holding down a patient on her bed to inject her with medication involuntarily and staff grabbing a patient causing bruising to her arms. See *infra* at 27-28.

The Department of Health (“DC Health”) has uncovered and documented numerous unsafe practices which violate District laws and federal regulations and place the health and safety of the patients at PIW at risk. During annual and complaint surveys and investigations, DC Health has cited PIW for violating federal regulations including:

- Insufficient numbers of qualified personnel to ensure ability to provide care to all patients, and failure to ensure a safe and secure environment for patients.⁴ Insufficient staffing on four of seven units reviewed.⁵
- PIW failed to comply with required staffing conditions and had an inadequate number of Registered Nurses (RNs) and Psychiatric Counselors to provide care to patients.⁶
- Medical staff failed to obtain consent for the administration of psychotropic medications, which was a repeat deficiency from a prior survey.⁷
- Nursing staff left nursing stations unattended with potentially dangerous objects readily available to patient access.⁸
- Medical records revealed significant medication errors. All patient medical records reviewed demonstrated errors, including the administration of the incorrect dosage of medication, administration by the incorrect route, administration of the wrong medication, and administration of medication without a physician’s order.⁹
- PIW “willfully facilitated or enabled the abuse or harassment of [a patient] by not taking appropriate precautions and not responding appropriately” after she reported an incident of sexual assault.¹⁰
- PIW staff failed to ensure an incident was properly reported and investigated in accordance with PIW policy nor did PIW notify any relevant external agencies of a sexual assault allegation.¹¹
- Nursing staff failed to follow a doctor’s order for one-to-one staffing and every fifteen-minute checks for a patient.¹²
- Inconsistencies between Medication Administration Records completed and Controlled Substance Administration Records indicating medication was removed but not administered.¹³
- Staff failed to perform a comprehensive physical assessment of a patient, who subsequently required resuscitative measures.¹⁴
- PIW failed to investigate incidents properly in accordance with its policies.¹⁵
- Staff did not appropriately document investigations and patient observations.¹⁶

DRDC received and analyzed a log of phone calls that indicates that the police are receiving calls from PIW frequently. The call log shows that between March 2019 and February

2022, there were more than 700 calls placed to the police from PIW. The high number of calls adds to DRDC's concerns that many incidents may be occurring in addition to the ones we are informed about. *See infra* at 29-30.

As the number of complaints and evidence of abuse and neglect increase, so do our concerns for the safety of the patients at PIW. The purpose of this report is to detail these serious incidents and evidence of abuse and neglect. This report should raise alarm bells with PIW and the District government agencies who have oversight authority. Exposing the District's residents to abuse and neglect -- patients who are admitted to PIW for mental health care and treatment -- should not happen.

DISABILITY RIGHTS DC RECOMMENDATIONS

- (1) PIW, with support from DBH, should retain the services of a consultant specializing in trauma informed care and the reduction and prevention of dangerous incidents in institutional settings.
- (2) DBH and DC Health must provide increased and meaningful oversight of PIW, including review and correction of PIW's quality improvement system, which must have reliable incident reporting and a robust investigatory process. Both DBH and DC Health must require PIW to adhere to all legal and policy requirements related to incidents and investigations.
- (3) PIW must examine the current staff ratios and increase staffing to levels that ensure a safe environment. Minimal staffing ratios may not be sufficient to keep the units safe.
- (4) PIW should allow DRDC in person access to conduct outreach and monitoring and provide DRDC with all requested records as required by federal law.

II. PATIENTS AT PIW HAVE A RIGHT TO BE SAFE.

PIW is the only private, for-profit hospital in Washington, D.C., that is solely focused on providing care for psychiatric and substance use disorders.¹⁷ PIW admits and discharges hundreds of patients each month on acute inpatient adult and adolescent units, as well as providing outpatient and partial hospitalization programs.¹⁸ PIW admits both voluntary and involuntary patients and houses them on locked units.¹⁹ The D.C. Department of Health (“DC Health”), and the D.C. Department of Behavioral Health (“DBH”) have the local responsibility of providing oversight for PIW’s services.²⁰

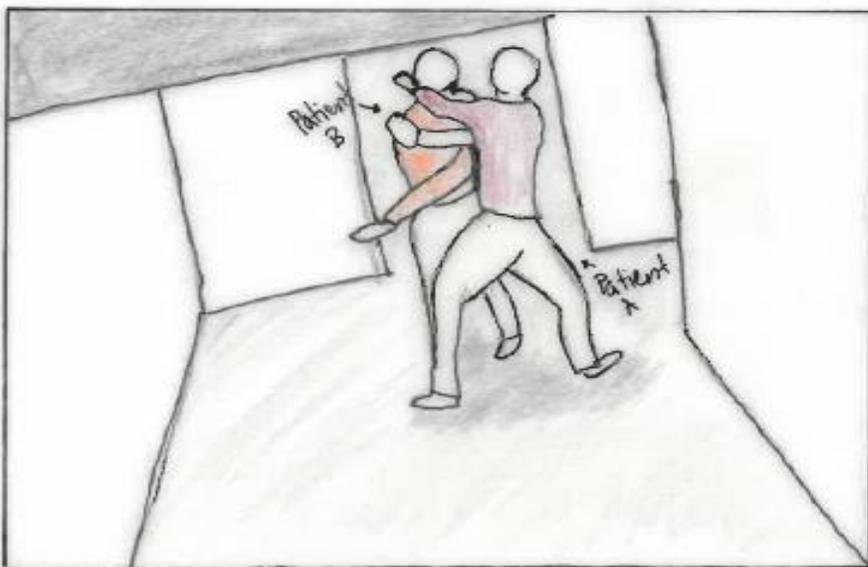
PIW is one of more than 400 facilities owned by Universal Health Services (UHS), a for-profit corporation and one of the largest owners of behavioral healthcare facilities nationally.²¹ The hospital chain’s revenues increased to \$12.6 billion in 2021, up 9.4 percent year over the previous year.²² While reaping such enormous profits, UHS-operated behavioral health facilities have been the subject of numerous investigations and lawsuits, which allege incidents of disturbing abuse and neglect, as well as violations of federal and state regulations.

In 2016 and 2017, an online news organization published a series of investigations into UHS operated behavioral health facilities, which detailed a pattern of staff abusing patients, understaffing, and inadequate staff training.²³ In February 2018, two employees at UHS owned North Spring Behavioral Healthcare were arrested and charged with manslaughter after the state medical examiner concluded that a teenage patient, whom they had restrained, died of positional asphyxiation.²⁴ In 2020, the United States Department of Justice settled with UHS for \$122 million involving allegations including UHS’ failure to provide adequate staffing, training, and supervision of staff, improper use of restraint and seclusion, failure to discharge patients when hospitalization was no longer necessary, failure to develop and/or update treatment plans, and failure to provide adequate psychotherapy and discharge planning.²⁵ In 2020 and 2021, three lawsuits were filed against a UHS owned facility in Virginia. Accusations from thirty-nine patient victims include claims of wrongful death of an 11-year-old patient, sexual abuse and battery, and encouraging doctors and staff to keep patients admitted for as long as the hospital could receive payment even when inpatient care or residential treatment was no longer medically necessary.²⁶

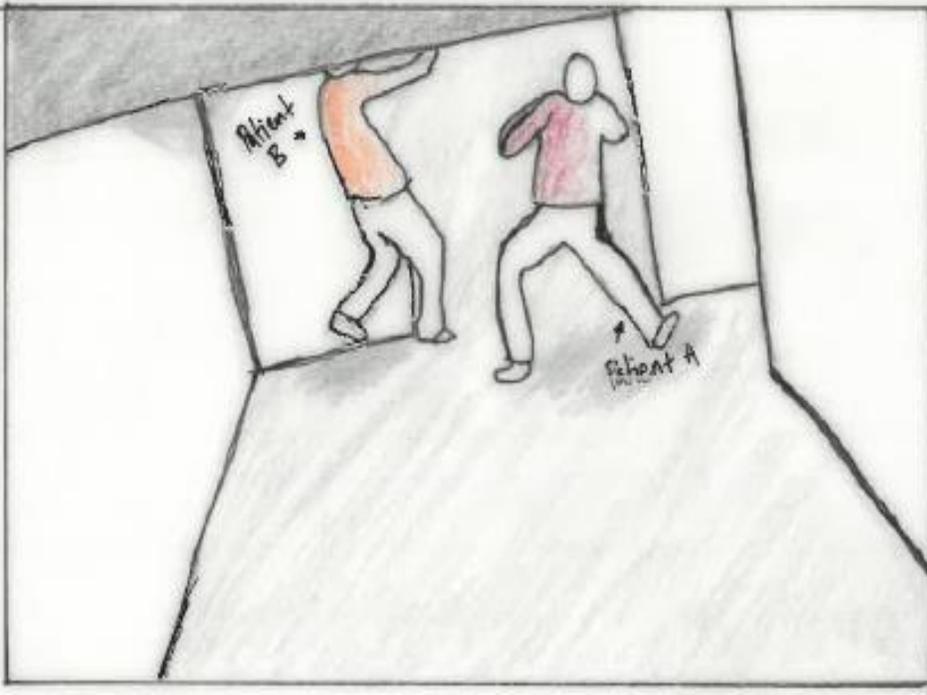
Disability Rights DC’s investigation of UHS-owned PIW has uncovered other serious concerns. Summarized below, our investigations revealed evidence of disturbing abuse and neglect and unsafe situations, where patients were exposed to frightening incidents, seriously injured, sent to the hospital and/or arrested. These outcomes cause lasting harm to the patients entrusted to PIW’s care. The hospital’s lack of adequate reporting, investigations, and follow up to these incidents is equally as troubling.

Chaotic and Dangerous Incident on the Adolescent Unit

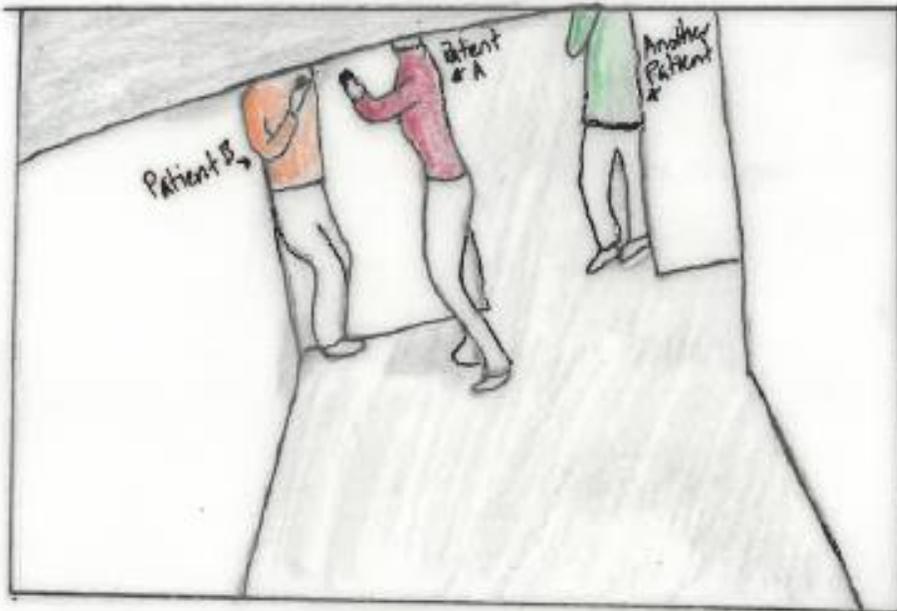
In May of 2021, DRDC investigated an incident of an adolescent patient who was stabbed in the cheek by another patient, which caused a laceration and facial fractures. DRDC reviewed over one hour of video footage of the unit, during which time the incident occurred. The videotape footage revealed an unsafe, and at times chaotic, unit with multiple adolescents involved in multiple altercations.²⁷ The videotape shows a striking lack of staff presence and effective staff interaction.²⁸ According to PIW documentation, PIW staff called the DC Metropolitan Police to arrest the patient who stabbed the other adolescent. Seven police officers responded and arrived on the unit nearly an hour after the incident occurred, which clearly distressed and disturbed the patients on the unit.²⁹ PIW staff, who are presumably more trained in the de-escalation of adolescents with psychiatric disorders than the police officers, did not appear to actively intervene or attempt to assist the police, deescalate and/or calm the patients or the situation.³⁰ More and better trained staff were clearly needed to ensure the safety of these adolescents, who were exposed to a terrifying experience. Below are tracings of the videotape footage. The videotape footage begins in a hallway at around 7:00 p.m. Two youths appear to be engaging in a physical altercation. No staff persons are visible for the duration of the altercation.³¹



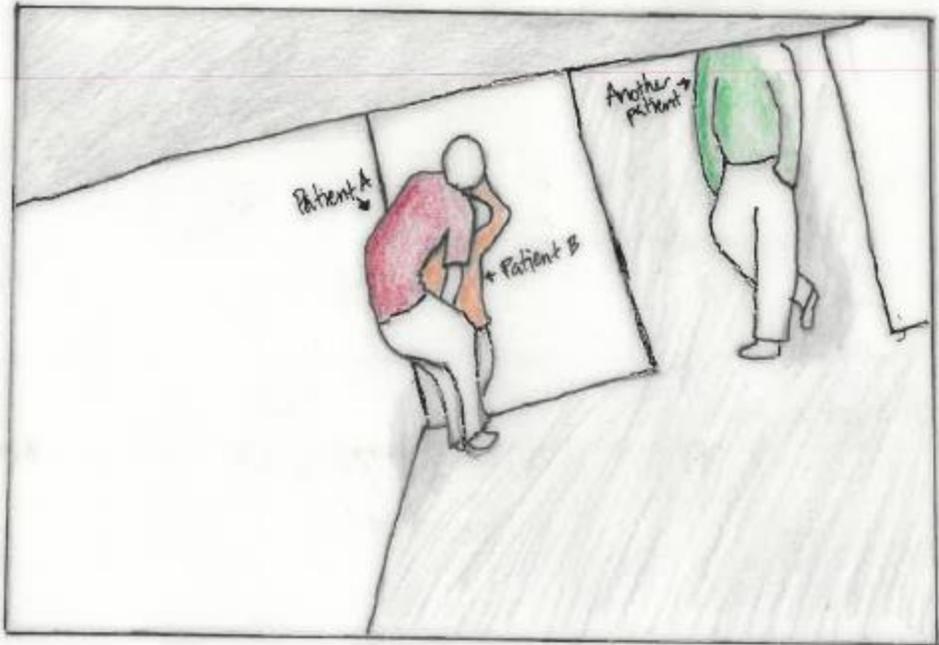
Two adolescents appear to hit at each other.³²



Youth B backs away from Youth A.³³



Youth A approaches Youth B as Youth A backs into the corner.³⁴



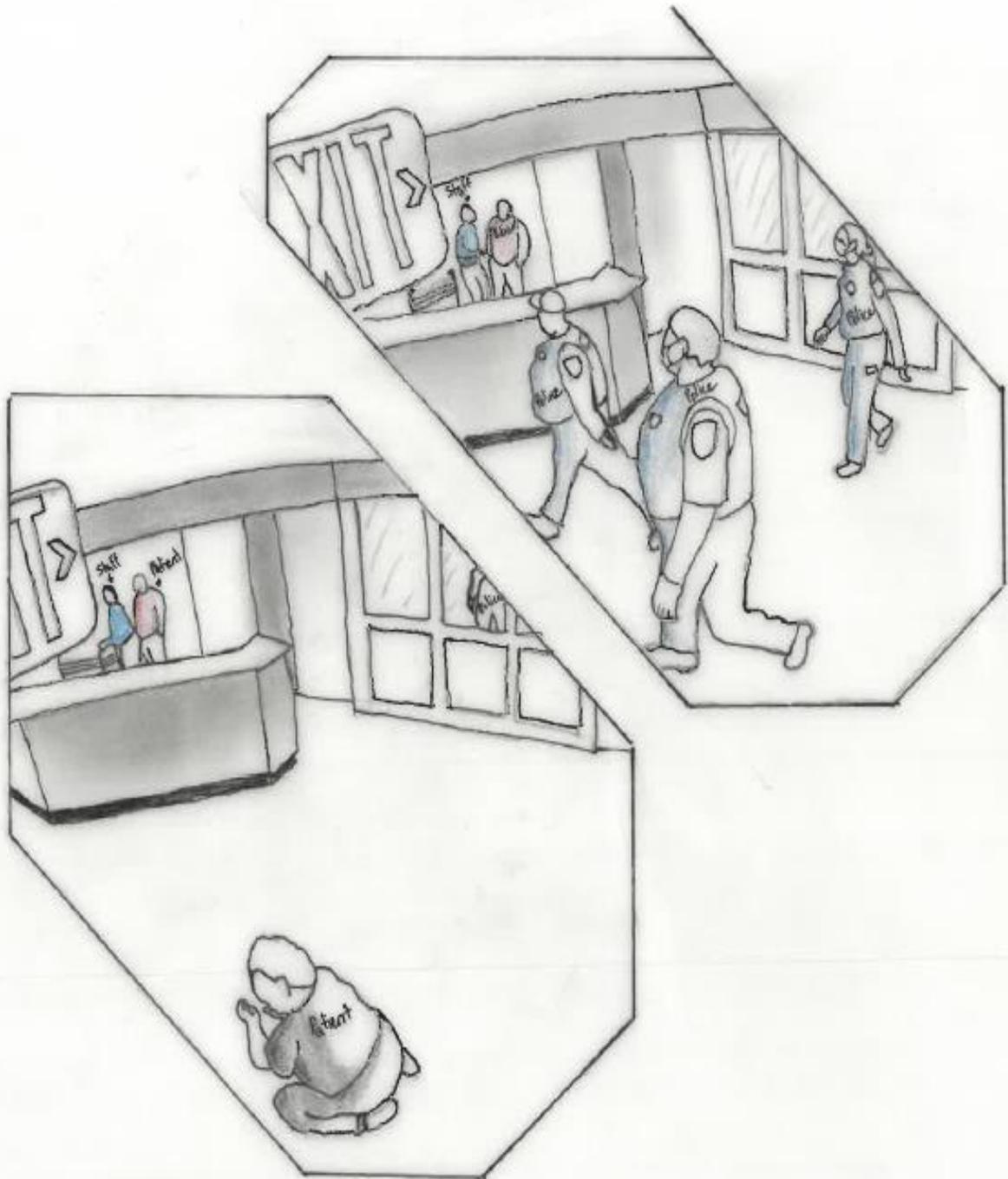
Youth B crouches in the corner as Youth A appears to hit her. Still no staff appear to be present.³⁵

Three patients then run from one patient room to another patient room and shut the door.³⁶ Another patient then runs into the same room.³⁷ Although not visible on the videotape footage, because cameras are not present in the patient rooms, according to PIW documentation, it was at around 7:10 p.m. when two of the youths were involved in a physical altercation in the patient rooms, where one youth punched another youth, who then retaliated and stabbed the first youth in the face causing a laceration and facial fractures.³⁸ Staff reportedly called the police after the stabbing, who arrived on the unit at approximately 8:00 p.m.³⁹ As will be detailed below, the police handcuffed and arrested the youth who allegedly stabbed the other youth and took him to jail.

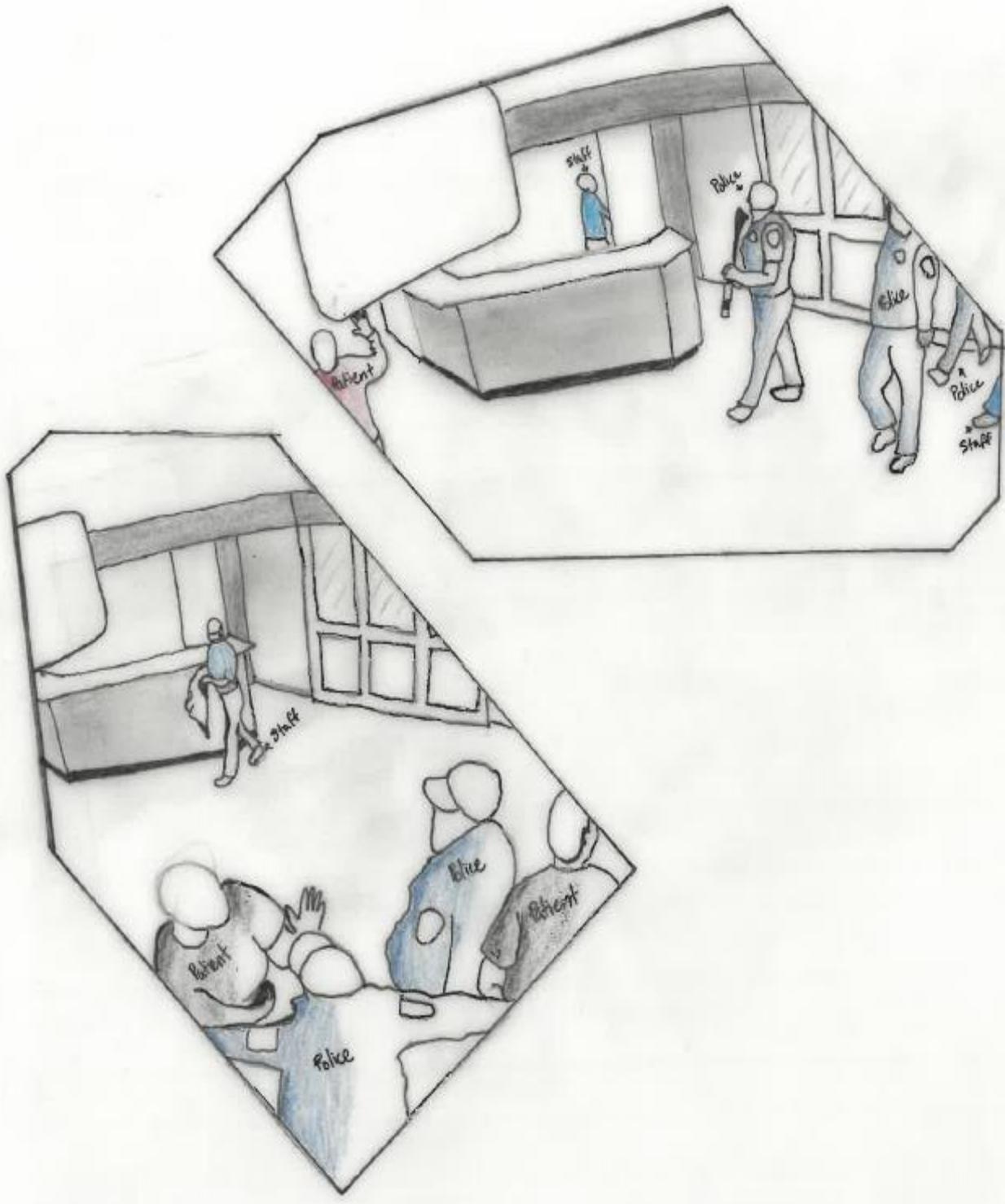
Just prior to 8:00 p.m. and prior to the police arrival, videotape footage from another camera shows two patients who appear to attack a staff person near the nurses' station. A patient appears to kick a staff person.⁴⁰ Another patient then appears to assault the same staff person as a different staff person walks past the altercation and does not appear to assist or intervene.⁴¹ At around the same time, the stabbed patient appears in the videotape footage holding a towel to his injured left cheekbone.⁴² A few minutes later, a youth crawls over the desk into the nurses' station and a staff person escorts her out thirty seconds later.⁴³ Another youth then crawls over the desk to the nurse's station and then exits.⁴⁴ Videotape footage then shows him kicking at the wall in the hallway.⁴⁵ A third youth then also enters the room behind the nurse's station.⁴⁶ As the staff person escorts the patient out, the patient appears to throw a cart towards the staff person.⁴⁷

A few minutes later, the disturbing and frightening scene continues as seven D.C. Metropolitan Police enter the unit and have physical encounters with several youths. As previously noted, PIW staff do not appear to attempt to intervene or deescalate any of the

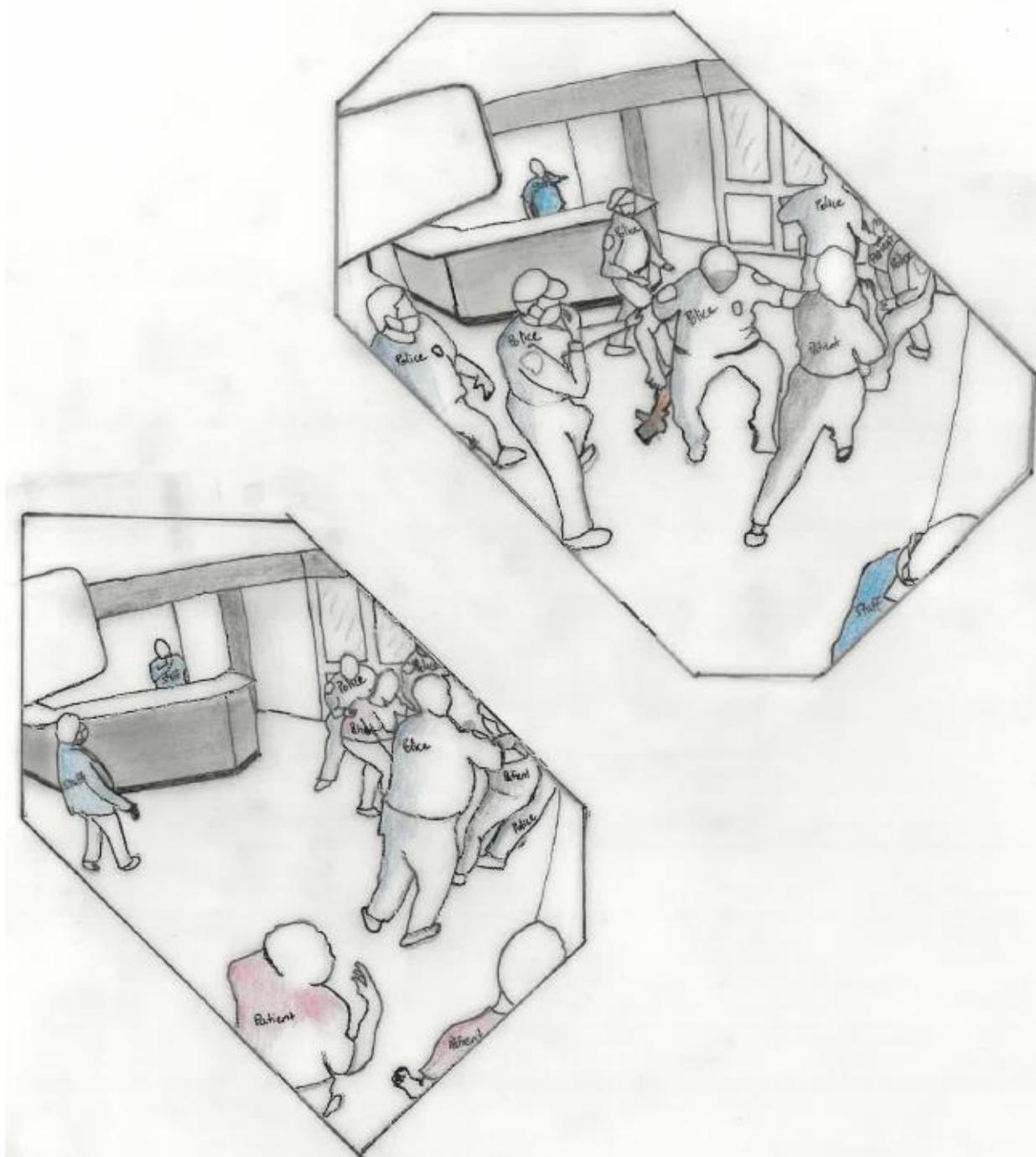
incidents, nor do they appear to provide support or comfort to either the youths involved or those who are watching. Below are videotape footage tracings of the police encounters.



Shortly after 8 p.m., the D.C. police arrive on the unit.⁴⁸ Just before more police enter the unit, a patient appears distressed then she sinks to the floor.⁴⁹



More police enter the unit as a patient can be seen with their hands in the air.⁵⁰ A police officer physically encounters a different approaching patient who appears upset and traumatized by the appearance of police. Staff look on and do not appear to intervene or de-escalate the situation.⁵¹



The police officers continue to physically block and restrain the patient while staff continue to look on. Another youth who also appears upset and traumatized by the police presence is then held back by police officers while two youths look on. Again, staff do not appear to intervene.⁵²

DRDC has not received a PIW investigation report or any evidence that PIW investigated or addressed the multiple dangerous and frightening situations captured on the videotape footage that these adolescents were exposed to, nor is there evidence that the incidents were reported to DBH or DC Health, with the exception of the stabbing incident.⁵³

Additional Dangerous Incidents on the Adolescent Unit

DRDC has received multiple allegations of similar physical altercations on the adolescent unit. DRDC reviewed the DBH Major and Unusual Incident Forms (“incident form” or “incident report”) completed by PIW which briefly describe these incidents. The videotape footage was not available for our review, however, the incident reports describe scenes that are dangerous and frightening for the youth entrusted to PIW’s care.

In April 2022, DRDC received an allegation of multiple physical altercations which resulted in a youth being injured and sent to the hospital.⁵⁴ The incident form notes “staff heard commotion coming from one of the male patient’s bedrooms” and discovered two male patients in a physical confrontation. Staff then “called a code,” and even though additional support responded, a female patient was then punched by another patient causing a contusion to her right eye.⁵⁵ (The patient was sent to the emergency room for evaluation.) “Shortly after the female physical confrontation” two more male youths engaged in a physical confrontation. The staff “notified the on-call MD and gave IM [injections] medication as necessary.”⁵⁶ The incident form does not indicate that PIW investigated these incidents, nor does it state that they reviewed the videotape. Instead, it provides a four-sentence description of separating the male and female patients onto separate units and reviewing programming as its intervention.⁵⁷ It does not describe how it will improve care. Also, PIW did not submit the incident form to DBH until over two weeks after the incident occurred.⁵⁸

Another very troubling incident occurred in June 2020. An incident form briefly describes that a group of adolescent patients became aggressive toward staff, but that staff was unable to deescalate the situation.⁵⁹ The incident report indicates that staff notified the Metropolitan Police Department and when they arrived, *they intervened and arrested seven patients.*⁶⁰ All seven patients were returned to PIW the following day, at which point they were all “medicated for agitation.”⁶¹ Having seven youth arrested was obviously not a desired outcome and was certainly traumatic for the youths who were at PIW for treatment; however, there is no evidence that the incident was investigated by PIW or DBH, nor is there evidence that PIW took any action to prevent further incidents; the “follow-up” portion of the incident form is blank.⁶²

Another incident report from February 2020 indicates patients on the adolescent unit were being aggressive and disruptive in the middle of the night.⁶³ Staff “isolated patients for privacy and safety and were able to medicate” two of the patients “without any restrictive interventions.”⁶⁴ A third patient “became combative and aggressive and was placed in a physical hold for safety” during administration of the medication.⁶⁵ One patient alleged that she was “punched in the chest area by a staff member” during medication administration.⁶⁶ Another

patient reported being “held on the neck area” by the same staff person and the third patient reported being “punched on the nose” by the same staff person.⁶⁷ Again, despite the very serious nature of the incidents, the “follow up” section of the incident form is blank.⁶⁸

Abusive Restraint and Seclusion Incidents

In addition to disturbing incidents on the adolescent units, DRDC has received numerous complaints of alleged abusive and neglectful staff practices during incidents on the adult unit, some involving restraint and seclusion. The patients involved in these incidents reported that they were fearful of PIW staff persons, and even other patients, because staff failed to adequately intervene in escalating situations or intervene at all. Sadly, these patients reported that many staff were not caring or therapeutic, and in some cases, staff were rude and disrespectful. It is particularly disturbing that the Registered Nurses on the unit appear to have either participated in these incidents and/or did not intervene to prevent staff abuse.

D.C. law, D.C. regulations and federal regulations generally prohibit the use of restraint and seclusion in psychiatric facilities such as PIW, carving out narrowly tailored exceptions.⁶⁹ These restrictions and requirements are essential to protect the safety and dignity of PIW’s patients.⁷⁰ D.C. law allows their use only in an emergency when necessary to prevent serious injury to the consumer or others.⁷¹ Restraint and seclusion must be implemented *in accordance with safe and appropriate techniques and only when less restrictive alternatives have been considered and determined ineffective.*⁷² Federal regulations also allow for restraint and seclusion only to ensure the immediate physical safety of the patient or staff and only when less restrictive interventions have been determined to be ineffective to protect the patient a staff member or others from harm.⁷³ PIW policy also has detailed requirements and restrictions related to the use of restraint and seclusion.⁷⁴

Violent Restraint of Sarah Simpson⁷⁵

DRDC’s investigation revealed that on at least two occasions staff implemented a dangerous restraint of Sarah Simpson using unapproved techniques. In both incidents, staff forced Ms. Simpson to the floor, a dangerous technique expressly prohibited by PIW policy.⁷⁶ In the first incident of restraint, six staff persons converged on Ms. Simpson causing her to fall and forcefully strike her head on the floor.⁷⁷ Staff then held Ms. Simpson on the floor with her arms held over her head for over eight minutes.⁷⁸ Ms. Simpson reports that the incidents not only caused her physical pain and injury, but they were also very frightening and traumatic for her.⁷⁹ PIW did not report the incidents of restraint and seclusion to DBH until almost three months later, and well after DRDC alerted PIW to the evidence of abuse on the videotape footage.⁸⁰

10/28/21 Incident

Videotape footage shows that for more than an hour prior to the restraint incident, Ms. Simpson appears to engage in conversations with staff and patients and pace slowly up and down the hallway.⁸¹ Ms. Simpson then appears to lunge towards a staff member. Instead of

employing an approved and appropriate intervention, six staff converged on her causing her to fall to the floor and strike her head so hard it appeared to bounce back up off of the floor.⁸² Staff then held her on the ground for eight minutes and injected a chemical restraint.⁸³ Below are tracings of the videotape footage.



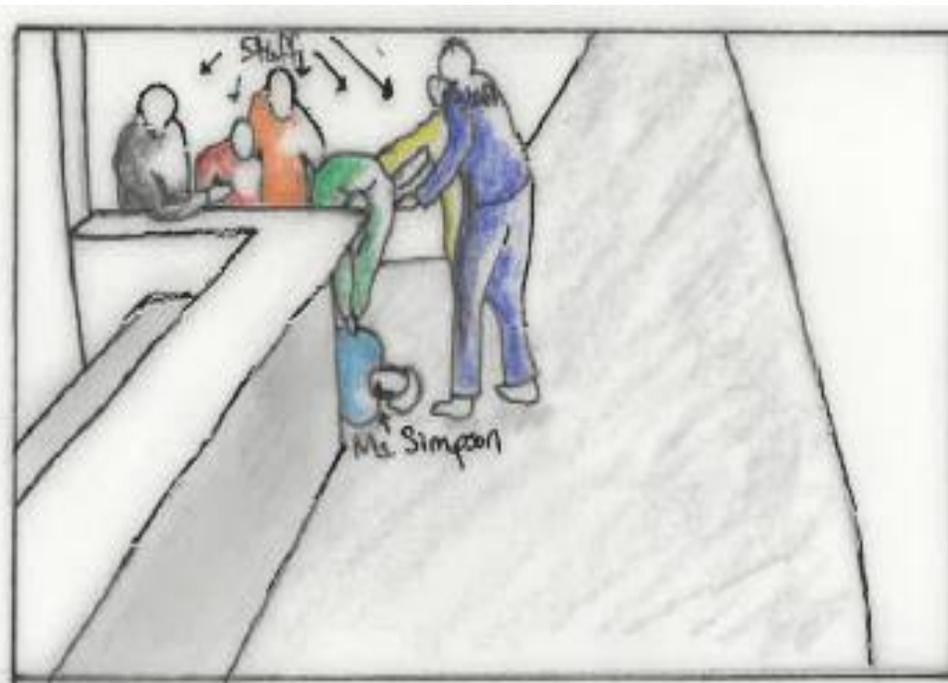
Ms. Simpson appears to lunge towards a staff person.⁸⁴



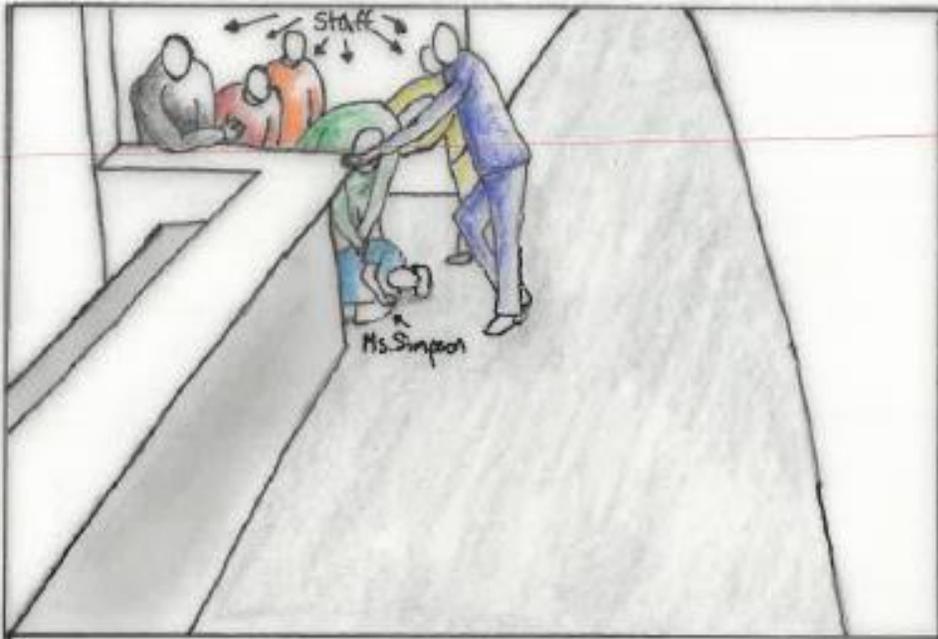
Staff converge on Ms. Simpson.⁸⁵



Ms. Simpson begins to fall or is pushed. She is surrounded by six staff persons.⁸⁶



Ms. Simpson either falls or is pushed to the floor. Her head appears to forcefully hit the floor.⁸⁷



Ms. Simpson's head appears to bounce back up off the floor.⁸⁸



A staff person pulls Ms. Simpson's arms up and over her head in a restraint and holds her in this restraint position for over 8 minutes.⁸⁹

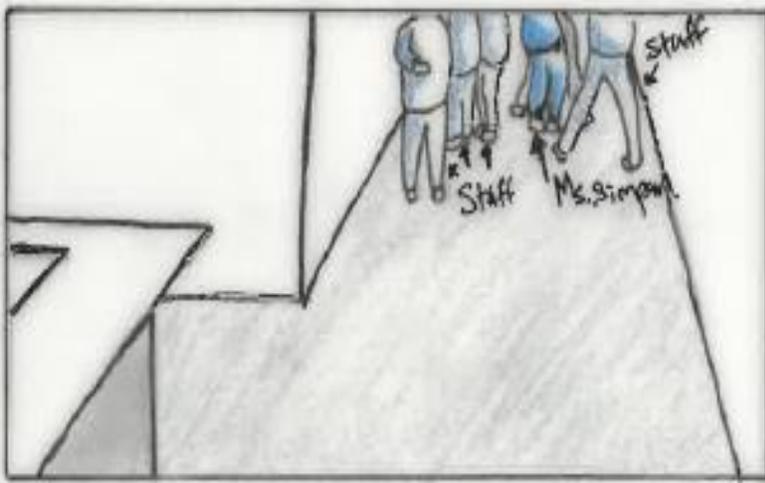


Staff let go of Ms. Simpson and she stands up on her own. Eight staff persons and another patient look on.⁹⁰

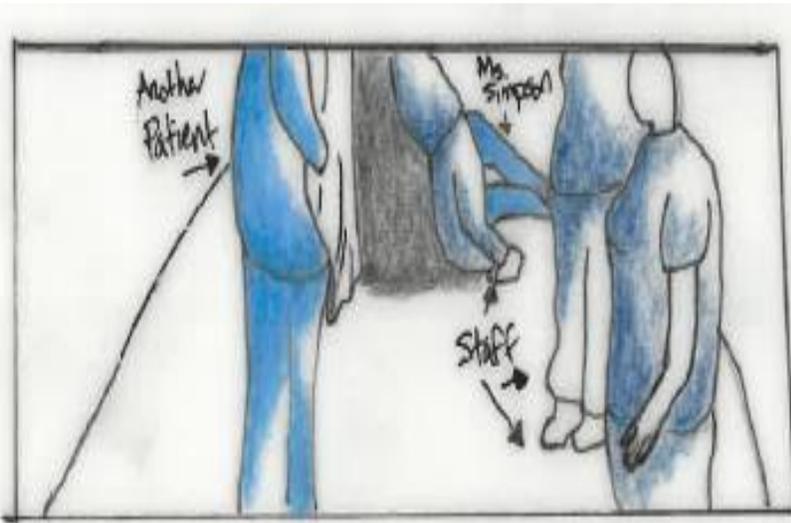
Inexplicably and disturbingly, except in the incident report prepared *after* DRDC reported the complaint, the PIW nursing and psychiatric staff failed to document that this significant physical restraint incident occurred at all. The record contains an order for a chemical restraint but not a physical restraint.⁹¹ Similarly, nursing progress notes indicate that staff administered an injection of multiple psychiatric medications, yet the nurses failed to document the physical restraint which caused Ms. Simpson to fall, nor did they document that they held her on the floor to administer the injection.⁹² Moreover, the psychiatry note from the day after the incident merely indicates that Ms. Simpson “required emergency medication last night for aggressive behavior,” indicating the psychiatrist was not even aware of the violent actions staff used to physically restrain her.⁹³ Shockingly, the record contains no evidence that a nurse or doctor assessed Ms. Simpson for physical injuries after the restraint or evaluated the seriousness of possible head injury and the impact of the use of subsequent involuntary medication.

10/29/21 Restraint and Seclusion

The next day staff again improperly physically restrained Ms. Simpson, injected her with a chemical restraint and placed her in the seclusion room. Although difficult to see because of the position of the video camera, staff appear to engage in a physical altercation with Ms. Simpson, take her to the floor and physically restrain her on the floor for more than nine minutes.⁹⁴ Medical records indicate that an RN administered a drug as a restraint via an injection during the restraint.⁹⁵



Staff surround Ms. Simpson who can be seen in blue scrubs. A struggle ensues.⁹⁶



Staff continue to restrain Ms. Simpson who appears to be being held on the floor by staff for approximately nine minutes.⁹⁷

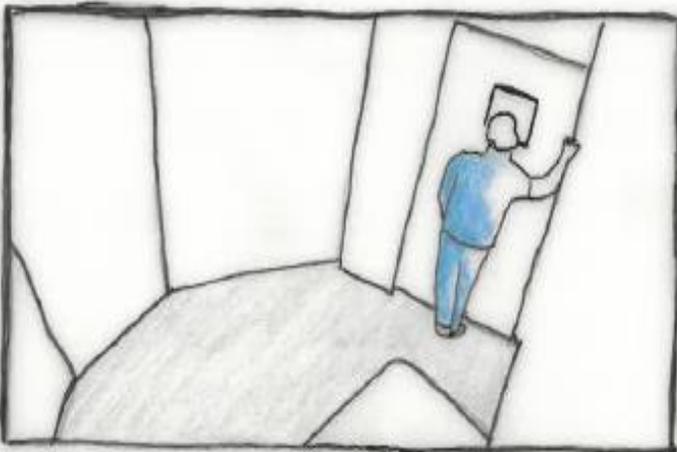
Approximately eight minutes later she is seen in the seclusion room where she remains for over an hour, despite being calm and showing no signs of agitation.⁹⁸ At no point did a Registered Nurse or psychiatrist come into the seclusion room to assess her for injuries.



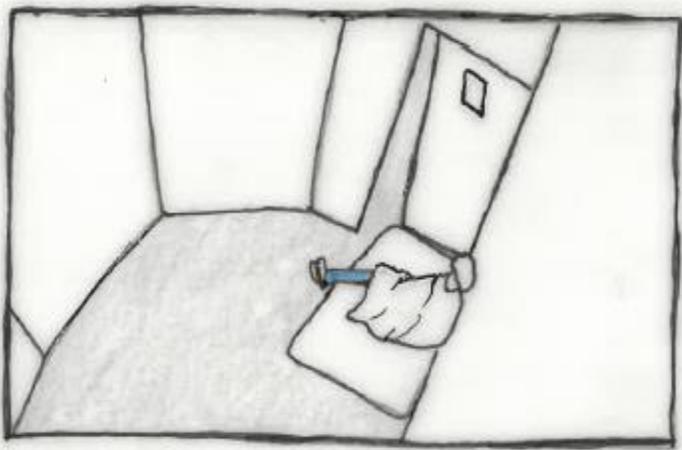
Staff lock Ms. Simpson in the seclusion room at 12:18 pm.⁹⁹



Ms. Simpson appears calm the entire time she is in the room, at times sitting or lying on the mattress.¹⁰⁰



Ms. Simpson stands at the door and look out the window. She does not appear agitated.¹⁰¹



*Staff finally release Ms. Simpson at 1:32a.m., over an hour from when they first locked her in seclusion.*¹⁰²

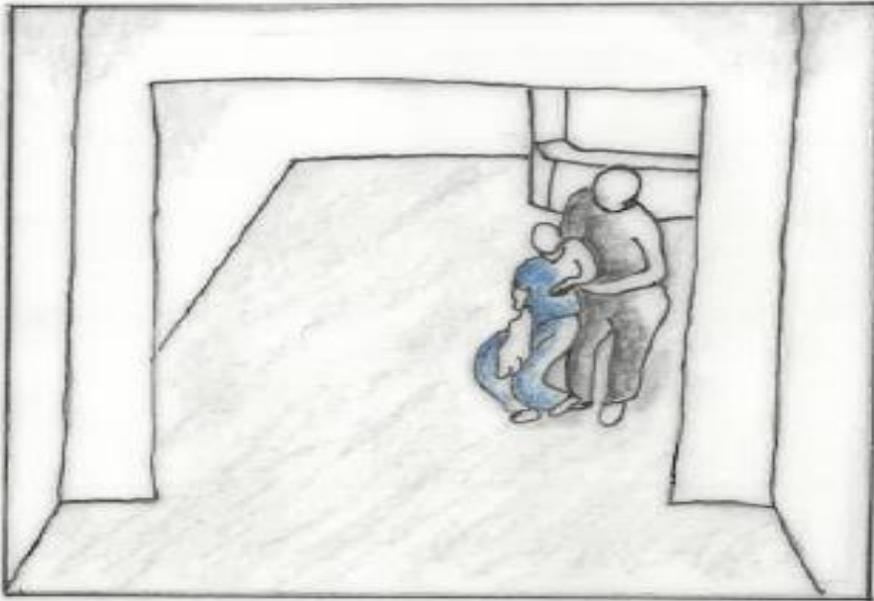
Staff's unsafe actions during these restraints and seclusion of Ms. Simpson violated multiple D.C. laws, federal regulations, and PIW policy requirements, including failure to use safe and appropriate seclusion and restraint techniques and failure to attempt less restrictive alternatives.¹⁰³ As previously noted, PIW's policy *specifically provides* that "in no case may a patient be taken to the floor."¹⁰⁴ D.C. law requires a restraint or a seclusion to end at the earliest possible time, regardless of the length of time indicated in the order.¹⁰⁵ Therefore, staff were required to end the seclusion when Ms. Simpson appeared calm.

After viewing the videotape footage, DRDC also reported the incidents to DBH.¹⁰⁶ Their investigation also found that PIW used improper and unsafe technique during the restraint causing Ms. Simpson's body and head to hit "the floor hard."¹⁰⁷ Equally as disturbing is the finding that PIW failed to provide timely medical care after Ms. Simpson complained of arm pain, including that they did not obtain an x-ray, which confirmed swelling, until five days after she initially complained of the arm pain.¹⁰⁸ DBH also noted that PIW failed to report the incident in a timely manner and failed to provide DBH with "any [of] the requested documents regarding their internal investigative report, retraining or any disciplinary actions."¹⁰⁹ Additionally, staff reported to the investigator that they had no memory of being interviewed by hospital management about the incident *and that their shifts were frequently understaffed.*¹¹⁰

Abusive Restraint and Seclusion of Maria Peters¹¹¹

DRDC's investigation into another allegation of abusive use of seclusion and restraints revealed an equally disturbing incident where a male staff person dragged Maria Peters across the floor twice and then pushed her into a room. Ms. Peters reported that she was crying throughout the encounter and asking to call her family and that the male staff person demanded that she get up from the floor and called her "disgusting" several times.¹¹² She indicated that she resisted being forced in the room because she was very frightened, and *she was fearful that the staff person was going to sexually assault her.*¹¹³

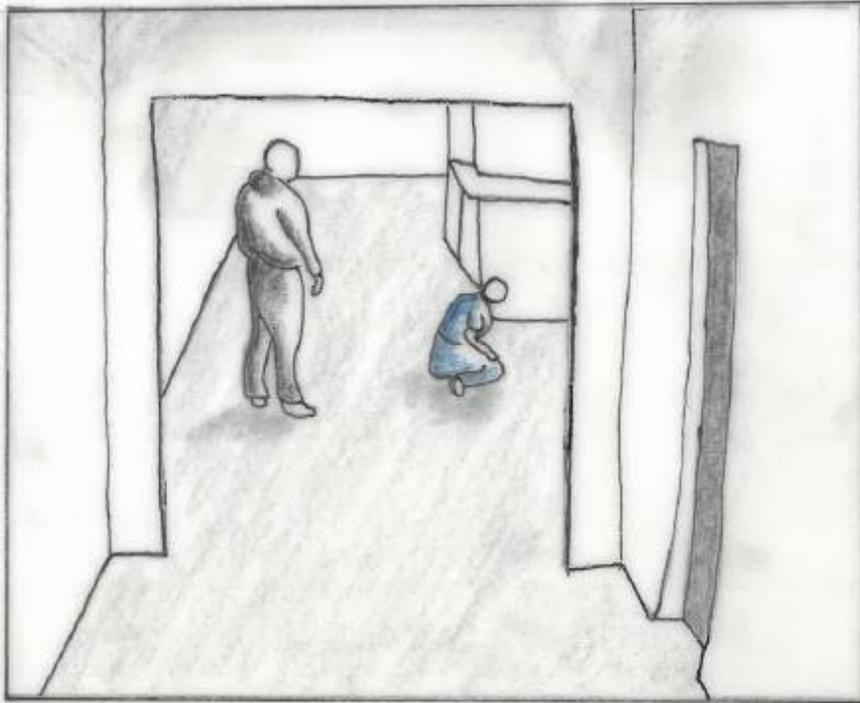
Videotape footage of the incident begins with Ms. Peters kneeling hunched over on the floor.¹¹⁴ A male staff person then approached her and appeared to pick her up under her arm and drag her across the floor.¹¹⁵ Ms. Peters then appeared to crawl back to the nurses' station and continue to kneel on the floor. About fifteen minutes later, the same staff person approached her again, appeared to drag her across the floor again and physically force her into a room.¹¹⁶ Ms. Peters appears to resist being forced in the room. Below are tracings from the PIW videotape footage.



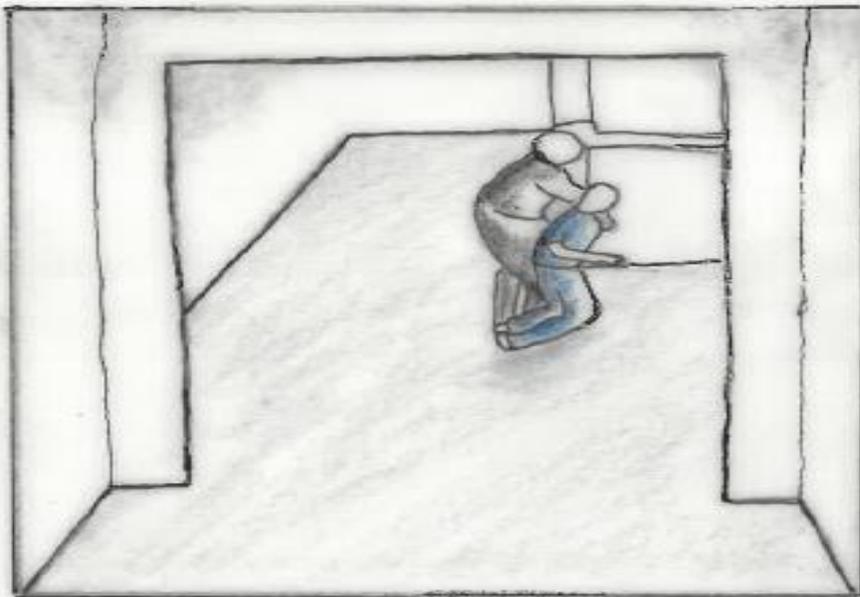
A male staff person picks up Ms. Peters and drags her across the floor.¹¹⁷



The staff person releases Ms. Peters.¹¹⁸



Ms. Peters crawls back and kneels by the nursing station. The staff person approaches Ms. Peters again, approximately fifteen minutes after he dragged her the first time.¹¹⁹



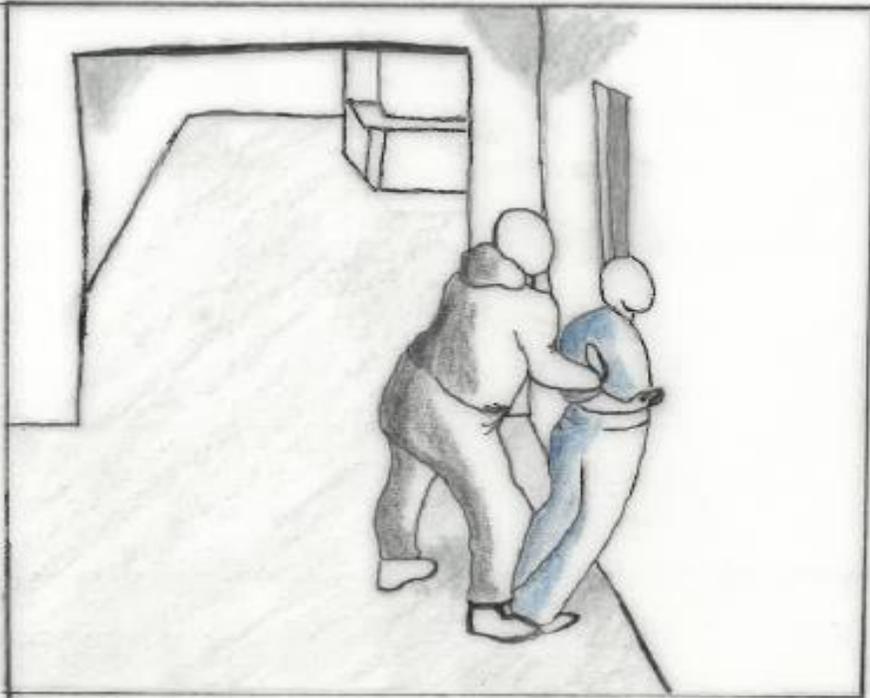
The staff person begins to drag her across the floor again.¹²⁰



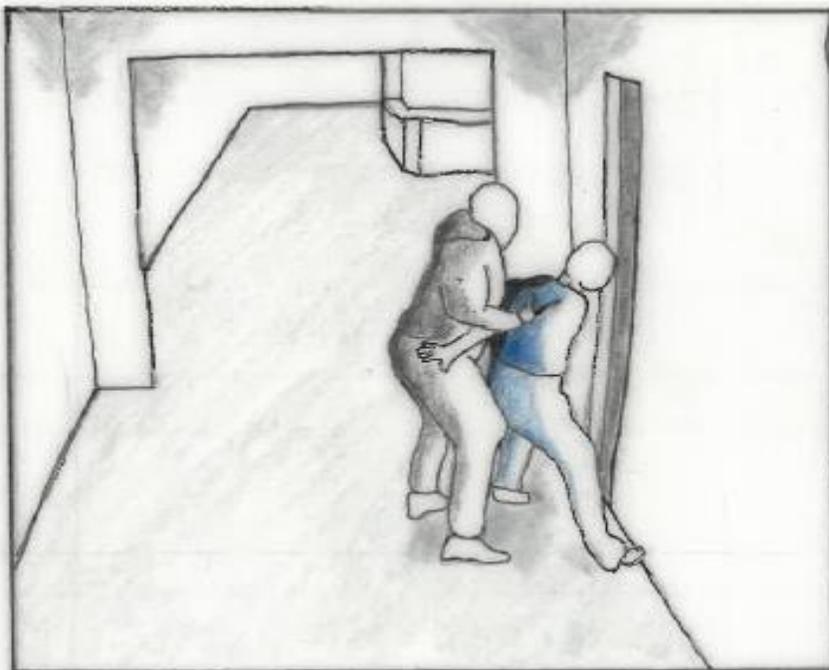
The staff person continues to drag Ms. Peters down the hallway.¹²¹



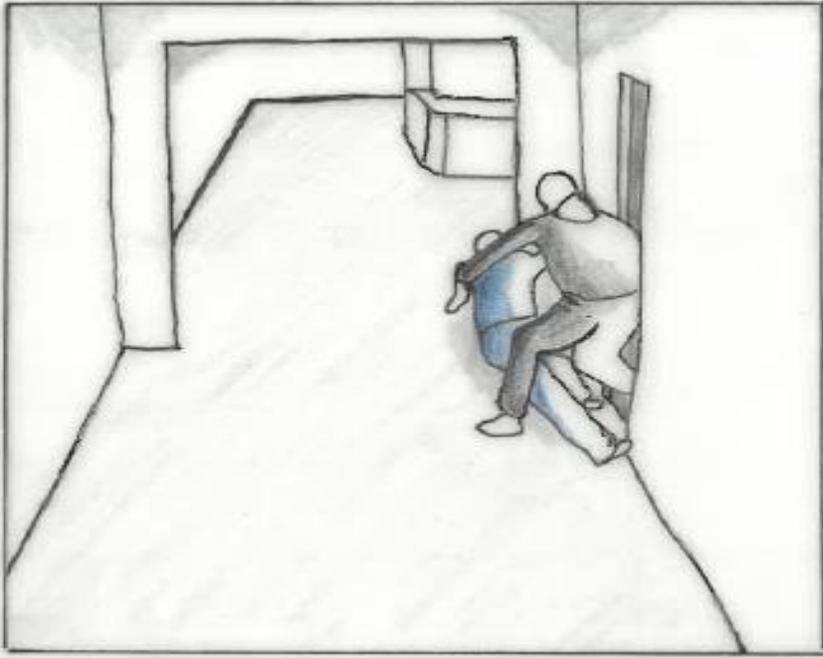
The staff person attempts to push her into a room. Ms. Peters resists by placing her foot on the outside of the door.¹²²



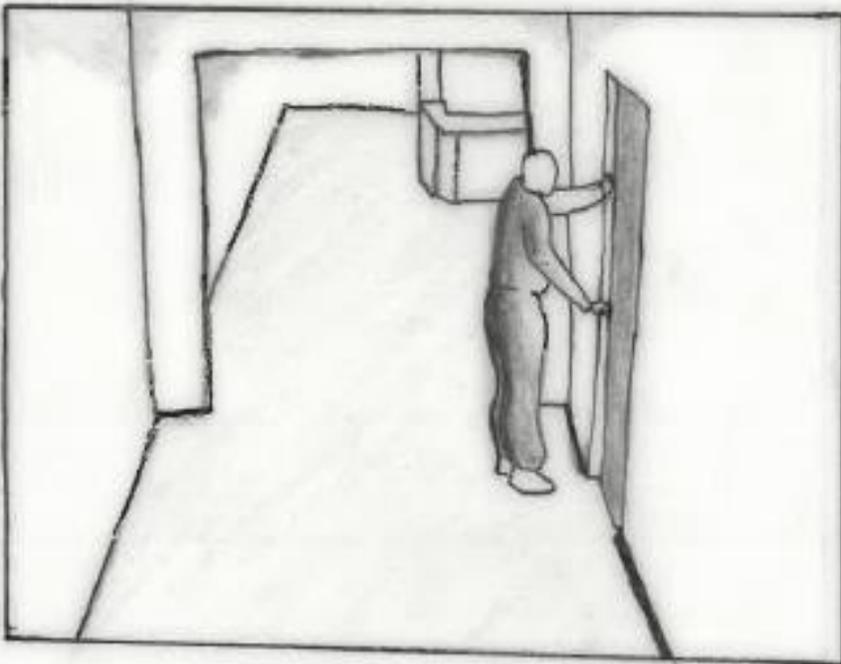
The staff person, grabs her and pulls her away from the wall.¹²³



Ms. Peters again resists being forced in the room by planting her feet on the floor.¹²⁴



The staff person forces Ms. Peters into the room.¹²⁵



The staff person holds the door closed for 5 minutes.¹²⁶

The staff's actions are abusive and clear violations of multiple D.C. laws and federal regulations, which allow physical restraint and seclusion only as a last resort if the individual is an imminent danger, only after less restrictive alternatives are attempted, and only if approved physical restraint techniques are used -- none of which occurred here. Nursing documentation

regarding the incident appears to be falsified, or at best, neglectfully incomplete. The nightshift staff progress note indicates that Ms. Peters was observed crawling and crying in the hall, that she “wants to talk to her family,” that the doctor ordered an injection of Benadryl and Ativan “for psychosis” and that “*no physical hold and no code was called.*”¹²⁷ This documentation contradicts the videotape footage as described above. The physical restraint and seclusion are not documented in the record, nor does the doctor appear to have been notified of the physical encounter. The PIW incident report indicates that “PIW opened an investigation,” however, PIW has not provided DRDC with an investigation report.¹²⁸ Also, the incident report form was not completed until almost two months after the incident occurred.¹²⁹

Ms. Peter’s records also indicate that PIW administered a chemical restraint (or drugs as a restraint) to her on multiple occasions.¹³⁰ Ms. Peters reported to DRDC that she did not consent to any of the injections, that she explicitly told staff that she did not want them, and that she was greatly concerned when staff injected her with powerful psychotropic medications that she did not want and felt she did not need.¹³¹ D.C. law states that except in limited circumstances, no patient shall be administered medication for mental health treatment without written informed consent.¹³² D.C. law carves out very narrow exceptions to informed consent for medication and classifies medication administered during an emergency as “drugs used as a restraint.”¹³³ In addition to requiring their use only in an emergency and only after less restrictive interventions are attempted, D.C. regulations have additional specific requirements including that the physician ordering a drug(s) to be used as a restraint shall conduct a face-to-face assessment within one hour and that nursing staff person regularly assess the consumer for the first two hours after the drug is administered.¹³⁴ Although Ms. Peters was exhibiting some concerning and disruptive behaviors, the records contain no evidence that staff attempted less restrictive alternatives prior to the injections, nor is there evidence a physician assessed her within one hour after the injections as required.¹³⁵

Similar Improper and Dangerous Restraints

DRDC recently received another allegation that PIW staff were physically abusive during a restraint. DRDC received and reviewed a PIW “Investigation Summary,” which indicates that when a female patient was exhibiting aggressive behaviors, staff intervened, “struggled to get her in a more secure hold,” then “eventually got [her] into a supine hold.”¹³⁶ The summary notes that “while in the supine hold, [the patient] continued to attempt to bite and spit at staff, *so staff laid a face mask over her mouth and put a face shield over her face.*” The patient then “transitioned from agitated to anxious and started shaking and crying, *stating she could not breathe.*”¹³⁷ Staff’s actions as described in the investigation summary are dangerous and violate D.C. regulations which specifically prohibit covering a patient’s face with any material or object during the process of restraint or seclusion.¹³⁸ Also, the summary indicates that staff held the patient in a supine position.¹³⁹ While it is not clear from the summary if staff held the patient on the floor, as noted above, PIW prohibits a staff person from taking a patient to the floor.¹⁴⁰

Another patient alleged that in April 2022, a PIW staff person pulled her arm and pushed her across the floor, causing bruises.¹⁴¹ Additionally, she reported staff physically

restrained her several times and that staff twice gave her injections she did not want.¹⁴² She told DRDC that the nurses were frequently not on the unit but instead stayed in the nurses' station and came out to give patients shots or medication. She also complained the unit was frequently understaffed and that sometimes no staff were in the day room.¹⁴³ Finally, in another episode, an incident report from January 2022 indicates that a patient sustained a facial injury and swelling to the left side of his face after videotape footage showed that staff "used improper technique."¹⁴⁴ Although DRDC did not review the videotape footage, the incident report notes that the staff "failed to display proper use of a physical hold" and "failed to report the incident," but does not provide further details or a description of staff actions on the videotape or a description of how to avoid such an incident in the future.¹⁴⁵

Additional Improper Administration of Drugs as a Restraint

In addition to the previous incidents described above, DRDC investigated two other incidents where PIW staff allegedly administered drugs as a restraint and forcibly injected patients with psychiatric medication against their will. In the fall of 2021, PIW patient Sarah Miller¹⁴⁶ reported that prior to an injection, three male staff and a female nurse approached her and told her she had to accept an injection, which she reported was very confusing and frightening to her.¹⁴⁷ Ms. Miller reports that she did not consent to the medication and told staff that she did not want it. Although progress notes indicate that Ms. Miller was "irritable," "threatening," and "cursing," the record contains no evidence that Ms. Miller was an imminent threat, nor that staff considered or attempted any less restrictive alternatives prior to the administration of the apparent chemical restraint, as the law requires.¹⁴⁸ Similarly, another patient, Jane Pearson¹⁴⁹ reported that in April 2022, multiple male PIW staff held her on her hospital bed and injected her with medication against her will after she became upset and wanted to speak to her doctor.¹⁵⁰ Ms. Pearson described the incident as a very traumatic experience.¹⁵¹ PIW staff's documentation regarding Ms. Pearson's restraint was equally troubling, noting only that "she became more violent and was given IM injection" but failing to provide any further detail about the alleged violent behavior.¹⁵² The psychiatrist fails to note any incidents of "violence" in the psychiatry progress notes.¹⁵³ The documentation only notes that Ms. Pearson "was given" an injection, but fails to indicate that physical hold or restraint was implemented, as reported by Ms. Pearson.¹⁵⁴ Again, staff did not document any attempt to employ less restrictive alternatives prior to the physical and chemical restraint as required.

Moreover, the records contain no evidence that the psychiatrist conducted a face-to-face assessment of either Ms. Miller or Ms. Pearson within one hour of administration of the medication, as required by D.C. regulations for drugs used as a restraint, nor is there evidence that nursing staff regularly assessed Ms. Miller or Ms. Pearson for the first two hours after administering the apparent drugs used as a restraint, as required by D.C. regulation.¹⁵⁵ This is especially concerning given that records indicated that staff "redirected" Ms. Miller to go to her room "several times" to prevent falling,¹⁵⁶ and that Ms. Miller reported that she fell after the administration of the drugs as a restraint and injured her back.¹⁵⁷

Patients Injured During Incidents

Another PIW patient recently indicated that he was punched in the nose by another patient, which caused him to fall to the floor and sustain a laceration and nasal fractures.¹⁵⁸ The patient reported that he attributes the attack to understaffing since only one staff person and no RNs were on the unit at the time he was attacked.¹⁵⁹ He indicated that prior to the incident, he reported to staff that he felt unsafe and had been threatened by two other patients, but staff did not adequately intervene and only told the other patients to not get close to him.¹⁶⁰ According to the incident report, the incident was “unwitnessed by staff.”¹⁶¹ The patient was sent to the emergency room, and in addition to the laceration, a CT scan showed that he sustained multiple nasal fractures.¹⁶² The incident report was submitted to DBH two months late, and DRDC did not receive an investigation report from PIW as requested and required by federal law.

Also recently, another patient relayed that he was physically assaulted by another patient in June 2022.¹⁶³ He reported that his scrubs were torn, that he was hit in the face and his glasses were knocked off, and that there was only one staff person in the dayroom who did nothing to intervene. He also reported witnessing a fight between two other patients later that same day when the unit was again understaffed.¹⁶⁴

III. THE POLICE RECEIVE CALLS FROM PIW AT ALARMING RATES

In February 2022, DRDC received a log of phone calls made from PIW to the Police Department. Although it is not clear who actually made the calls, and they could be made by patients or family members in addition to staff, the log indicates that the police are receiving calls from PIW frequently. The police logs reveal that between March 2019 and February 2022, someone from PIW called the police on 368 days for a total of 700 calls.¹⁶⁵ Police receive calls on more than 60 percent of the days listed, with an *overall average of 1.2 calls per day*.¹⁶⁶ Alarming, there were eighty-eight days (13%) where between three and seven calls were made.¹⁶⁷ *The frequent calls to DC police raise questions as to whether PIW has sufficient staffing ratios, staff support, and staff training.* The log lists a one-word category as the reason for each call but does not provide further detail. Twenty-eight percent (28%) or 190 calls were labeled as “MENTAL,” (although it is not clear what type of call the police would consider to be a “mental” call). **Ninety-nine calls (14%) were labeled as assault.**¹⁶⁸ Seventy-six calls (11%) were labeled as disorderly, eleven calls (2%) were labeled suicide attempt, six (1%) were thefts, and twenty-four

(3%) were threats.¹⁶⁹ Finally, and equally as disturbing, thirty-five calls (5%) involved a missing person, most labeled as “missing person critical.”¹⁷⁰

The high number of calls from PIW to the police department adds to DRDC’s concerns that many more incidents may be occurring in addition to the ones we are receiving as complaints. Although PIW has facilitated DRDC in conducting *virtual* outreach and monitoring during the pandemic, PIW has continued to deny DRDC access to in-person monitoring and outreach even though other institutional settings have allowed us to return in person.¹⁷¹ In-person monitoring is a critical to DRDC’s role because patients learn about services from us directly, patients can freely discuss issues with DRDC in private, and DRDC can observe the unit.

IV. PIW’S INCIDENT AND INVESTIGATION SYSTEM IS INADEQUATE

An adequate quality improvement program, which includes incident reporting and conducting in-depth investigations, is essential for maintaining patient safety and ensuring quality care, as well as reducing incidents of abuse and neglect and preventing them. For these reasons, CMS requires PIW to have an adequate quality improvement system.¹⁷² DRDC’s investigations into allegations of abuse and neglect at PIW raise serious questions about the efficacy of PIW’s risk management system. Among other requirements, PIW must report major unusual incidents (“MUIs”) to DBH.¹⁷³ (MUIs are also referenced in this report as “incident reports” or “incident forms”). Among the categories that DBH identifies as MUIs are: restraint, seclusion, suicide attempts, physical assault, sexual assault, physical abuse, physical injury, death, psychological or verbal abuse, neglect, medical emergencies, and falls.¹⁷⁴ DBH policy further provides that MUIs must be reported timely and accurately.¹⁷⁵ However, despite these multiple reporting requirements, *PIW has failed to send the requisite MUIs to DBH for years*, significantly hampering DBH’s critical oversight a role. In fact, according to DBH, from April 2021 through June 2, 2022, PIW had only submitted four MUIs to DBH.¹⁷⁶ Of the four, three involved incidents that DRDC investigated and were not submitted until well after DRDC notified PIW of the allegations. This is quite alarming and raises questions as to whether serious incidents at PIW are going unreported.¹⁷⁷

Equally as important is a hospital’s internal investigatory process. As such, PIW’s own policy requires that they conduct rigorous investigations, stating that PIW will conduct a “full investigation” for all hospital occurrences “for which all details are not self-evident.”¹⁷⁸ Moreover, DBH Policy requires PIW to submit a follow-up report or internal investigation report to DBH within ten business days, if requested by DBH, following the provider’s internal

procedures for investigations.¹⁷⁹ DRDC has repeatedly requested that PIW provide its internal investigation reports and requested that DBH and DC Health provide any PIW prepared investigation reports in their possession. Although PIW represents that they conduct investigations into certain incidents, *DRDC has yet to receive a single full investigation report.*¹⁸⁰ In August 2021, DC Health found that PIW repeatedly failed to ensure adequate follow-up and investigation of incidents in accordance with their own hospital policy.¹⁸¹ The DC Health inspection revealed that a total of 50 incidents had not been investigated in the 21 days, and there was no additional documented evidence of any follow-up in response to the incidents.¹⁸² Moreover, the DC Health inspection report also noted that PIW did not have a risk manager for months – that as of July 29, 2021, the risk manager position had been vacant since “the last of April.”¹⁸³

V. DC HEALTH SURVEYS AND INVESTIGATIONS DOCUMENT SERIOUS PIW NEGLECT

DC Health licenses and certifies health care facilities for compliance with state and federal health and safety rules and regulations by scheduling and conducting on-site surveys of facilities and hospitals in the District.¹⁸⁴ DC Health conducts surveys to identify deficiencies that may affect state licensure or eligibility for federal reimbursements under the Medicare and Medicaid programs.¹⁸⁵ These regular, on-site surveys allow DC Health “to ensure health, safety, sanitation, fire, and quality of care requirements.”¹⁸⁶ DC Health also conducts investigations and complaint surveys. Disability Rights DC reviewed several surveys and associated investigation reports from May 2021 through February 2022. These investigations and surveys reveal serious and concerning deficiencies at PIW that violate multiple CMS Conditions of Participation.¹⁸⁷

PIW Staff Neglected a Dying Patient

DRDC investigated an allegation of serious nursing neglect related to a patient death that occurred at PIW in April 2020, which we described in detail in a report released in June 2021, and which we reported to DC Health.¹⁸⁸ Videotape footage revealed that during the time in which nursing staff left the patient unsupervised, he became unresponsive and appeared to stop breathing.¹⁸⁹ Once staff, including nursing staff, discovered him in this condition, they did not act. Inexplicably, *they failed to properly assess him, failed to perform CPR, and failed to provide any potentially lifesaving treatment for at least 21 minutes.*¹⁹⁰ In addition, although a physician ordered a patient to receive 1:1 staffing for safety purposes, nursing staff failed to follow this order.¹⁹¹

After reviewing the videotape footage, DRDC reported the neglect to DBH and DC Health in July 2020. DC Health’s final investigation report, provided to DRDC in May 2021, uncovered multiple significant violations of federal regulations and concluded that nursing staff failed to ensure the patient’s right to receive care in a safe setting.¹⁹² DC Health’s findings included that the nursing staff failed to touch or perform a hands-on assessment of the patient after video footage shows he stopped moving.¹⁹³ The investigation also found that *on the day prior to his death*, staff failed to document that the patient experienced a “code blue” incident and was unresponsive with a very low oxygen level. Equally as troubling, nursing staff failed to notify the doctor about the incident.¹⁹⁴

DC Health Found Multiple Deficiencies When Investigating an Allegation of Sexual Assault

In July 2021, DRDC investigated an allegation that a PIW patient was sexually assaulted by another patient and reported the allegation to DBH and DC Health. While DC Health could not conclusively substantiate the allegation, they did substantiate inappropriate and nonconsensual touching of the patient and noted that “PIW willfully facilitated or enabled the abuse or harassment of [the patient] by not taking appropriate precautions and not responding appropriately.”¹⁹⁵ DC Health cited multiple deficiencies including that staff failed to ensure the incident was properly reported and investigated in accordance with PIW policy, noting that PIW “presented an incident report completed by nursing staff” but did not provide an investigation report or “any further documentation,” nor did PIW notify any relevant external agencies of the sexual assault allegation.¹⁹⁶ The investigation also cited PIW for staffing deficiencies -- noting an insufficient staffing on four of seven units reviewed -- and found that nursing staff failed to follow a doctor’s order for one-to-one staffing and every 15 minute checks for a patient.¹⁹⁷

DC Health Surveys Revealed Significant PIW Staff Deficiencies

Annual and complaint surveys conducted by DC Health in 2020 and 2021 revealed multiple violations of CMS Conditions of Participation, placing patients at PIW at serious risk.¹⁹⁸ These deficiencies included insufficient numbers of qualified personnel to ensure an ability to provide care to all patients, and failure to ensure a safe and secure environment for patients.¹⁹⁹ The surveys found that PIW failed to comply with required staffing conditions and had an inadequate number of Registered Nurses and Psychiatric Counselors to provide care to patients.²⁰⁰ The May 2021 survey noted that PIW nursing staff failed to properly address the needs of patients on sexual aggression precautions, including that staff failed to develop a plan of care after a sexual encounter between adolescent patients and that staff failed to conduct 15 minute checks for sexual aggression as ordered by the physician.²⁰¹ Additionally, nursing staff failed to clarify parameters for the administration of hypertensive medication, failed to ensure vital signs were completed as ordered, and failed to update treatment plans.²⁰² Moreover, the May 2021 survey found the medical staff failed to obtain consent for the administration of psychotropic medications, which was a repeat deficiency from a survey conducted in January 2020.²⁰³

The May 2021 survey also reported that nursing staff at PIW left nursing stations open and unattended with potentially dangerous objects readily available to patient access, including unsecured telephone cording, alcohol-based hand sanitizer bottles, and a metal flashlight.²⁰⁴ Findings also revealed PIW's failure to ensure the maintenance of the facility in a sanitary manner for the safety of patients.²⁰⁵ Unsanitary conditions were documented in the toilets of two rooms and the showers of twelve rooms,²⁰⁶ and hot water temperatures for showers in some patient rooms were found to be as low as 67 degrees Fahrenheit.²⁰⁷

DC Health conducted a survey in February 2022 in response to four complaints received, which revealed repeat violations and additional evidence of violations that continue to put patients at risk.²⁰⁸ DC Health's review of daily staffing documentation revealed PIW's continuing failure to ensure adequate numbers of staff.²⁰⁹ For example, on one day in February 2022, staffing records showed six instances of insufficient staff across four different units.²¹⁰ Review of medical records revealed significant medication errors. *All* patient medical records reviewed demonstrated errors, including the administration of the incorrect dosage of medication, administration by the incorrect route, administration of the wrong medication, and administration without a physician's order.²¹¹ Further, the review revealed alarming inconsistencies between Medication Administration Records completed and Controlled Substance Administration Records indicating medication was removed but not administered.²¹² Review of patient medical records also revealed continued failure to obtain consent for the administration of psychotropic medication -- a failure cited in 2020 and 2021 as discussed above -- as well as the failure of a physician to sign orders given for chemical restraints.²¹³

The survey also revealed that clinical staff failed to accurately document that a patient's doctor's order contained fall precautions and staff failed to adhere to the level of monitoring required.²¹⁴ In a separate instance, staff failed to update one patient's individualized care plan after a reported patient fall.²¹⁵ Clinical staff also failed to complete important information on the "Leaving Against Medical Advice" forms for six of 17 patient records reviewed, and failed to complete discharge in accordance with hospital policy for five of eleven records reviewed.²¹⁶ The surveyors also observed a patient advocate failing to wear proper PPE when engaging in conversation with a patient with her mask pulled down and without a face shield.²¹⁷ The survey also found that patients continued to endure no hot water for showering or hand washing, as hot water temperatures in most patient rooms continued to be significantly below the allowable range and as low as 56 degrees.²¹⁸

VI. SYSTEMIC FAILURES

Systemic, chronic abuse and neglect in institutional settings likely has multiple root causes. Poor and ineffective leadership and administration, insufficient staffing, insufficient staff

support, insufficient staff training, and an ineffective and insufficient risk management system can all contribute to systemic failures. DBH, DC Health, and PIW must each address all such deficiencies and ensure the safety and well-being of the patients at PIW. In addition to an insufficient risk management department, examples of other possible approaches are discussed below.

Inadequate Staff Training and Support

DRDC has been told by numerous patients that a “culture” exists on the units where staff do not treat patients with respect, dignity or caring. Patients report that the nursing staff frequently stay behind the desk in the nurses’ station and react as though they are annoyed when approached by patients. Patients repeatedly report that they do not feel safe, and that staff do not intervene when other patients threaten them or physically attack them.

According to an article in the JAMA Health Forum, “inpatient psychiatry that serves individuals in their greatest time of need, is broken.”²¹⁹ The authors report disturbing common statements made by inpatient psychiatric patients similar to those expressed to DRDC by PIW patients, such as “my most recent hospitalization experience felt more like a prison than a place of healing;” “I am terrified of hospitals and have no idea how to get help when I need it;” “I just stay quiet and isolate myself away;” and “I was not suicidal when I entered this unit, but I was when I left.”²²⁰ The authors opine that a “patient-centered care (PCC)” approach, which is “respectful, transparent, and responsive to patients’ needs and preferences” should be prioritized and is “central to evidence based models for preventing and reducing conflict, trauma, and use of restraint and seclusion.”²²¹

Nursing Administration and Nursing Leadership

As discussed throughout this report, numerous DRDC investigations reveal evidence of an inadequate staff response to agitated patients or that, sometimes, staff’s action escalates situations and physical altercations. The safety and treatment issues raised in this report may result from a lack of nursing leadership, which can be reflected in abusive and illegal actions, the failure of RN intervention, and poor nursing documentation. According to an expert in patient safety on psychiatric units, “Nurses play an important role in patient safety, especially in inpatient psychiatric wards ... The head nurse plays an important role in encouraging patient safety culture among other nursing staff. The head nurse should do the following: communicate effectively, contribute to leadership, maintain a positive culture and provide patient-centered care. The presence of nurses with experience in dealing with psychiatric patients is strongly connected to the high quality of patient care and to better outcomes.”²²² According to a leading mental health journal, although psychiatric staff face both verbal and physical aggression, conflict is “less likely to exist in a setting characterized by strong leadership, effective staffing practices, a culture of cohesiveness, and effective communication and structure.”²²³

VII. CONCLUSION

Disability Rights DC cannot overstate our concern for the patients at PIW. The steady and ever-increasing stream of serious allegations of abuse and neglect from PIW patients and other stakeholders and findings from DRDC's and government agencies' investigations, as described herein, are extremely alarming. At a minimum, DBH, DC Health, and PIW must ensure that patients are safe. PIW represents that their goal is "to provide a stabilizing, healing environment" and that "[e]xcellence in behavioral health programs for children, adolescents and adults has been the mission of [PIW] since it opened nearly 50 years ago." These statements do not reflect how many patients described their stay at PIW, and this is not what multiple investigations uncovered.

DISABILITY RIGHTS DC RECOMMENDATIONS

- (1) PIW, with support from DBH, should retain the services of an independent consultant specializing in trauma informed care and the reduction and prevention of dangerous incidents in institutional settings.
- (2) DBH and DC Health must provide increased and meaningful oversight of PIW, including review and correction of PIW's quality improvement system, which must have reliable incident reporting and a robust investigatory process. Both DBH and DC Health must require PIW to adhere to all legal and policy requirements related to incidents and investigations.
- (3) PIW must examine the current staff ratios and increase staffing to levels that ensure a safe environment. Minimal staffing ratios may not be sufficient to keep the units safe.
- (4) PIW should allow DRDC in person access to conduct outreach and monitoring and provide DRDC with all requested records as required by federal law.

¹ Disability Rights DC expresses gratitude for the contributions made to this report by Arie Wright, a J.D. Candidate at Georgetown University Law Center.

² Disability Rights DC has the authority to “investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to [Disability Rights DC] or if there is probable cause to believe that the incidents occurred.” 42 U.S.C. § 10805(a)(1)(A).

³ *A Disturbing Death: A Lack of Oversight at the Psychiatric Institute of Washington* (June 2021) <https://www.uls-dc.org/media/1209/abuseunabatedfinal.pdf>.

⁴ DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 19-20 (Completed: February 18, 2022); DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 7-8 (Completed: August 31, 2021); DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 8 (Completed: May 17, 2021).

⁵ DC Health Investigation Report DC-10133 at 6-7 (Not dated).

⁶ DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 19-20 (Completed: February 18, 2022); DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 7-8 (Completed: August 31, 2021).

⁷ DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 12-14 (Completed: May 17, 2021).

⁸ *Id.* at 8-11.

⁹ DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 57-60, 62-63 (Completed: February 18, 2022).

¹⁰ DC Health Investigation Report DC-10133 at 6 (Not dated).

¹¹ *Id.*; DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 4-7 (Completed: August 31, 2021).

¹² DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 10-11 (Completed: August 31, 2021).

¹³ DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 60-63 (Completed: February 18, 2022).

¹⁴ DC Health Investigation Report Nos. DC-09862; IHF2000007 at 10 (Not dated).

¹⁵ DC Health Investigation Report DC-10133 at 6 (Not dated).

¹⁶ *Id.*

¹⁷ Psych. Inst. of Washington, *About the Psychiatric Institute of Washington*, <https://psychinstitute.com/about-us/> (last visited July 18, 2022). St. Elizabeths Hospital is also a psychiatric facility located in Washington, D.C. However, in contrast to PIW, it is a nonprofit public facility, not private, and is operated by DC’s Department of Behavioral Health. See Dep’t of Behav. Health, *Saint Elizabeths Hospital*, <https://dbh.dc.gov/page/saint-elizabeths-hospital> (last visited July 18, 2022).

¹⁸ Psych. Inst. of Washington, *Outpatient and Inpatient Treatment Programs*, <https://psychinstitute.com/treatment-services/> (last visited July 16, 2022).

¹⁹ Contract, Dep’t of Behav. Health, Psych. Inst. of Washington C.1.2.3 (signed Sept. 27, 2013).

²⁰ D.C. Code §§ 7–731(4), 7–1141.06(3).

²¹ Universal Health Servs., *UHS Healthcare Facility Locations*, <https://www.uhsinc.com/our-communities/> (last visited July 7, 2022); Universal Health Servs., *About UHS*, <https://uhs.com/about-uhs/> (last visited July 18, 2022).

²² See Ayla Ellison, *UHS Annual Profit Grows to \$991M*, Becker’s Healthcare newsletter (February 24, 2022) <https://www.beckershospitalreview.com/finance/uhs-annual-profit-grows-to-991m.html#:~:text=King%20of%20Prussia%2C%20Pa.,hospitals%20contributed%20to%20the%20growth>.

²³ See Rosalind Adams, *Videos Show UHS Hospital Staff Assaulting Young Patients*, BuzzFeed News (November 11, 2017, 11:00 am) <https://www.buzzfeednews.com/article/rosalindadams/videos-show-uhs-hospital-staff-assaulting-young-patients>; see also Rosalind Adams, *Videos Show the Dark Side of Shadow Mountain Youth Psych Facility*, BuzzFeed News (April 11, 2017, 5:57 am) <https://www.buzzfeednews.com/article/rosalindadams/shadow-mountain>. An investigation into large UHS owned Oklahoma psychiatric hospital Shadow Mountain found evidence of a “profoundly troubled facility where frequent violence endangers patients and staff alike, where children as young as 5 are separated from their parents and held in dangerous situations, and where wards lack adequate staffing and staff lack adequate training.” The state has repeatedly put the facility on probation, citing allegations

including an inadequate number of nursing staff, medication errors and failure to report incidents of sexual misconduct. One unit “had barely a third of the staff it needed,” and “[o]ver the last three years, police logs show, officers have been called to the facility at least 340 times.” Findings of a UHS owned facility in Alabama included videotape footage showing a male staff beating an adolescent patient, allegations of staff “beating and dragging” adolescent patients, using chokeholds or twisting the arms and legs of patients to control them, and roaches and dead rodents rotting in traps in the facility’s kitchen.

²⁴ Ellie Silverman, *Second Worker Charged in Teen Patients Death at Health Care Center*, Washington Post (February 15, 2018, 6:53 pm) https://www.washingtonpost.com/local/public-safety/second-worker-charged-in-teen-patients-death-at-health-care-center/2018/02/15/cbd0d0ba-129a-11e8-8ea1-c1d91fcec3fe_story.html.

²⁵ U.S. Dep’t of Just. Off. of Pub. Affs., *Universal Health Services, Inc. And Related Entities to Pay \$122 Million to Settle False Claims Act* (July 10, 2020), <https://www.justice.gov/opa/pr/universal-health-services-inc-and-related-entities-pay-122-million-settle-false-claims-act> (last visited July 12, 2022). Specifically, 18 lawsuits brought against UHS and related entities were resolved through this settlement. Allegations of inappropriate billing were made in addition to inadequate treatment. Along with this settlement, UHS also entered into a five-year Corporate Integrity Agreement with the U.S. Department of Health and Human Services Office of Inspector General (OIG), requiring UHS to “retain an independent monitor, selected by the OIG, which will assess UHS’s Behavioral Health Division’s patient care protections and report to the OIG.” Further, UHS’s inpatient behavioral health claims that are submitted to federal health care programs will undergo annual reviews performed by an independent review organization.

²⁶ Laura French, *Mother of Former Cumberland Children’s Hospital Patient Files \$25 Million Wrongful Death Complaint*, 6 News Richmond (October 27, 2021, 1:57 pm) <https://www.wtvr.com/news/problem-solvers/problem-solvers-investigations/mother-of-former-cumberland-childrens-hospital-patient-files-25-million-wrongful-death-complaint>; see also Complaint & Demand for a Jury Trial, *Nevins v. Cumberland Hospital, LLC*. (July 19, 2021) <https://ewscripps.brightspotcdn.com/20/2a/f98f48934fa4ab04fa40653d0e83/redact2nd-complaint-filed.PDF>.

²⁷ See Videotape: Security Footage from the Adolescent Unit Hallway, Psych. Inst. of Wash., 06:58:00 pm to 07:20:43 pm (May 9, 2021) [hereinafter Adolescent Hallway Video]; Videotape: Security Footage from the Adolescent Unit Nurse’s Station, Psych. Inst. of Wash., at 07:00:14 pm to 08:10:14 pm (May 9, 2021) [hereinafter Adolescent Nurse’s Station Video].

²⁸ Adolescent Hallway Video, *supra* note 20, at 06:58:00 pm to 07:20:43 pm; Adolescent Nurse’s Station Video, *supra* note 20, at 07:00:14 pm to 08:10:14 pm.

²⁹ Adolescent Nurse’s Station Video, *supra* note 20, at 08:04:45 pm to 08:10:14 pm.

³⁰ The PIW website states: “Our Adolescent Treatment Program is highly structured to meet each patient’s special needs. We have staff on hand who specifically specialize in various mental health disorders and substance abuse treatments for teens.” *Adolescent Services*, Psych. Inst. of Wash., <https://psychinstitute.com/treatment-services/adolescent-acute-inpatient/> (last visited June 17, 2022).

³¹ Adolescent Hallway Video, *supra* note 20, at 06:58:50 pm to 06:59:05 pm.

³² *Id.* at 06:58:54 pm.

³³ *Id.* at 06:58:57 pm.

³⁴ *Id.* at 06:59:01 pm.

³⁵ *Id.* at 06:59:03 pm.

³⁶ *Id.* at 7:11 pm.

³⁷ *Id.*

³⁸ According to the Major and Unusual Incident Form, at around 7:10 p.m., two patients engaged in a physical altercation where one patient (patient 1) threw water on another patient (patient 2) who retaliated by punching patient 1, who then stabbed patient 2 in the cheek. Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Wash. (May 9, 2021, at 7:11 pm).

³⁹ *Id.*

⁴⁰ Adolescent Nurse’s Station Video, *supra* note 20, at 07:56:22 pm to 07:56:43 pm.

⁴¹ *Id.* at 07:56:35 pm.

⁴² *Id.* at 07:56:40 pm.

⁴³ *Id.* at 07:58:48 pm to 07:59:27 pm.

⁴⁴ *Id.* at 08:04:01 pm.

⁴⁵ *Id.* at 08:04:38 pm.

⁴⁶ *Id.* at 08:02:05 pm.

⁴⁷ *Id.* at 08:04:42 pm.

⁴⁸ *Id.* at 08:04:48 pm.

⁴⁹ *Id.* at 08:05:18 pm.

⁵⁰ *Id.* at 08:05:36 pm.

⁵¹ *Id.* at 08:07:02 pm.

⁵² *Id.* at 08:07:12 pm.

⁵³ DRDC reported the stabbing incident allegation to DC Health. The DC Health investigation report substantiated that PIW violated the stabbed patient’s “right to receive care in a safe setting,” however, the report notes that DC Health did not view the videotape footage, having been told PIW only retains the video for thirty days, and there is no evidence that they were aware of the multiple other incidents that were captured on the videotape. (PIW provided the video to DRDC.). DC Health Investigation Report Nos. DC-10258; DC20-136 at 1, 8 (Not dated).

⁵⁴ Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Wash. (April 6, 2022).

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* The Incident form was prepared on April 22, 2022.

⁵⁹ Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Wash. (June 10, 2020).

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.* The “detailed description of follow-up actions” portion of the form is blank.

⁶³ Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Wash. (Feb. 10, 2020).

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ D.C. law defines seclusion as “any involuntary confinement of a consumer alone in a room or an area from which the consumer is either physically prevented from leaving or from which the consumer is led to believe he or she cannot leave at will.” D.C. Code § 7-1231.02(24). D.C. law defines restraint as “either a physical restraint or a drug that is being used as a restraint.” D.C. Code § 7-1231.02(23).

⁷⁰ D.C. regulations specifically explain the reasons for the multiple legal requirements that staff must follow prior to, during and after a restraint, noting that their purpose includes: (1) to provide a safe and therapeutic environment to significantly reduce the incidence of emergencies that necessitate the use of restraints and seclusion; (2) to establish positive, trusting relationships among consumers and mental health provider staff; and (3) to reduce and minimize the use of restraints and seclusion in an emergency in favor of less restrictive behavior management techniques. D.C. Mun. Regs. tit. 22A § 500.1. PIW’s own restraint and seclusion policy has similar requirements: that staff (1) use restraint and seclusion only as a last resort; (2) exhaust all less restrictive techniques prior to resorting to restraint and seclusion; (3) use only approved techniques trained through the aggression management program; and (4) in no case may take a patient to the floor. PIW Policy NSG.168.

⁷¹ D.C. Code § 7-1231.09(c).

⁷² D.C. Code § 7-1231.09(c)(d). D.C. law also specifies that patients “have the right to be free from seclusion and restraint of any form that is not medically necessary or that is used as a means of coercion, discipline, convenience, or retaliation by staff.” D.C. Code § 7-1231.09(a). D.C. regulations have similar specific documentation requirements staff must follow, including that within one hour of the restraint the registered nurse in charge must document: “(1) the justification for the use of restraints or seclusion; (2) alternative strategies which failed to manage the consumer’s behavior or why other strategies were considered but deemed impractical or unsafe; (3) the consumer’s current behaviors and mental and emotional status; and (4) the consumer’s physical status. D.C. Mun. Regs. tit. 22A § 506.2 (b).

⁷³ 42 C.F.R. § 482.13(e). CMS indicates that the intent of their requirements is to “identify patients’ basic rights, ensure patient safety, and *eliminate the inappropriate use of restraint or seclusion.*” CMS Interpretive Guidelines for 42 C.F.R. § 482.13(e), at p. 90 (emphasis added).

⁷⁴ See PIW Policy NSG.168. Staff techniques to avoid restraint and seclusion should be deliberate and meaningful, thus the policy provides examples of multiple interventions staff should employ before resorting to restraint or seclusion. PIW Policy NSG.168 at p. 2 (“Examples of less restrictive measures include, but are not limited to: 1. Verbal interventions such as talking quietly with the patient, 2. Environmental intervention through reduction of stimuli causing irritation, 3. Relaxation techniques, 4. Physical activity, 5. Psychoactive medications, 6. Reality Orientation, 7. Seclusion time, 8. Time out/time away.”)

⁷⁵ Pseudonym used to protect patient privacy.

⁷⁶ PIW Policy NSG.168 (4.1) (“In no case may a patient be taken to the floor or held in a prone position.”).

⁷⁷ Videotape: Security Footage of Simpson 10/28 Restraint, Psych. Inst. of Wash., 09:47:36 am. (October 28, 2021) [hereinafter Simpson 10/28 Restraint Video].

⁷⁸ *Id.* at 09:47:32 pm to 09:56:03 pm.

⁷⁹ DRDC interview with Ms. Simpson (11/3/2021).

⁸⁰ Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (October 28, 2021), form prepared on January 25, 2022; Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (October 29, 2021), form prepared on January 25, 2022.

⁸¹ Simpson 10/28 Restraint Video, *supra* note 64, 08:39:58 to 09:47:30 am.

⁸² *Id.* at 09:47:32 pm to 09:56:12 pm.

⁸³ *Id.* at 09:47:42 pm to 09:56:03 pm.

⁸⁴ *Id.* at 09:47:32 pm.

⁸⁵ *Id.*

⁸⁶ *Id.* at 09:47:34 pm.

⁸⁷ *Id.* at 09:47:35 pm.

⁸⁸ *Id.*

⁸⁹ *Id.* at 09:48:29 pm.

⁹⁰ *Id.* at 09:56:05 pm.

⁹¹ Psych. Inst. of Wash., Seclusion/Restraint Order (October 28, 2021, 08:45 pm).

⁹² Psych. Inst. of Wash., Night Shift RN Assessment and Progress Note (October 28, 2021).

⁹³ Physician Progress Note dated 10/29/2021, timed at 5:40 PM.

⁹⁴ Videotape: Security Footage of Simpson 10/29 Restraint, Psych. Inst. of Wash., at 12:09:20 pm to 12:18:20 pm (October 29, 2021) [hereinafter Simpson 10/29 Restraint Video].

⁹⁵ Simpson 10/29 Restraint Video, *supra* note 91, at 11:57:55 am, 11:58:26 am, 12:09:20 pm. According to the medical records, Ms. Simpson had “poured water on a staff, yelling, cursing, and throwing things around.” Psych. Inst. of Wash., Seclusion/Restraint Order (October 29, 2021). The video footage shows that Ms. Simpson threw a cup of water cup 11:57 am, then walked away from the staff and entered her room at 11:58 am. It was over 10 minutes later, at 12:09 pm, that staff approached Ms. Simpson’s room and the altercation began.

⁹⁶ *Id.* at 12:09:21 pm.

⁹⁷ *Id.* at 12:10:45 pm.

⁹⁸ Videotape: Security Footage from the Seclusion Room, Psych. Inst. of Wash., at 12:18:28 pm to 01:32:25 pm (October 29, 2021) [hereinafter Seclusion Room Video].

⁹⁹ *Id.* at 12:18:28 pm.

¹⁰⁰ *Id.* at 12:18:04 pm to 12:34:23 pm, 01:00:49 pm to 01:32:25 pm.

¹⁰¹ *Id.* at 12:34:23 pm to 01:00:49 pm.

¹⁰² *Id.* at 01:32:25 pm.

¹⁰³ See DC Code § 7–1231.09(c)(2); 42 C.F.R. § 482.13(e)(2); PIW Policy NSG.168 (4.1).

¹⁰⁴ PIW Policy NSG.168 (4.1).

¹⁰⁵ 42 C.F.R. § 482.13(e)(9); D.C. Code § 7–1231.09(d)(3).

¹⁰⁶ Email from DRDC to DC Health (February 23, 2022).

¹⁰⁷ DBH Investigation Report (May 3, 2022) at 21, 24.

¹⁰⁸ *Id.* at 22 - 24.

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- ¹⁰⁹ *Id.* at 23, 24.
- ¹¹⁰ *Id.* at 6-10.
- ¹¹¹ Pseudonym used to protect patient privacy.
- ¹¹² DRDC Interview with Maria Peters (December 2, 2021; April 1, 2022); Although progress notes do not document the incident, they do indicate that Ms. Peters was crying and asking for help. Psych. Inst. of Wash., Night Shift RN Assessment and Progress Note, “Month” 18, 2021.
- ¹¹³ DRDC Interview with Maria Peters (December 2, 2021; April 1, 2022).
- ¹¹⁴ Videotape: Security Footage of Peters Restraint, Psych. Inst. of Wash., at 11:13:01 pm to 11:31:09 pm (“Month” 17, 2021) [hereinafter Peters Restraint Video].
- ¹¹⁵ *Id.* at 11:13:33 pm.
- ¹¹⁶ *Id.* at 11:13:01 pm to 11:31:09 pm.
- ¹¹⁷ *Id.* at 11:13:37 pm.
- ¹¹⁸ *Id.* at 11:13:41 pm.
- ¹¹⁹ *Id.* at 11:30:23 pm.
- ¹²⁰ *Id.* at 11:30:32 pm.
- ¹²¹ *Id.* at 11:30:36 pm.
- ¹²² *Id.* at 11:30:39 pm.
- ¹²³ *Id.* at 11:30:49 pm.
- ¹²⁴ *Id.* at 11:30:50 pm.
- ¹²⁵ *Id.* at 11:30:52 pm.
- ¹²⁶ *Id.* at 11:31:39 pm.
- ¹²⁷ Psych. Inst. of Wash., Night Shift RN Assessment and Progress Note, dated “Month” 18, 2021.
- ¹²⁸ Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (Prepared on December 9, 2021). The incident report prepared by PIW indicates that the video showed evidence that PIW staff person used “improper technique,” and that he was placed on administrative leave pending investigation.
- ¹²⁹ *Id.*
- ¹³⁰ Psych. Inst. of Wash., Day Shift RN Assessment and Progress Note dated “Month” 11, 2021, “Month” 15, 2021, “Month” 18, 2021.
- ¹³¹ DRDC Interview with Maria Peters (December 2, 2022; April 1, 2022).
- ¹³² D.C. Code § 7-1231.08(a). In seeking a consumer’s informed consent, the provider must “present the consumer with information about the proposed medication, including the purpose for its administration, possible side effects, and its potential risks and benefits, as well as information about feasible alternative treatments.”
- ¹³³ DC law defines drugs as a restraint as “a medication that is used in addition to or in place of the consumer’s regular, prescribed drug regimen to control extreme behavior during an emergency.” D.C. Code § 7-1231.02(9).
- ¹³⁴ D.C. Mun. Regs. tit. 22A § 514.6.
- ¹³⁵ Psych. Inst. of Wash., Day Shift RN Assessment and Progress Note dated “Month” 11, 2021, “Month” 15, 2021, “Month” 18, 2021; Psych. Inst. of Wash., Night Shift RN Assessment and Progress Note dated “Month” 18, 2021; Psych. Inst. of Wash., Physician Progress Note dated “Month” 11, 2021, “Month” 15, 2021, “Month” 18, 2021; *see, e.g.*, 42 CFR 482.13(e)(12).
- ¹³⁶ PIW Investigation Summary (Not dated).
- ¹³⁷ *Id.*
- ¹³⁸ D.C. Mun. Regs. tit. 22A § 505.1 (h).
- ¹³⁹ PIW Investigation Summary (Not dated).
- ¹⁴⁰ PIW Policy NSG.168 (4.1). The investigation summary does not indicate that PIW reviewed videotape footage of this incident and the video footage provided to DRDC does not show the restraint, due to camera angles. PIW Investigation Summary (Not dated); Videotape: Security Footage of Front Desk, Psych. Inst. of Wash., at 04:48:28 pm to 04:40:40 pm (June 8, 2022).
- ¹⁴¹ DRDC Interview with PIW patient (May 4, 2022).
- ¹⁴² *Id.*
- ¹⁴³ *Id.*
- ¹⁴⁴ Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (January 10, 2022).
- ¹⁴⁵ *Id.*

¹⁴⁶ Pseudonym used to protect patient privacy.

¹⁴⁷ DRDC interview with Sarah Miller (November 22, 2021).

¹⁴⁸ RN Progress note dated 11/11/21, timed at 2:30 p.m.; D.C. Code § 7–1231.09(c)(2); 42 C.F.R. § 482.13(e)(2).

¹⁴⁹ Pseudonym used to protect patient privacy.

¹⁵⁰ DRDC interview with Jane Pearson (May 27, 2022).

¹⁵¹ *Id.*

¹⁵² RN Progress note 4/19/22, times at 7:50 a.m.

¹⁵³ See Psychiatry Progress Notes (4/19/22 and 4/20/22).

¹⁵⁴ RN Progress note 4/19/22, 7:50 a.m.

¹⁵⁵ D.C. Mun. Regs. tit. 22A § 514.4, 514.7.

¹⁵⁶ RN Progress note dated 11/11/21, timed at 2:30 p.m.

¹⁵⁷ DRDC interview with Sarah Miller (November 22, 2021).

¹⁵⁸ Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Wash. (April 11, 2022); DRDC interview with patient (April 15, 2022).

¹⁵⁹ DRDC interview with patient (April 15, 2022).

¹⁶⁰ *Id.*

¹⁶¹ Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington 1-2 (April 11, 2022).

¹⁶² *Id.*

¹⁶³ DRDC Interview with PIW patient (June 10, 2022).

¹⁶⁴ *Id.*

¹⁶⁵ Police Call Log provided to DRDC. Roughly half of the days in the overall time period have no data at all. There are 593 days with data provided, and there were calls logged on 368 of those days. DRDC’s analysis reveals 489 (70%) of the 700 calls occurred in the afternoon or evening. The longest continuous time period with data provided is between June 8, 2020, and October 8, 2020. During this period of 123 days, police received 150 calls regarding PIW, which averages to 1.2 calls per day.

¹⁶⁶ *Id.* There were 225 days with no calls.

¹⁶⁷ *Id.*

¹⁶⁸ *Id.* Calls were labeled with ASLT and another descriptor, for example ASLTFIGHT or ASLTOTH. This is the aggregated number for all calls labeled with ASLT.

¹⁶⁹ *Id.*

¹⁷⁰ *Id.* Thirty of the calls were labeled as MISCRIT, four were labeled MISADLT, and one just as MISSING.

¹⁷¹ For example, St. Elizabeths Hospital and Department of Youth Rehabilitative Services (DYRS) have allowed DRDC to return to in-person monitoring with DRDC following each facility’s Covid precautions.

¹⁷² PIW’s Human Care Agreement with DBH specifies that PIW will conform with “generally accepted standards of care as defined by the Centers for Medicare and Medicaid Services (“CMS”) and the Joint Commission,” which include that a hospital’s “governing body ... medical staff, and administrative officials are responsible and accountable for ensuring ... that an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.” Contract, Dep’t of Behav. Health, Psych. Inst. of Washington C.3.2.1 (signed Sept. 27, 2013) (first quote); 42 CFR § 482.21 (second quote). Also, as part of its program, a hospital “must set priorities for its performance improvement activities that (i) [f]ocus on high-risk, high-volume, or problem-prone areas; (ii) [c]onsider the incidence, prevalence, and severity of problems in those areas; and (iii) [a]ffect health outcomes, patient safety, and quality of care.” 42 C.F.R. § 483.75(e)(1).

¹⁷³ DBH policy defines MUIs as “[a]dverse events that can compromise the health, safety, and welfare of persons, such as employee misconduct, fraud, and actions that are in violations of law or policy. Dep’t of Behav. Health Policy No. 480.1A (12). DBH policy states that “allegations of abuse, neglect or exploitation of consumers shall be reported and investigated as a major unusual incident” and that each DBH provider “shall follow DBH policies on reporting and investigating incident reports.” Dep’t of Behav. Health Policy No. 482.1 (6b)(5), (7a).

¹⁷⁴ Dep’t of Behav. Health Policy No. 482.1 at Ex.1A. Dep’t of Behav. Health Policy No. 482.1 (7a), (6a).

¹⁷⁵ Dep’t of Behav. Health Policy No. 480.1A (4), (5b)(1), (5b)(2).

¹⁷⁶ Disability Rights DC sent a Freedom of Information Act (“FOIA”) request to DBH, requesting all Major Unusual Incidents (“MUIs”), complaints, grievances and investigation reports related to PIW for the period from April 21,

2021, to June 2, 2022. Alarming, the FOIA responses contained only four MUIs submitted to DBH from PIW over the more than a year period.

¹⁷⁷ Compare with St Elizabeths reported number of MUIs for the year 2021, which was 769 total MUIs.

Performance Related Information for Staff and Managers, Dept. of Behav. Health (Jan. 2022)

<https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Jan%20PRISM.pdf>.

¹⁷⁸ Psych. Inst. of Washington Policy No. ADM.041. The policy further provides that “an [i]nvestigation is an inquiry for ascertaining facts” and “consists of a detailed, careful examination of, but is not limited to, staff and patient interviews, review of pertinent documentation, and review of video footage.” The policy requires that PIW produce a written investigation report with detailed findings, stating that “the Risk Manager or designee will review medical records and other pertinent documentation for inclusion into the final investigation report.” Moreover, DBH Policy requires PIW to submit a follow up report or internal investigation report to DBH within ten business days, if requested by DBH, following the provider’s internal procedures for investigations. Psych. Inst. of Washington Policy No. ADM.041 at 1. See also Psych. Inst. of Washington Policy No. ADM.143 (stating that the PIW risk manager shall “[w]hen necessary, confidentially investigate serious and critical occurrences”).

¹⁷⁹ Dep’t of Behav. Health Policy No. 480.1A (4), (5b)(5).

¹⁸⁰ Federal regulations allow DRDC access to all records, which are defined as “reports prepared by any staff of a facility rendering care and treatment or reports prepared by an agency charged with investigating reports of incidents of abuse, neglect, and injury occurring at such facility that describe incidents of abuse, neglect, and injury occurring at such facility and the steps taken to investigate such incidents, and discharge planning records.” 42 U.S.C. § 10806(3)(A).

¹⁸¹ Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 4-7 (Completed: August 31, 2021).

¹⁸² *Id.* at 5.

¹⁸³ *Id.*

¹⁸⁴ D.C. Mun. Reg. Ch. 22-A3401.4.

¹⁸⁵ DC Health, *Health Regulation and Licensing Administration*, <https://dchealth.dc.gov/page/health-regulation-and-licensing-administration> (last visited June 16, 2021).

¹⁸⁶ DC Health, *Healthcare Facilities Licensing*, <https://dchealth.dc.gov/node/188332> (last visited June 16, 2021).

¹⁸⁷ PIW is required to adhere to CMS Conditions of Participation to receive federal reimbursement for Medicare patients. 42 C.F.R. § 482.13.

¹⁸⁸ *A Disturbing Death: A Lack of Oversight at the Psychiatric Institute of Washington* (June 2021) <https://www.uls-dc.org/media/1209/abuseunabatedfinal.pdf>.

¹⁸⁹ Videotape: Security Camera Footage of Patient Death, Psych. Inst. of Wash., at 11:30:56 am to 12:38:06 pm (April 26, 2020).

¹⁹⁰ *A Disturbing Death: A Lack of Oversight at the Psychiatric Institute of Washington* at 4 (June 2021)

<https://www.uls-dc.org/media/1209/abuseunabatedfinal.pdf>.

¹⁹¹ Psych. Inst. of Washington, *Final Ancillary Orders: Precautions and Observations* (April 25, 2020, at 23:00);

Videotape: Security Camera Footage of Patient Death, Psych. Inst. of Wash., at 11:30:56 AM to 12:38:06 PM (April 26, 2020).

¹⁹² DC Health Investigation Report Nos. DC-09862; IHF2000007 (Not dated).

¹⁹³ *Id.*

¹⁹⁴ *Id.* DRDC’s review of the medical records also contain no evidence that the doctor was aware of the incident, and the records contain no evidence that a medical doctor assessed or provided treatment, which may have possibly been lifesaving, especially considering the patient died the following day.

¹⁹⁵ DC Health Investigation Report DC-10133 at 6 (Not dated).

¹⁹⁶ *Id.*; DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington at 6-7 (Completed: August 31, 2021).

¹⁹⁷ DC Health Investigation Report DC-10133 at 6-7 (Not dated); See also DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 10-11 (Completed: August 31, 2021).

¹⁹⁸ DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington (Completed: May 17, 2021).

¹⁹⁹ DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 19-20 (Completed: February 18, 2022) (lack of staff); DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 7-8 (Completed: August 31, 2021) (lack of staff); DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 8-11 (Completed: May 17, 2021) (unattended nurse's station with easily accessible objects).

²⁰⁰ DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 19-20 (Completed: February 18, 2022); Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 7-8 (Completed: August 31, 2021).

²⁰¹ DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 16-22 (Completed: May 17, 2021).

²⁰² *Id.* at 18-19.

²⁰³ *Id.* at 12-14; Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 23-24 (Completed: January 15, 2020).

²⁰⁴ DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 9-11 (Completed: May 17, 2021).

²⁰⁵ *Id.* at 36.

²⁰⁶ *Id.* at 36-37

²⁰⁷ *Id.*

²⁰⁸ Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington (Completed: February 18, 2022).

²⁰⁹ *Id.* at 19-21.

²¹⁰ *Id.* at 20.

²¹¹ *Id.* at 57-60, 62-63.

²¹² *Id.* at 60-63.

²¹³ *Id.* at 24-25, 73.

²¹⁴ *Id.* at 41.

²¹⁵ *Id.* at 54-56.

²¹⁶ *Id.* at 45, 66.

²¹⁷ *Id.* at 9.

²¹⁸ *Id.* at 13-14. Notably, water temperatures for patients showering in on a unit ranged from 56 degrees to a maximum of only 80 degrees Fahrenheit. *Id.* at 13-14.

²¹⁹ Morgan C. Shields & Rinad S. Beidas, *The Need to Prioritize Patient-Centered Care in Inpatient Psychiatry as a Matter of Social Justice*, JAMA Health Forum, February 4, 2022 <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2788761>.

²²⁰ *Id.*

²²¹ *Id.*

²²² Alessandro Cuomo et al., *Patient Safety and Risk Management in Mental Health*, in *Textbook of Patient Safety and Clinical Risk Management* 287, 294 (2020) https://link.springer.com/chapter/10.1007/978-3-030-59403-9_20.

²²³ Erin L. Kelly et al., *Well-Being and Safety among Inpatient Psychiatric Staff: The Impact of Conflict, Assault, and Stress Reactivity*, *Adm. Policy Ment. Health* (2017) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4794422/>.