Office of Health Facility Licensure and Certification (OHFLAC) Behavioral Health Program




Legislative Oversight Commission on Health and Human Resources Accountability

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WEST VIRGINIA Department of Health & Human Resources
Office of Inspector General

Behavioral Health Centers

- Behavioral health centers provide a continuum of services for the treatment of individuals at-risk of or suffering from mental, behavioral, or addictive disorders. These facilities serve individuals who require a higher level of care than many other facility types, including one-on-one care and daily nursing care. These facilities are in great demand and serve some of our most vulnerable citizens.

- 64CSR11 establishes general standards and procedures for the licensure of behavioral health services and supports pursuant to W. Va. Code §27-1A-7 and related federal and state codes.

- Behavioral Health Center -- A provider, entity, or facility that provides behavioral health services, supports, or both.

- Behavioral Health Services -- A direct service provided as an inpatient, residential, or outpatient service to an individual with mental health, addictive, behavioral, or adaptive challenges that is intended to improve or maintain functioning in the community. The service is designed to provide treatment, habilitation, or rehabilitation.

Updates Effective June 1, 2021

- To assess civil money penalties
- To clarify requirements relating to patient rights, care, and safety
- To allow certain facility types to waive their exemption, should they desire state licensure as a behavioral health facility
- To include building and construction requirements; currently being used for alterations and new construction
- To update the role and accountability relating to the governing body
- To amend the legislative rules terms and definitions and to clarify that DHHR licenses behavioral health centers and not individual services, consistent with language in Chapter 27 of the W. Va. Code

Types of Behavioral Health Providers

- Group homes, including Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and residential units
- Outpatient behavioral health services, including counseling, day program sites, and other services
- Substance use disorder facilities providing behavioral health services
- 611 licensed behavioral health sites **(this does not include waiver homes with 3 or fewer individuals; however, providers of these services are licensed)**
    - 228 of these sites are residential (ICF/IID, group homes)

Top Citations for ALL Behavioral Health Centers Calendar Year 2020
Basic Rights
Employee, Volunteer, and Student Records
Medication Control and Administration
Human Rights Committee
Safety and Environmental Quality
Violation of Consumer Rights
Abuse and Neglect

Individuals with Intellectual/Developmental Disabilities (IDD)

Individuals served live in different types of settings including homes of their own, with a family member, with a host family, or in a provider-owned or operated setting.

- Group homes with four or more consumers
  - These homes are licensed by the Office of Health Facility Licensure and Certification (OHFLAC) and specifically listed on a provider's license
- Intensively Supported Settings (ISS) with three or fewer consumers
  - These homes are not licensed or regularly surveyed; homes are only entered by OHFLAC if a complaint is received or if a home is selected for a site visit when surveying a licensed provider
  - ISS includes homes owned or rented by consumers or family member; some homes are owned by provider subsidiary companies and then rented to the consumer
- ICFs/IID
  - ICFs/IID are federally certified and monitored; penalties for federal citations, including closure, are assessed by DHHR's Bureau for Medical Services on behalf of the Centers for Medicare and Medicaid Services (CMS); survey activity is conducted by OHFLAC, the state survey agency

ICF/IID Citations

ICF/IID Top 25 Citation Calendar Year 2020			
Tag	**Tag Description**	**% Providers Cited**	**% Surveys Cited**
W0454	INFECTION CONTROL	20.90%	47.20%
W0122	CLIENT PROTECTIONS	10.40%	27.80%
W0127	PROTECTION OF CLIENTS RIGHTS	10.40%	27.80%
W0111	CLIENT RECORDS	11.90%	25.00%
W0455	INFECTION CONTROL	6.00%	19.40%
W0339	NURSING SERVICES	9.00%	19.40%
W0406	PHYSICAL ENVIRONMENT	7.50%	19.40%
W0481	MENUS	7.50%	16.70%
W0112	CLIENT RECORDS	7.50%	13.90%
W0318	HEALTH CARE SERVICES	7.50%	13.90%
W0159	QIDP (Qualified Intellectual Disability Professions)	6.00%	13.90%
W0189	STAFF TRAINING PROGRAM	4.50%	13.90%
W0153	STAFF TREATMENT OF CLIENTS	6.00%	13.90%
W0460	FOOD AND NUTRITION SERVICES	4.50%	11.10%
W0331	NURSING SERVICES	6.00%	11.10%
W0154	STAFF TREATMENT OF CLIENTS	4.50%	11.10%
W0486	DINING AREAS AND SERVICE	3.00%	8.30%
W0477	MENUS	3.00%	8.30%
W0336	NURSING SERVICES	4.50%	8.30%
W0136	PROTECTION OF CLIENTS RIGHTS	4.50%	8.30%
W0149	STAFF TREATMENT OF CLIENTS	4.50%	8.30%
W0196	ACTIVE TREATMENT	3.00%	5.60%
W0195	ACTIVE TREATMENT SERVICES	3.00%	5.60%
W0266	CLIENT BEHAVIOR & FACILITY PRACTICES	3.00%	5.60%
W0114	CLIENT RECORDS	3.00%	5.60%

ICF/IID and Waiver Concerns

There has been a trend of incidents within behavioral health centers with major issues increasing in severity related to consumer rights, care, and safety. Numerous incidents have resulted in consumer deaths and serious injuries.

Survey activity disclosed serious, systemic issues:

- Critical medication errors
- Failure to provide and obtain emergency medical attention
- Failure to secure chemicals and other dangerous substances
- Failure to activate door alarms to prevent elopement when required by individual's behavioral needs
- Lack of staffing
- Abuse and neglect by staff
- Failure to report incidents, investigate incidents, correct deficient practices, and provide training

List of critical issues identifies specific situations found in ICFs/IID, waiver, and group home settings

Examples of Serious Incidents

Investigation disclosed that a 19-year-old individual, requiring direct staff supervision at all times, repeatedly informed facility staff he did not feel well, telling them that he drank antifreeze.

The antifreeze was unsecured in a facility owned van. This individual was outside of the group home without staff when he drank the antifreeze.

The individual exhibited symptoms of dizziness around 3:30 p.m. and reported to staff he drank antifreeze. Staff verified antifreeze was in the vehicle and notified the management, including nursing staff, of the incident. No one recommended calling 911 or seeking outside medical evaluation.

The individual exhibited abnormal symptoms and behaviors. At dinner, he fell face first into his plate. He still was not medically evaluated.

After midnight, the individual got out of bed and fell. Staff on duty sent the individual to a local emergency room for the fall. Staff did not report the antifreeze ingestion to hospital staff. It was discovered by hospital staff as a result of abnormal lab results. The facility staff initially denied the client had access to anything more toxic than hand soap.

Individual was diagnosed with Acidosis and treated for the ingestion of antifreeze. He went into respiratory failure, was intubated, placed on a ventilator (life support) and was then life-flighted to a Charleston hospital where he spent approximately a week in ICU.

Individual was diagnosed with Ethylene Glycol Poisoning (ingredient of antifreeze), unresponsive, and on a ventilator for four days. His kidneys shut down requiring dialysis for 11 days. After removal from ventilator, he had difficulty swallowing, required thickened liquids for 18 days, and had vision problems. Individual was treated for pneumonia and sepsis during hospitalization; and would have died if left without treatment until the following morning.

This facility failed to get this individual emergency medical attention for antifreeze poisoning. He only received the lifesaving care he needed because he was sent to the hospital for an entirely unrelated issue approximately 9 1/2 hours later.

Examples of Serious Incidents

Individual receives services, including 24-hour staffing, from a behavioral health provider in his own rented apartment.

A direct care staff member attempted to intervene in an elopement situation; this staff member physically assaulted the individual by punching him in the face several times with a closed fist. Two other staff witnessed the assault and attempted to intervene. However, the staff member continued to punch the victim in the face several more times until law enforcement arrived. This provocation of the individual further provoked the individual causing him being subdued with a taser and taken into police custody.

At a later date, this same individual sustained a second degree burn injury to his right forearm from a burner on his cookstove at 4:28 p.m. On-duty staff notified the on-call RN and the program manager within minutes of the injury. The RN did not respond nor was EMS/911 called. Staff did not transport the individual to the hospital for the stated reason: they did not have enough staff. The individual was finally taken to the hospital at 9:52 p.m. This delay in emergency medical intervention caused the individual to suffer unnecessarily for over five hours, without any type of medical treatment or pain management.

An individual was restrained on many occasions with heavy blankets piled on top of him, even covering his head. Multiple staff sat on him, even sleeping on top of him, for long periods of time while playing on their phones.

Considerations

West Virginia has 67 ICFs/IID. One facility is pending certification based on previous legislation.

- Closing ICFs/IID limits placements of West Virginia's most vulnerable residents. The state moratorium prohibits new ICFs/IID. Once a certified facility closes, beds cease to exist based on CMS policy.
- Additional waiver slots and expansion of waiver providers
- Waiver homes are preferred by advocates and other groups as they are considered more home and community-based, where as ICFs/IID, by definition, are institutional
- Would allow for placement of individuals previously residing in ICFs/IID
- Waiver homes have also had serious and critical surveys; however, development of additional providers is permitted
- Waiver program may need amended to allow for appropriate nursing care
- Oversight, as certain waiver homes are not licensed or regularly surveyed

What Are We Doing?

- Providers are being held accountable
- Admission bans and census reductions
- Enforcement orders requiring additional reporting
- Collaboratively working with DHHR bureaus to address considerations from previous slide and other provider issues
  - DHHR's Bureau for Medical Services has been critical in assisting with difficult placements from facilities assessed admission bans or census reductions
  - DHHR's Bureau for Children and Families' Adult Protective Services regularly visits their clients, shares information with OHFLAC, and assists other bureaus with placement
  - DHHR Secretary's Office has met with providers multiple times to stress quality of care and that issues must be fixed
- Regular contact with advocates regarding provider concerns and solutions

What Next?

- Continue working with DHHR bureaus and other stakeholders
- Assess civil money penalties, combined with other available enforcement actions, based on new legislation and continue holding providers accountable
- Close non-compliant providers
- Involve any other affected party
  - Olmstead Coordinator and Council: vision is for all West Virginians with disabilities to live, learn, work, and participate in the most integrated setting in the community of their choice
  - Others?
- Review DHHR policies to identify areas requiring change based on health and safety trends or issues identified during the survey process
- Determine best practices to develop additional providers for waiver services
- Stay diligent and open to suggestions and improvements

Contact

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