



**Disability Law Colorado's Secondary Investigation Report Regarding the
Body Inspections at Pueblo Regional Center
July 27, 2015**

In late March and early April of 2015, the guardians of several residents at Pueblo Regional Center (PRC) contacted Disability Law Colorado (DLC) and reported concerns about unclothed body audits/body inspections ("body inspections") which were allegedly performed on March 25 and 26, 2015, on all residents of PRC by staff members from Wheat Ridge Regional Center (the WRRC Team). Staff from DLC completed interviews of each guardian that contacted us and then interviewed 6 verbal PRC residents. The Colorado Department of Public Health and Environment (CDPHE) received a complaint about the above allegations and also received 9 complaints from guardians of affected residents. CDPHE performed an investigation of the situation. In addition, the Colorado Department of Human Services (CDHS), CDPHE, and the Pueblo Sheriff's Department each also investigated the precipitating events that initially led CDHS to order the body inspections.

Disability Law Colorado is the designated Protection and Advocacy System for individuals with developmental disabilities for the state of Colorado, as authorized by the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. §§ 15043(a)(2)(B) (DD Act). Disability Law Colorado is charged with performing primary and/or secondary investigations when we determine there is probable cause due to allegations of abuse, neglect and rights violations of people with developmental disabilities. When there are state agencies involved who perform investigations as part of their own oversight duties, then DLC typically will do a secondary investigation whereby we review the state agency's primary investigation for thoroughness and adequate results.

DLC's investigation focused on two questions:

1. Did the body investigations involve rights violations of the residents at PRC?
2. Was the CDPHE investigation thorough and did it yield acceptable results?

Brief answers to those questions:

1. Yes. At least in the instances of some residents, CDHS employees of Wheat Ridge Regional Center, who were acting upon the orders of administrators at CDHS, violated the rights of some of the residents of PRC.
2. The CDPHE investigation was thorough, and the Plans of Correction (POC) have many useful elements, however, the POC should provide greater protections to residents of PRC.

Disability Law Colorado's Recommendations to strengthen the Plans of Correction:

1. Incorporate additional monitoring efforts of the POCs from entities outside of CDHS.
2. Perform post-incident therapeutic assessments and needed treatments of individuals who were subjected to the body inspections.
3. Provide information and training to PRC residents regarding their rights and the PRC policies that affect those rights.
4. Provide information and training to the guardians of PRC residents regarding PRC resident rights and the PRC policies that affect those rights.

The following is a detailed explanation of Disability Law Colorado's secondary investigation.

1. Course of Disability Law Colorado's Investigation

In the course of this investigation, DLC staff reviewed material including, but not limited to:

- CDPHE investigation documents to include 4/22/15 survey findings and 6/25/15 plans of correction on each of the 10 PRC group homes and the Direct Service PRC program. These documents are available on CDPHE's website.

DLC Staff interviewed the following people:

- Several guardians of residents at PRC.
- Several residents at PRC.
- Viki Manley, CDHS, former Director for the Office of Community Access and Independence.
- Follow up questions regarding the CDPHE investigation report answered by Thomas Miller, CDPHE Licensing, Policy and Enforcement Branch Chief.

2. Legal Standards Related to DLC's Secondary Investigation

- a. 42 U.S.C. § 15001(c)(4) services, supports, and other assistance should be provided in a manner that demonstrates respect for individual dignity...
- b. 42 U.S.C. § 15009(3)(B)(i) Rights of individuals with developmental disabilities...Programs funded by federal government or states should meet minimum standards relating to provision of care that is free of ...violations of legal and human rights and that subjects individuals with developmental disabilities to no greater risk of harm than others in the general population.

- c. C.R.S. 25.5-10-221 (2) Right to humane treatment...All service agencies shall prohibit mistreatment, exploitation, neglect, or abuse in any form of any person receiving services.
- d. C.R.S. 25.5-10-221 (3) Right to humane treatment...Service agencies shall provide every person receiving services with a humane physical environment.
- e. C.R.S. 26-3.1-101(6) “Least restrictive intervention” means acquiring or providing services, including protective services, for the shortest duration and to the minimum extent necessary to remedy or prevent situations of actual mistreatment, self-neglect, or exploitation.
- f. C.R.S. 26-3.1-101(9) “Protective services” means services provided by the state or political subdivisions or agencies thereof in order to prevent the mistreatment, self-neglect, or exploitation of an at-risk adult. Such services include, but are not limited to: Receiving and investigating reports of mistreatment, self-neglect, or exploitation...protection from mistreatment...
- g. 6 CCR 1011-1 Chap 02 (6.104)(1)(c) Patient Rights Policy.¹ (c) Each patient...has the right to refuse any drug, test procedure, or treatment.
- h. 6 CCR 1011-1 Chap 02 (6.104)(1)(d) Patient Rights Policy. (d) Each patient...has the right to care and treatment...that is respectful, recognizes a person’s dignity, cultural values and religious beliefs, and provides for personal privacy to the extent possible during the course of treatment.
- i. 6 CCR 1011-1 Chap 02 (6.104)(1)(g) Patient Rights Policy. (g) Each patient...has the right to give informed consent for all treatment and procedures. It is the responsibility of the licensed independent practitioner and other health professionals to obtain informed consent for procedures that they provide...
- j. 6 CCR 1011-1 Chap 08 (9.2)(C) Resident Rights. The facility administrator shall ensure implementation of the following items. (C) The facility demonstrates that the residents are informed of their rights and those rights are protected.
- k. 6 CCR 1011-1 Chap 08 (9.2)(E) Resident Rights. The facility administrator shall ensure implementation of the following items. (E) Reporting of any alleged incident or occurrence to the parent, guardian or authorized

¹ Note, the referenced patient rights found in 6 CCR 1011-1 Chapter 2 apply to hospitals and health facilities, but are specifically incorporated by reference in 6 CCR 1011-1 Chapter 08 (9.1) to apply to facilities for persons with intellectual and developmental disabilities.

representative within 24 hours, and to the department by the next business day...

- l. 10 CCR 2505-10 8.608.8(B)(9) Abuse, Mistreatment, Neglect, and Exploitation. ...Regional centers shall have written policies and procedures for handling cases of alleged or suspected abuse, mistreatment, neglect, or exploitation of any person receiving services. These policies and procedures must be consistent with state law and: ... (9) Provide necessary victim supports.

3. Facts related to the rights violation of residents at PRC when they were subjected to body inspections against their will.

- a. CDPHE interviewed numerous PRC residents and their attending PRC staff. The results of these interviews indicated some residents made it very clear to the WRRC Team the residents' discomfort and/or attempted refusals of the body inspections and these refusals were ignored by at least some members of the WRRC Team, who then continued to perform the body inspections even though the residents refused.
- b. DLC interviewed 6 residents of PRC and 4 of the 6 stated they told the people performing the body inspections that they wanted the inspections to stop, but the inspections did not stop, and the residents were told they had to allow the inspections - that they had no choice.
- c. CDPHE interviewed some members of the WRRC Team who performed the body inspections. WRRC Team members interviewed indicated that there was no common understanding among the WRRC Team about how or if rights of PRC residents were ensured. Additionally, the members of the WRRC Team were not directed to ensure informed consent was received from the residents or their guardians prior to or during the body inspections. WRRC Team members indicated that if residents refused the body inspections or showed discomfort, the team members honored that refusal and did not conduct the body inspections.
- d. CDPHE's investigation report indicates that of the 33 guardians identified providing supports to 40 of the 62 PRC residents, records showed that by 4/2/15 (8 days after the body inspections were conducted), only 17 guardians had been notified about the full body inspections.

4. Disability Law Colorado's findings regarding alleged rights violations of residents at PRC resulting from the body inspections conducted by CDHS.

- a. **Not allowing residents to refuse the body inspections was a violation by CDHS of the residents' right to refuse treatment.** Both the DLC interviews of

selected PRC residents and the CDPHE interviews of residents and their attending PRC staff resulted in similar descriptions of residents clearly refusing the inspections, these refusals being ignored and the residents being wrongfully subjected to violations of their rights to refuse treatment (“Patient Rights Policy ...each patient...has the right to refuse any drug, test procedure, or treatment 6 CCR 1011-1 Chap 02 6.104 (1)(c)).

- b. **CDHS (via the WRRRC Team sent by CDHS) failed to demonstrate respect for individual human dignity in the provision of their investigatory services in violation of law. 42 U.S.C. 15001(c)(4).** In interviews with CDPHE, PRC staff relayed numerous instances of the WRRRC Team’s complete disregard of very clear indications by some PRC residents of their discomfort at being subjected to the body inspections. In one interview the PRC staff indicated that a resident “was afraid, very afraid, he was shaking and he was saying No...the resident was fearful, striking out and pushing them away... was batting them away the whole time...he was fearful; you could tell he was fearful.” Even with these signals of fear and refusal, the WRRRC Team continued the body inspection. CDHS, via members of the WRRRC Team, disregarded the individual human dignity of the PRC residents in the manner in which they forced residents to submit to unclothed inspections even though the residents communicated they did not want to do so. CDHS violated 6 CCR 1011-1 Chap 02 (6.104)(1)(d) Patient Rights Policy which states, “each patient...has the right to care and treatment...that is respectful, recognizes a person’s dignity, cultural values and religious beliefs, and provides for personal privacy to the extent possible during the course of treatment.”
- c. **Performing body inspections for those residents about whom no specific concerns were present, was also a violation of state law requiring that the least restrictive intervention be used in the provision of services necessary to remedy or prevent situations of *actual* mistreatment, self-neglect, or exploitation. “Least restrictive intervention” means acquiring or providing services including protective services, for the shortest duration and to the minimum extent necessary to remedy or prevent situations of actual mistreatment, self-neglect, or exploitation. C.R.S. 26-3.1-101(6).** Although one can imagine the mounting sense of concern among CDHS management as more and more allegations of wrongdoings by PRC staff were discovered in the months leading up to the choice to do the body inspections, it was a violation of policy and law to then institute unclothed examinations of *all* residents of PRC, including those who were not involved in specific reports of possible abuse/neglect. It was improper to use the vulnerability of these residents to search for evidence of other abuse/neglect, and in so doing, subject all the residents to additional trauma and violations of their persons and rights.

- d. **Guardians were not notified in a timely manner of the body inspections nor of the fact that the body inspections occurred in violation of state regulations which indicate that the facility administrator shall ensure implementation of the following items. (E) Reporting of any alleged incident or occurrence to the parent, guardian or authorized representative within 24 hours, and to the department by the next business day... 6 CCR 1011-1 Chap 08 (9.2)(E).** Guardians were not provided immediate notification of allegations of abuse/neglect of their wards. CDPHE's investigation report indicates that of the 33 guardians identified providing supports to 40 of the 62 PRC residents, records showed that by 4/2/15 (8 days after the body inspections were conducted), only 17 guardians had been notified about the full body inspections.

5. **Facts related to the thoroughness of the CDPHE investigation and adequacy of the results.**

- a. CDPHE completed a record review, numerous staff interviews (both PRC and CDHS), guardian interviews, and interviews of PRC residents.
- b. CDPHE issued the following findings:
- i. CDHS, as the governing body, failed to establish policy that defined its composition and more notably where and how it exercised its authority over PRC. This failure created and promoted confusion as to roles and responsibilities of the governing body (CDHS) in regard to PRC, which resulted in CDHS implementing body inspections system-wide, thereby causing potential for harm and promoted a lack of adherence to residents' individual rights to privacy, dignity and respect.
 - ii. CDHS failed to establish oversight policies that provided for a system for monitoring the medical care and health of the residents of PRC. This failure led to CDHS being unaware of potential issues and concerns and contributed to CDHS conducting total body inspections system-wide of all 10 PRC group homes instead of conducting focused singular investigations of individual allegations of abuse as they were reported.
 - iii. CDHS failed to implement and enforce policy and procedure in regards to the basic rights of all patients/individuals. This failure led to CDHS conducting body inspections system-wide of all residents at PRC without adherence to their individual rights to dignity, respect

and personal privacy, along with their rights to informed consent and to make decisions about their medical care. The body inspections were unexplained to the residents.

- iv. CDHS failed to adhere to established policies and procedures with regard to mistreatment, abuse, neglect and exploitation (MANE). In doing so they failed to protect the rights of individuals while investigating allegations of abuse and neglect.
- v. CDHS failed to allow the individuals or their guardians the opportunity to consent to inspections of their bodies.

6. Disability Law Colorado's findings regarding the thoroughness of the CDPHE investigation and adequacy of the results.

- a) The CDPHE investigation was thorough.** CDPHE interviewed representatives from all categories of individuals involved in this matter. The findings were unbiased and addressed numerous concerns.
- b) The Plans of Correction (POC) have many useful elements, however, the POC should provide greater protections as detailed below.**

The Plans of Correction (POC) currently have many elements that will improve the likelihood that residents of PRC will be safe including:

- i. Creation of a Governing Body Policy**
 - A. Provides for monitoring and reviewing the medical care and health of PRC residents.
 - B. Will be reviewed and evaluated for its effectiveness within the first year of implementation by DRCO.
- ii. RE-issued/Revised PRC Policies**
 - A. Policy 1.4 – Rights of Persons Receiving Services
 - B. Policy 1.4.A2 – MANE Policy
 - C. Policy 1.5A1 – Emergency on Call Duty Officer
 - D. Policy 1.5C1h – Human Rights Policy and Human Rights Committee Procedure
 - E. Policy 1.5.I1 – Incident Reporting

The POC states the above re-issued policies will improve internal oversight (through detailed staff workflows for critical and non-critical incidents) and external oversight (through reporting to parents or guardians, law enforcement, and the

third-party advisory Human Rights Committee [HRC]). In addition, all critical incidents and all allegations of MANE will be communicated to CDHS executive management within 24 hours of receipt of incident report. Each critical incident will be reported to the Community Centered Board (CCB) and the HRC and will trigger a review by the Quality Assurance and Performance Improvement (QAPI) committee. Staff will be trained on these policies.

To ensure the POC is effective, all incident reports are reviewed daily, Monday through Friday, by an outside consulting agency (since 5/14/15 and continuing as needed). On an ongoing basis the incident reports will be reviewed daily, Monday through Friday, by the PRC Quality Assurance (QA) staff, and as necessary, the QAPI committee or the PRC Director will address any identified deviation from policy or state reporting rules with the responsible staff and supervisor. At least twice a year the DRCO Director, and if applicable, other CDHS staff, shall make unannounced visits to PRC to ensure operational compliance.

iii. Creation of the Quality Assurance and Performance Improvement (QAPI) Policy and Committee

- A. Mandatory members of the new PRC QAPI Committee: QA Staff (who will be relied upon to report resident and staff concerns), PRC Director, Director of Nursing/Infection Control Nurse, Program Services Director, Direct Care Staff, Safety Representative.
- B. Other members may include: Environment/Facilities Representative, Health Services Director/Medical Director, Occupational Therapist, other members as deemed appropriate.
- C. Functions of the QAPI: review the Governing Body Policy, meet monthly and assess outcomes and trends within PRC, make recommendations to improve resident quality of life through additions or revisions to the Governing Body Policy.

Disability Law Colorado is concerned with the completeness of the POC because the bulk of the monitoring functions outlined in the POC involved self-monitoring efforts by CDHS. Moreover, the POC does not provide for the potentially unaddressed therapy needs of the residents who underwent body inspections against their wishes. Actions that would remedy these shortcomings in the POCs are detailed below.

7. Disability Law Colorado's Recommendations to strengthen the Plans of Correction

a. Incorporate additional monitoring efforts of the POCs from entities outside of CDHS. Disability Law Colorado finds additional monitoring efforts are necessary for several reasons. First, CDHS disputed in the POC that they needed consent for the body inspections, either from the person with disabilities or their guardian, stating that “such a broad informed consent requirement would undermine CDHS’ ability to protect residents’ health and safety against imminent threats and its compliance with the law.” Secondly, CDHS appears to maintain that the WRRRC Team did nothing wrong in how they administered the body inspections. CDHS’ insistence on no wrongdoing by the WRRRC Team persisted *even after* CDPHE reported the results of their interviews with residents and attending PRC staff in which several instances were described of the WRRRC Team disregarding the residents’ refusal of the body audits. The last reason for the need for additional monitoring efforts from entities outside of CDHS is that the bulk of the monitoring functions outlined in the Plans of Correction involve self-monitoring efforts by CDHS. The POC does have some outside entities involved in monitoring, such as the HRC and the CCB, Colorado Bluesky, which will then send Critical Incident Reports on to CDPHE. In addition, CDPHE has confirmed with DLC that they conduct revisits on all POCs to determine if the corrections listed in the facility’s plan of correction have been implemented. However, given that the bulk of the monitoring provided for in the POC are self-monitoring, DLC recommends additional monitoring and public accountability as follows:

- i. Disability Law Colorado, as the Protection and Advocacy System, will gather data from CDHS/PRC regarding implementation of the corrective actions and will conduct post-investigation monitoring visits to ensure that elements of the POC are being implemented.
- ii. The QAPI should have members who are not state government employees, such as staff from members from the quality assurance department of the CCB.
- iii. The QAPI Committee’s monthly meeting report/recommendations should be made public (of course, with appropriate redaction of persons’ names and other identifying information).

b. Perform post-incident therapeutic assessments and needed treatments of individuals who were subjected to the body inspections. Mental

health evaluations should be performed on all PRC residents who underwent the body inspections to assess for therapeutic needs due to the trauma of the body inspections. Many residents of PRC have heightened vulnerability to trauma (for example, those with Post Traumatic Stress Disorder, and those with any history of sexual abuse/trauma). Because of the nature of the body inspections, and because some of the inspections were done even though the resident refused, the body inspections may have resulted in additional trauma to the already-traumatized residents, who may now have additional therapeutic needs. The POCs do not provide for any remedies related to the damage done to the PRC residents, but rather all the changes in the POCs speak only to preventing continued problems. The MANE regulations indicate that regional centers are supposed to provide victim supports (10 CCR 2505-10 8.608.8(B)(9)). The current POC does not address victim supports in any way.

- c. Provide information and training to PRC residents regarding their rights and the PRC policies that affect those rights.** While we realize some of the PRC residents do not have the cognitive abilities to comprehend the concept of “rights,” there are definitely some of the residents who would understand a basic explanation of their rights. Pueblo Regional Center has a responsibility to inform the residents of their rights (6 CCR 1011-1 Chap 08 (9.2)(C)), and residents have a right to attempt to influence policies of PRC (C.R.S. 25.5-10-228). Disability Law Colorado recommends PRC implement regular trainings of the residents to educate the residents as to what their rights are and what the PRC policies are that affect their rights. This will add more safeguards against future abuse and rights violations because it will aid the residents in self-advocating if they know what is/is not supposed to happen to them.
- d. Provide information and training to the guardians of PRC residents regarding PRC resident rights and the PRC policies that affect those rights.** In addition to providing training for the residents living at PRC, it would also add to the safeguards against future abuse and rights violations if the guardians of the residents at PRC also had training and information as to what the law requires regarding resident rights.

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