A Disturbing Death:
Lack of Oversight at the
Psychiatric Institute of Washington

June 2021

Disability Rights DC at University Legal Services, Inc.
The Protection and Advocacy Agency for the District of Columbia

Address
Suite 130
220 I Street NE
Washington, DC 20002

Contact
Phone: (202) 547-0198
Fax: (202) 547-2662
TTY: (202) 547-2657

Website
www.uls-dc.org
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 staff 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.

For more information about this report or to request additional copies, please contact:

Jane Brown
Executive Director
University Legal Services, Inc.
220 I Street, N.E.
Suite 130
Washington, D.C. 20002
202.547.0198 (voice)
202.547.2657 (tty)

Or visit our website at:

I. EXECUTIVE SUMMARY

As the federally mandated Protection and Advocacy program for the District, Disability Rights DC has the authority to conduct investigations into allegations of abuse and neglect at the District’s psychiatric institutions.\(^1\) What appear to be very disturbing specific and systemic failures by PIW, DBH and DC Health surfaced during multiple Disability Rights DC investigations into allegations of abuse and neglect at PIW over the past several years. The purpose of this report is to emphasize and detail these apparent failures, to bring attention to these practices, and to elicit improved protection of patients and increased oversight of services by District leadership.

The Psychiatric Institute of Washington (“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.\(^2\) PIW admits and discharges hundreds of patients each month and offers a spectrum of services, including acute inpatient adult and adolescent units, as well as outpatient and partial hospitalization programs.\(^3\) PIW admits both voluntary and involuntary adult and adolescent patients and houses them on locked units.\(^4\) 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.\(^5\)

PIW is one of 400 facilities owned by Universal Health Services (UHS), a large corporate entity that provides healthcare services nationally.\(^6\) UHS-operated behavioral health services have received criticism nationally, recently culminating in a $122 million civil settlement with the United States Department of Justice (DOJ) in 2020.\(^7\) Allegations made in lawsuits that were resolved as a result of this DOJ settlement include the failure to provide adequate staffing,

---

\(^1\) 42 U.S.C. § 10805(a)(1)(A) (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…”).
\(^2\) Psych. Inst. of Washington, About the Psychiatric Institute of Washington, [https://psychinstitute.com/about-us/](https://psychinstitute.com/about-us/) (last visited June 16, 2021). St. Elizabeths Hospital is also a psychiatric facility located in Washington, D.C. However, in contrast to PIW, it is public, 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](https://dbh.dc.gov/page/saint-elizabeths-hospital) (last visited June 16, 2021).
\(^3\) Psych. Inst. of Washington, Outpatient and Inpatient Treatment Programs, [https://psychinstitute.com/treatment-services/](https://psychinstitute.com/treatment-services/) (last visited June 16, 2021).
\(^4\) Contract, Dep’t of Behav. Health, Psych. Inst. of Washington C.2.3.1 (signed Sept. 27, 2013).
\(^5\) D.C. Mun. Reg. Ch. 22-A3401.5; D.C. Code §§ 7–731(4), 7–1141.06(3).
training, and supervision of staff, as well as the improper use of restraint and seclusion. Additional allegations included the failure to discharge patients when hospitalization was no longer necessary, the failure to develop and/or update treatment plans, and the failure to provide adequate psychotherapy and discharge planning.

This report examines allegations of specific incidents of abuse and neglect at PIW, as well as systemic failures in PIW’s quality improvement system, which are very troubling. Concerns that the District government is not sufficiently providing the required oversight of PIW are equally as alarming.

The Death of William Grant: PIW Staff Failed to Initiate Timely, Potentially Life-Saving Measures.

Disability Rights DC was alerted to allegations of serious staff neglect related to the death of William Grant on April 26, 2020, and in an additional incident involving Mr. Grant that occurred two days prior on April 24, 2020. On the day of his death, videotape footage reveals that during the time in which nursing staff left this patient unsupervised, Mr. Grant became unresponsive and appeared to stop breathing. Although a physician ordered Mr. Grant to receive 1:1 staffing for safety purposes, nursing staff failed to follow this order. Inexplicably, once staff, including nursing staff, discovered him in this condition, they did not act: PIW staff failed to properly assess him, failed to perform CPR, and failed to provide any potentially lifesaving measures for at least 21 minutes. Furthermore, Disability Rights DC has extensively reviewed the videotape footage from the time of Mr. Grant’s death and has found that the footage is widely inconsistent with PIW staff’s documentation of the circumstances surrounding his death.

The District Itself Failed to Adequately Investigate Disability Rights DC’s Allegations of Abuse & Neglect at PIW or Provide Adequate Oversight.

In response to our initial review of Mr. Grant’s death, Disability Rights DC reported these serious allegations of neglect to PIW, DC Health, and DBH. Only DC Health eventually investigated; however, it took them nearly eight months to provide Disability Rights DC with their

---

8 Id. (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).

9 Id.

10 Pseudonym used to protect patient privacy.


14 See Attachment I for detailed analysis of Videotape Footage.

15 Email from Staff Attorney at Disability Rights DC to DBH, DC Health, and PIW (July 9, 2020, 5:25 PM) (formal allegations attached) (on file with author).
report on March 5, 2021. This DC Health report investigated a prior incident involving Mr. Grant on April 24, 2020, in which serious nursing deficiencies were substantiated. These substantiated deficiencies include PIW staff’s failure to document and inform Mr. Grant’s physician of a serious change in his medical condition in which Mr. Grant’s oxygen saturation became dangerously low, he required oxygen administration, a code blue was called for him, and Emergency Medical Services were called to intervene. The seriousness of these deficiencies cannot be understated, as Mr. Grant died under what appear to be similar circumstances two days after this first incident. Moreover, the investigation report failed to adequately address the neglect allegations on the day of Mr. Grant’s death, rather it chose to focus on the prior incident.

A revised investigation report by DC Health, sent to Disability Rights DC on March 8, 2021, fails to adequately investigate the allegations of neglect related to Mr. Grant’s death. The investigation incorrectly analyzed the videotape footage, as it stated that staff found Mr. Grant unresponsive at 12:40 PM and that a “code for medical support was called.” However, Disability Rights DC’s analysis of the videotape reveals that staff did not begin resuscitation until 1:01 PM, 21 minutes after PIW staff first entered Mr. Grant’s room and videotape footage showed he appeared not to be breathing.

Finally, PIW has its own policies that require investigations. If PIW did investigate Mr. Grant’s death, it failed to provide evidence of this investigation to Disability Rights DC, in violation of federal law. DBH’s failure to follow up with the DC Health investigation of Mr. Grant’s death and the failure to require PIW to investigate these allegations of serious neglect demonstrates another critical flaw in the District’s oversight of its behavioral health facilities.

Allegations of Serious Neglect Demonstrates Considerable Flaws in the District’s Oversight of its Behavioral Health Facilities.

PIW is required to adhere to the Center for Medicare and Medicaid Services ("CMS") Conditions of Participation to receive federal reimbursement for Medicare patients. Additionally, PIW is accredited by the Joint Commission, and therefore is required to adhere to Joint Commission requirements to maintain their accreditation. CMS and the Joint commission

---

16 D.C. Health Investigation Report for Psych. Inst. of Washington Complaint No. DC00009862 (undated) (attached to email from Associate Director, Office of Health Facilities, DC Health, to Staff Attorney, Disability Rights DC (Mar. 5, 2021, 3:40 PM) (on file with author).
17 Id.
18 Id.
19 Id.
20 See Revised D.C. Health Investigation Report for Psych. Inst. of Washington Complaint No. DC00009862 3 (undated) (attached to email from DC Health to Disability Rights DC, Mar. 8, 2021, 7:07 PM) (on file with author).
21 See Attachment I: Summary of Videotape Footage and Tracings.
22 See infra § III.C and notes 113-19.
have similar standards in that they require facilities to maintain an effective risk management system and an ongoing quality improvement system.26

The District is obligated to provide oversight of PIW to ensure an effective quality improvement system and patient safety, but it appears to be failing with PIW. Both D.C. Law and the Human Care Agreement between DBH and PIW provide that DBH has oversight authority with regard to patient care at PIW.27 As part of its oversight authority, D.C. Law requires DBH to investigate, or ask another agency to investigate, “upon request” or at its “own initiative” “any complaint alleging abuse or neglect of any consumer of behavioral health services.”28 In addition, PIW’s own internal investigation policy recognizes the need to investigate “hospital occurrences,”29 including deaths, suicide attempts, chemical or physical restraint, seclusion, any sexual activity between patients or between patients and staff, any abuse, neglect, or exploitation of a patient by staff, any assault of a patient by staff or another patient, and “[a]ny major threats, contraband, riots, significant destruction of property, or any incident that requires the intervention of the Police and/or Fire Department.”30

As part of its investigation into PIW’s systemic failures related to incidents and investigations, Disability Rights DC sent two separate Freedom of Information Act (“FOIA”) requests to DC Health and DBH, requesting all Major Unusual Incidents (“MUIs”), complaints, grievances and investigation reports related to PIW occurring during a thirteen-month period. Responses to these FOIA requests reveal at least twelve (12) serious and disturbing incidents that should have necessitated investigations based on DBH or PIW policies.32 However, despite Disability Rights DC’s explicit request to DBH for any and all investigation reports related to PIW, none were provided. The lack of any investigations completed by DBH related to PIW or provided to DBH by PIW for over a year’s time raises serious concerns about DBH’s oversight of PIW’s adherence to investigation procedures dictated by DBH and PIW policies.

June 16, 2021) (stating their mission “is to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. Its vision is that all people always experience the safest, highest quality, best-value health care across all settings”).

26 42 CFR § 482.21(c)(2); The Joint Commission, Program: Behavioral Health and Human Services: Performance Improvement, PI 01.01.01 (e-dition on file with author).

27 Contract, Dep’t of Behav. Health, Psych. Inst. of Washington C.2.3.1 (signed Sept. 27, 2013). The contract also specifies that PIW “shall make beds available to provide acute psychiatric care and treatment to persons referred by the DBH for admission on both a voluntary and an involuntary basis,” C.1.2.2, and that PIW “shall provide acute psychiatric care and treatment to persons referred by DBH for admission on both a voluntary and involuntary basis...in accordance with acceptable standards of care.” C.1.2.3.

28 D.C. Code § 7-1141.06 (12) The Department “shall” . . . “Upon request or on its own initiative, investigate, or ask another agency to investigate, any complaint alleging abuse or neglect of any consumer of behavioral health services, and, if the investigation by the Department or an investigation by any other agency or entity substantiates the charge of abuse or neglect, take appropriate action to correct the situation, including notification of other appropriate authorities.” Cf., DBH Policy 662.1 Major Investigations (Aug. 31, 2015).


30 Psych. Inst. of Washington Policy No. ADM.143.

31 Freedom of Information Act Request from Disability Rights DC to Dep’t of Health (June 17, 2020); Freedom of Information Act Request from Disability Rights DC to DBH (Jan. 21, 2021); Freedom of Information Act Request from Disability Rights DC to DC Health (May 18, 2020).

32 Dep’t of Behav. Health Policy No. 480.1A §§ 5c(2), 5c(7); Psych. Inst. of Washington Policy No. ADM.143.
Furthermore, despite reporting requirements, the DBH FOIA responses contained very few Major Unusual Incident reports submitted by PIW during that thirteen-month period. An MUI report contains an initial brief description of serious incidents to be completed by PIW staff involved in the incident. 33 Certain MUIs then must be submitted to DBH, including all restraints, seclusions, suicide attempts, falls, injuries, deaths, sexual assault, physical abuse, and employee neglect. 34 Remarkably, in 13 months, PIW only reported 33 MUIs. By contrast, during the same one-year period, St. Elizabeths Hospital’s published data indicates 1,029 MUIs occurred. 35 Moreover, of the 33 MUIs at PIW, only six (6) MUIs involved restraint and seclusion. Again, by contrast, during the first three months of 2021, St. Elizabeths Hospital’s MUI reports indicate that staff employed seclusion and restraint approximately 80 times, excluding chemical restraint. 36 Such a significant disparity should be addressed by DBH to ensure that PIW is adequately documenting and reporting all major unusual incidents as policies require.

Additionally, DBH requires that “a follow-up report shall be submitted by the provider within ten (10) business days from the date of the initial submission of the written MUI report to DBH...when more information is needed in the MUI report.” 37 However, the follow-up sections on most of the MUIs provided to Disability Rights DC by DBH are blank, so there is no evidence that PIW submitted follow-up information and/or investigation reports or that DBH requested additional information.

DC Health Surveys Detail More Neglect and PIW’s Lack of Compliance with CMS Regulations.

In the past few years, DC Health has conducted several regulatory surveys which reveal serious violations of CMS Conditions of Participation, many placing patients at PIW at risk. 38 These include a lack of an effective monitoring system and failure to ensure an effective quality improvement program, 39 non-compliance with narcotics administration and storage, 40 substandard facility maintenance and sanitation, 41 inadequate medical record keeping, 42 inadequate risk management, 43 and a failure to adhere to infection control procedures. 44 These findings should alert DC Health, DBH, and others to the need for greater accountability and oversight. Yet, Disability Rights DC has not seen evidence of this.

33 See Dep’t of Behav. Health Policy No. 480.1A, Ex. 2.
34 Id. at 480.1A, Ex. 1a.
36 Disability Rights DC analyzed redacted MUI reports from St. Elizabeths Hospital from January 1, 2021 through March 31, 2021, of which approximately 80 involved incidents of seclusion and/or restraint, excluding chemical restraint.
37 Dep’t of Behav. Health Policy No. 480.1A § Se(1).
40 Id. at 18-19.
42 D.C. Health Investigation Report for Psych. Inst. of Washington Complaint No. DC00009862 5, 6 (undated) (attached to email from DC Health to Disability Rights DC, Mar. 8, 2021, 7:07 PM).
District residents with mental health disabilities are entitled to quality behavioral health services that are, first and foremost, safe and protect them from harm. An adequately resourced and robust incident and investigation system is an integral part of any quality improvement system and is imperative in maintaining patient safety, as well as protecting patients’ rights and improving the quality of services. Meaningful government oversight is equally as important to ensure quality care and protect PIW patients from harm. Serious incidents of abuse and neglect, including PIW staff’s failures to initiate potentially life-saving measures after Mr. Grant became unresponsive and appeared to have stopped breathing, are very troubling. Moreover, the lack of evidence that any PIW investigation reports were submitted to DBH for over a year, the failure to fully investigate Mr. Grant’s death, the relatively few MUIs that PIW submitted to DBH, as well as the lack of evidence of follow up related to the MUIs submitted to DBH, all raise serious questions as to whether PIW is adhering to these important requirements and whether PIW is allocating adequate resources to its quality performance improvement system.

Disability Rights DC Recommendations

(1) DBH and DC Health must provide increased and meaningful oversight of PIW’s quality improvement system, including incident reporting and investigatory processes. Both DBH and DC Health must require PIW to provide a robust risk management response to major unusual incidents at PIW and require more in-depth follow-up and investigations that will ensure improved patient care. The District must also ensure that PIW is adhering to all DBH and DC Health/CMS requirements.

(2) PIW should provide DBH, DC Health, and Disability Rights DC with a corrective action plan describing (a) how they will ensure that they are adhering to all DBH and PIW requirements related to incidents and investigations, and (b) how they will ensure that PIW’s risk management and quality improvement is adequately resourced. DBH and DC Health must ensure the plan is implemented.

(3) Disability Rights DC requests a meeting with DBH, DC Health, and PIW to discuss the issues raised in this report.
II. PIW Staff Failed to Initiate Timely, Potentially Life Saving Measures.

In May of 2020, Disability Rights DC opened an investigation into the death of William Grant, who was a patient at PIW, after Disability Rights DC received a complaint with allegations of abuse and neglect regarding the treatment PIW provided. Pursuant to its federal authority, Disability Rights DC received and reviewed Mr. Grant’s medical records, videotape footage from the day of his death, and other documentation. Disability Rights DC’s investigation revealed what appears to be serious and disturbing PIW staff neglect surrounding Mr. Grant’s death.

A. Videotape Footage Shows Disturbing Conduct.

Videotape footage clearly shows that staff failed to provide potentially life-saving treatment for at least twenty-three (23) minutes after Mr. Grant appeared to have stopped breathing and twenty-one (21) minutes after staff entered the seclusion room where he lay. Videotape footage begins with Mr. Grant alone in a seclusion room lying on a thin mat, naked, with only a sheet covering his lower body. [The DC Health investigation report notes that staff placed Mr. Grant in the seclusion room because that was “where [Mr. Grant] slept due to his loud snoring and complaints from his roommate.”] Mr. Grant can be seen breathing, as his chest and abdomen are rising and falling in a respiratory pattern. At approximately 12:30 PM, he rolls on his side and appears to still not be breathing. Two minutes later, a staff person enters the room and discovers Mr. Grant lying motionless, face down on a mat where he appears not to be breathing. Staff #1 appears to attempt to speak to Mr. Grant and moves his arm out from underneath him. Almost two minutes later, while Mr. Grant has still not moved and appears to still not be breathing, another staff enters the room. The two staff engage in an animated discussion for seven (7) minutes instead of assessing Mr. Grant, calling for help, or implementing

---

45 Pseudonym used to protect patient privacy.
46 42 U.S.C. § 10805(a)(1)(A) (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…”).
47 See infra Attachment I: Summary of Videotape Footage and Tracings.
49 See Revised D.C. Health Investigation Report for Psych. Inst. of Washington Complaint No. DC00009862 (undated) (attached to email from DC Health to Disability Rights DC, Mar. 8, 2021, 7:07 PM) (on file with author).
50 Id.
52 Id. at 12:32:23 PM.
53 Id. at 12:37:49 PM. to 12:38:06 PM.
54 Id. at 12:40:03 PM.
55 Id. at 12:40:26 PM.
56 Videotape at 12:42:08 PM.
resuscitation efforts. Approximately nine (9) minutes after the first staff entered the room, another staff, who appears to be a nurse, enters. She also fails to conduct an adequate physical assessment, nor does she begin resuscitation efforts -- even though Mr. Grant still appears to have stopped breathing and is unresponsive. Instead, she places her hands on her hips, looks down at Mr. Grant from several different angles, but does not turn him over, touch him, or manually check for a pulse. At approximately 12:56 PM, staff finally turn Mr. Grant over on his back. His face appears blue and again, he is not moving and shows no signs that he is breathing. Only at that point did staff begin resuscitation measures and CPR -- twenty-three (23) minutes after the video footage shows that Mr. Grant appeared to have stopped breathing and twenty-one (21) minutes after the first staff person entered the room. See Attachment I for a detailed summary of the videotape footage and tracings of key moments in the videotape.

The PIW staff and nurses failed to implement basic nursing standards of patient care and are shockingly inconsistent with national guidelines for the appropriate response to an unconscious and/or unresponsive patient. The National Institutes of Health standards of care recommend an initial assessment of an unconscious or unresponsive patient by utilizing the “ABCDE” approach, which assesses the patient’s airway, breathing, circulation, disability, and exposure by checking for a pulse and performing a physical assessment. This initial assessment cannot be delegated by the nurse to other members of staff and, thus, the nurse was required to perform the initial assessment of Mr. Grant. The videotape footage clearly shows that, after the nurse entered the room, she observed Mr. Grant while he was lying face down on the mat, yet she failed to even touch him to obtain whether he had a pulse, nor did she turn him over to check his airway and to properly assess his breathing status for six (6) minutes. The nurse also violated D.C. Board of Nursing standards that prohibit a nurse from leaving a patient for any length of time, “that exposes the [patient] unnecessarily to risk of harm” when, after entering the room and seeing Mr. Grant was unresponsive, she left the room to get a blood pressure cuff, permitting Mr. Grant to be unattended by nursing staff. Furthermore, CMS Conditions of Participation require a registered nurse to be immediately available for the care of any patient, yet it took over nine minutes for a nurse to enter Mr. Grant’s room after staff first discovered him unresponsive.

57 Id. at 12:42:24 PM to 12:48:40 PM, 12:48:40 PM and 12:48:53 PM (at 12:48:40 PM Staff #1 and Staff #2 leave the room to presumably get Staff #3).
58 Id. at 12:49:11 PM.
59 Id. at 12:49:17 PM.
60 Id.
61 Videotape at 12:56:01 PM.
62 Id.
63 Id. at 1:01:08 PM.
64 National Institutes of Health, A Systematic Approach to the Unconscious Patient (Feb., 2020) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6330912/ (stating “a systematic and structured ABCDE (airway, breathing, circulation, disability, exposure) approach should be employed by teams caring for unconscious patients”).
65 Id.
66 DC Board of Nursing Standard 5415.14(a).
68 DC Board of Nursing Standard 5416.4(b).
69 42 CFR § 482.23(b).
B. Medical Records Do Not Match the Video.

Medical records indicate that Mr. Grant’s physician had ordered him to be on a one to one (“1:1”) staff ratio.71 A doctor’s progress note dated April 25, 2021, indicates that “patient is still on 1:1 [staffing] for safety.”72 However, the videotape footage shows that staff did not provide 1:1 staff oversight.73 The videotape footage reveals that staff did not enter the seclusion room for at least one hour and 10 minutes prior to Mr. Grant having convulsions and ceasing to breathe.74 Thus, staff failed to observe Mr. Grant’s apparent shortness of breath and convulsions and failed to observe him for at least two minutes after he became unresponsive and appeared to stop breathing.

Mr. Grant’s medical records contain a Registered Nurse (RN) narrative note, timed at 11:30 on the morning of his death, indicating that Mr. Grant was alert and verbally responsive, assisted by staff into the bathroom for his ADLs, ate breakfast, returned back to his bed and fell asleep snoring.75 However, at 11:30 AM, Mr. Grant was not in his bed but can be seen on the videotape footage naked, covered only by a sheet, lying on a thin mat in a stark and empty seclusion room.76 The note then states that “staff requested for the nurse to come see the patient because he was not breathing well.”77 The note continues that Mr. Grant was “slumped breathing; and he was turned on his back, flat on the floor.”78 However, the videotape footage clearly shows that when the nurse arrived in the room, Mr. Grant was laying on his stomach, not “slumped” and appeared to not be breathing.79 Furthermore, the video tape reveals that staff did not turn Mr. Grant over on his back for almost 7 minutes after the nurse first came onto the room.80

Similarly, the emergency service transfer note, completed by an RN, states that Mr. Grant “was found unresponsive in open door quiet room at 12:50 PM.”81 The note states that Mr. Grant “suddenly became unresponsive with no pulse” and that “oxygen was started,” “CPR was initiated” and “continued for 10 minutes. . .”82 However, the note fails to note that CPR was not initiated until over 21 minutes after staff first came into Mr. Grant’s room.83 The note also states that Mr. Grant “had 1:1 ongoing,”84 which contradicts the videotape as it does not show evidence that a 1:1 staff was with Mr. Grant. The note also indicates that Mr. Grant’s blood pressure was 138/85, his pulse was 54, and his oxygen level was 88%.85 This is questionable, given that, from

73 Videotape at 11:30:56 AM to 12:38:06 AM (April 26, 2020).
74 Id.
76 Videotape at 11:30:56 AM.
78 Id.
79 Videotape at 11:30:56 AM (April 26, 2020).
80 Id. at 12:56:01 PM.
81 Psych. Inst. of Washington, Emergency Service Transfer Note (April 26, 2020, 1:30 PM).
82 Id.
83 Videotape at 1:01:08 PM.
84 Psych. Inst. of Washington, Emergency Service Transfer Note (April 26, 2020, 1:30 PM).
85 Id.
the video, Mr. Grant appears to have stopped breathing at least 10 minutes prior to the nurse attempting to take his blood pressure, and given that his face color appears to be blue.\footnote{Videotape at 12:52:40 PM, 12:55:08 PM, 12:56:06 PM (April 26, 2020).} Moreover, according to the video, it appears staff did not even attempt to take his blood pressure until over twelve (12) minutes after he was found unresponsive. The nurse did not attempt to take his vital signs until almost six (6) minutes after she entered the room.\footnote{Id. at 12:49:11 PM to 12:55:08 PM.}

Finally, the Patient Observation Form, dated 4/26/20, indicates that staff observed Mr. Grant every 15 minutes on the day of his death and that he was sleeping from 11:30 AM to 12:45 PM.\footnote{Psych. Institute of Washington, \textit{Patient Observation Chart} 11:30 AM to 12:45 PM (April 26, 2020, signed at 12:50 PM).} However, from 11:30 AM to 12:40 PM, no staff can be seen entering the seclusion room; the videotape footage provides no evidence that staff were looking at Mr. Grant from the doorway, much less coming into the room to observe him.\footnote{Videotape at 11:30:56 AM to 12:40:03 PM.} Nor does the Patient Observation Form indicate that he is in the seclusion room.\footnote{Psych. Institute of Washington, \textit{Patient Observation Chart} 11:30 AM to 12:45 PM (April 26, 2020, signed at 12:50 PM).}

\section*{C. Nursing Deficiencies are Evident Two Days Prior to Mr. Grant’s Death.}

In response to our initial review of Mr. Grant’s death, Disability Rights DC reported these serious allegations of neglect to PIW, DC Health, and DBH.\footnote{Email from Staff Attorney at Disability Rights DC to DBH, DC Health, and PIW (July 9, 2020, 5:25 PM) (formal allegations attached) (on file with author).} Only DC Health eventually investigated; however, it took them nearly eight months to provide Disability Rights DC with their report.\footnote{D.C. Health Investigation Report for Psych. Inst. of Washington Complaint No. DC00009862 (undated) (attached to email from Associate Director, Office of Health Facilities, DC Health, to Staff Attorney, Disability Rights DC (Mar. 5, 2021, 3:40 PM) (on file with author).} This DC Health report investigated an incident involving Mr. Grant on April 24, 2020, two days prior to his death, in which serious nursing deficiencies were substantiated.\footnote{Id. at 4, 5.} These substantiated deficiencies include PIW staff’s failure to document and inform Mr. Grant’s physician of a serious change in his medical condition in which Mr. Grant’s oxygen saturation became dangerously low, he required oxygen administration, a code blue was called for him, and Emergency Medical Services were called to intervene.\footnote{Id. at 5, 6.}

The investigation report indicates that the RN reported the following regarding the April 24, 2021 incident:

\begin{quote}
I was called to the seclusion room by the Psychiatric Counselor, where the patient was sleeping, and He [the patient] was not responding [to verbal attempts to] wake up. I called a code Blue and 911 [Emergency Medical Services] and administered oxygen to the patient as his Oxygen [PO2 Oxygen Saturation %] was 86%. After 911 arrived, His [the patient] oxygen was 97%, and he was eating and
\end{quote}
moving around. The patient shook his head "no" when asked to go to the emergency room to both myself and 911."\textsuperscript{95}

The investigator then notes:

At the time of the telephone interview, Employee #2 [the registered nurse] acknowledged that her daily nursing note dated 04/24/2020 at 6:00 AM did not document the change in the patient's medical condition. She further stated she did not document details, including the patient's 86% oxygen saturation, unresponsiveness, Code Blue, and the Emergency Medical Services in attendance who provided interventions. Additionally, she did not document the physician was notified regarding the change in Patient #1's condition.\textsuperscript{96}

Disability Rights DC also found no evidence that this incident was documented in the medical record progress notes, or that the nurse notified Mr. Grant's physician about the incident. In fact, according to Mr. Grant's physician, he saw Mr. Grant the evening of April 24, 2020 and "saw no documentation, information, unusual medical findings or reports, or any episode about him at the time of my visit with [Mr. Grant]."\textsuperscript{97} The lack of evidence that Mr. Grant's doctor was notified of this significant change in clinical condition is even more alarmingly given that Mr. Grant experienced what appears to be a similar incident two days later, one in which he did not survive, thus demonstrating the importance of such documentation.

D. The Allegations of Staff Neglect Have Not Been Adequately Investigated.

As will be discussed in detail in Section III of this report, the District is obligated to investigate certain incidents, including the death of patient at PIW.\textsuperscript{98} However, neither DBH or DC Health conducted an adequate investigation of the allegations of staff neglect after Mr. Grant became unresponsive and appeared to have stopped breathing.

DC Health's initial investigation report send to Disability rights DC on March 5, 2021, failed to address the neglect allegations on the day of Mr. Grant’s death, and rather chose to focus on the incident that occurred two days prior on April 24, 2020.\textsuperscript{99} A revised investigation report from DC Health, sent to Disability Rights DC on March 8, 2021, fails to adequately investigate the allegations of neglect on the day of Mr. Grant’s death.\textsuperscript{100} The revised report contains interviews of two of the PIW staff involved in the incident the day of Mr. Grant’s death, but fails to contain
evidence that the RN involved that day was interviewed. The revised report also incorrectly analyzed the videotape footage, as it stated that staff found Mr. Grant unresponsive at 12:40 PM and that a “code for medical support was called.” However, Disability Rights DC’s analysis of the videotape reveals that staff did not begin resuscitation until 1:01 PM, 21 minutes after PIW staff first entered Mr. Grant’s room and footage showed he appeared not to be breathing.

PIW also failed to provide evidence that they investigated Disability Rights DC’s allegations of neglect related to Mr. Grant’s death. Pursuant to its federal investigatory authority, Disability Rights DC requested that PIW provide any investigation reports related to Mr. Grant’s death; however, PIW did not provide any investigation reports. Nor did PIW provide evidence that it investigated the failure of nursing staff to document the “code blue” two days prior to Mr. Grant’s death or the nurse’s failure to report this serious medical occurrence to Mr. Grant’s doctor. DBH’s failure to follow up with the DC Health investigation into Mr. Grant’s death and the failure to require PIW to investigate these allegations of serious neglect demonstrates another critical flaw in the District’s oversight of its behavioral health facilities.

III. PIW’s Incident and Investigation/Quality Improvement System Appears to Need Significant Improvement.

A. CMS and Joint Commission Requirements Include Risk Management and Quality Assurance.

PIW is required to have an adequate quality improvement system. 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.” Moreover, PIW is required to adhere to CMS Conditions of Participation to receive federal reimbursement for Medicare patients. These 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

101 Id.
102 Id.
103 See Attachment I: Summary of Videotape Footage and Tracings.
104 See generally Dep’t of Behav. Health Off. of Accountability, DBH Mortality Review Report Form completed by PIW (signed June 18, 2020) (although PIW provided Disability Rights DC with a mortality report, it was completed prior to Disability Rights DC’s allegations and only briefly summarized Mr. Grant’s hospital course and circumstances surrounding his death as noted in the medical records and does not address Disability Rights DC’s allegations of neglect surrounding Mr. Grant’s death).
reduction of medical errors, is defined, implemented, and maintained.” A hospital’s performance improvement activities must “track medical errors and adverse patient events, analyze their causes, and implement preventative actions and mechanisms that include feedback and learning throughout the hospital.” Further, the hospital must ensure that “adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital’s performance and reducing risk to patients.” 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.”

In addition, PIW is accredited by the Joint Commission, and therefore is required to adhere to Joint Commission requirements to maintain their accreditation. Similar to the CMS standards, the Joint Commission standards require that PIW have an effective risk management system that tracks and analyzes data to “improve its ability to provide quality care, treatment, or services,” especially those that “involve risk and can harm the individuals served.” These include “high-risk, high-volume, problem-prone processes provided to high-risk or vulnerable populations” such as “the use of restraints, seclusion, suicide watch, and behavior management and treatment.” The failures examined in this report raise serious questions as to whether PIW is adhering to these important requirements and whether PIW is allocating adequate resources to its performance improvement system. Equally as concerning is DBH’s lack of adequate oversight to ensure an effective system and, thus, protect the patients at PIW.

B. DBH Has Oversight Authority Over PIW.

DBH is the “exclusive agency to regulate all behavioral health services and behavioral health supports” in the District. Moreover, a contract between PIW and DBH specifically obligates DBH to provide oversight authority, stating that DBH “shall oversee and monitor the provision of acute inpatient psychiatric care and treatment to patients” at PIW. In addition to

---

107 42 CFR § 482.21 (e)(1); see 42 CFR § 482.42 (requiring psychiatric hospitals to meet the requirements of 42 CFR §§ 482.1 through 482.23 and 482.25 through 482.57.
108 42 CFR § 482.21 (c)(2).
109 42 CFR § 482.21 (e)(4) (emphasis added).
110 42 CFR § 482.21 (c)(1).
111 Psych. Inst. of Washington, Licensing and Accreditation, https://psychinstitute.com/licensing-accreditation/ (last visited June 16, 2021); see also Joint Commission, About the Joint Commission, https://www.jointcommission.org/about-us/ (last visited June 16, 2021) (stating their mission “is to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. Its vision is that all people always experience the safest, highest quality, best-value health care across all settings”).
112 The Joint Commission, Program: Behavioral Health and Human Services: Performance Improvement, PI 01.01.01 (e-dition on file with author).
113 Id. at PI.01.01.01 § 20.
114 D.C. Code § 7–1141.06(10).
115 Contract, Dep’t of Behav. Health, Psych. Inst. of Washington C.2.3.1 (signed Sept. 27, 2013). The contract also specifies that PIW “shall make beds available to provide acute psychiatric care and treatment to persons referred by the DBH for admission on both a voluntary and an involuntary basis,” C.1.2.2, and that PIW “shall provide acute psychiatric care and treatment to persons referred by DBH for admission on both a voluntary and involuntary basis...in accordance with acceptable standards of care.” C.1.2.3.
the CMS requirements that PIW establish an adequate performance improvement system.\textsuperscript{116} DBH mandates that DBH contractors shall establish policies and procedures that address “investigation, documentation, follow-up, and monitoring.”\textsuperscript{117}

As part of its oversight authority, DBH is obligated to conduct investigations, or ask another agency to, investigate certain serious occurrences at PIW, including any complaint of abuse or neglect of any consumer of behavioral health services.\textsuperscript{118} DBH policy explains that consumer deaths related to suicide or unexpected deaths at a DBH certified program or facility must be investigated in accordance with DBH policy.\textsuperscript{119} DBH policy also states that “allegations of abuse, neglect, or exploitation of consumers shall be reported and investigated as a major unusual incident in accordance with DBH policies and regulations,” \textsuperscript{120} and that they “shall” investigate incidents that require notification of law enforcement, as well as “[i]ncidents related to consumer care that raises immediate concerns...regarding the health and safety of any consumer...”\textsuperscript{121} However, as discussed in detail below, DBH failed to provide any investigation reports related to PIW for over a one-year time period pursuant to Disability Rights DC’s request.

**C. PIW Own Policies Require Investigations.**

In addition to DBH’s investigation obligations, PIW also has its own internal investigation requirements pertaining to “hospital occurrences.”\textsuperscript{122} PIW policy defines a hospital occurrence as “any event that is outside the realm of daily hospital routine, and is reportable as defined by [PIW] policy and/or by policy of any external regulatory agency.”\textsuperscript{123} Included as a hospital occurrence are deaths, suicide attempts, chemical or physical restraint, seclusion, any sexual activity between patients or between patients and staff, any abuse, neglect, or exploitation of a patient by staff, any assault of a patient by staff or another patient, and “[a]ny major threats, contraband, riots, significant destruction of property, or any incident that requires the intervention of the Police and/or Fire Department.”\textsuperscript{124}

PIW policy states that it will conduct a “full investigation” for all hospital occurrences “for which all details are not self-evident.”\textsuperscript{125} 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.”\textsuperscript{126} Finally, the policy details investigation procedures, including that the Risk Manager

\begin{itemize}
\item \textsuperscript{116} See \textit{supra} § III.A and notes 99-103.
\item \textsuperscript{117} Dep’t of Behav. Health Policy No. 482.1(8).
\item \textsuperscript{118} See D.C. Code § 7–1141.06 (12).
\item \textsuperscript{119} Dep’t of Behav. Health Policy No. 662.1(6)(a)(1). This policy further states that all investigation reports will be forwarded to the DBH Office of General Counsel and processed in accordance with the D.C. Freedom of Information Act; Dep’t of Behav. Health Policy No. 662.1(6)(d)(2).
\item \textsuperscript{120} Dep’t of Behav. Health Policy No. 482.1(7)(a).
\item \textsuperscript{121} Dep’t of Behav. Health Policy No. 480.1A §§ 5c(2), 5c(7).
\item \textsuperscript{122} Psych. Inst. of Washington Policy No. ADM.041.
\item \textsuperscript{123} \textit{Id.}
\item \textsuperscript{124} Psych. Inst. of Washington Policy No. ADM.143.
\item \textsuperscript{125} Psych. Inst. of Washington Policy No. ADM.041; \textit{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”).
\item \textsuperscript{126} Psych. Inst. of Washington Policy No. ADM.041 at 1.
\end{itemize}
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.

D. DBH and DC Health Replies to FOIA Requests Did Not Contain Investigation Reports.

In 2020 and 2021, Disability Rights DC sent two separate Freedom of Information Act (“FOIA”) requests to DC Health and DBH, requesting all Major Unusual Incidents (“MUIs”), complaints, grievances and investigation reports related to PIW for over a year’s time -- from November 1, 2019 through June 17, 2020, and again from July 1, 2020 through January 21, 2021.

Alarming ly, the FOIA responses contained zero investigation reports. Therefore, (1) there is no evidence that DBH conducted any investigations at PIW for over a year, (2) nor is there evidence that PIW has submitted any investigation reports to DBH during the thirteen-month long FOIA request period.

In response to the Disability Rights DC FOIA request, DBH provided thirty-three (33) redacted MUIs submitted to DBH from PIW over the specified time-period. These forms, required by DBH, contain space for a brief, initial description of the incidents to be completed by the provider staff after the incidents occur, and also provide space for follow up information. Many of the MUIs involve troubling and serious incidents which meet the criteria for a PIW and/or DBH investigation, yet as noted above, Disability Rights DC did not receive evidence that DBH conducted an investigation, nor did PIW submit any investigation reports to DBH. Equally troubling, for most of the incidents, there is no evidence that DBH followed up after the initial brief description of the incident was submitted, nor did PIW submit follow-up information to DBH in most cases. Examples are summarized below.

Incidents Involving Alleged Staff Abuse and Neglect on the Adolescent Unit

1) According to an incident report, on June 7, 2020, a group of adolescent patients became aggressive toward staff, and staff were unable to deescalate the situation. The incident report indicates that staff notified the Metropolitan Police Department (“MPD”) and when they arrived, they intervened and arrested seven patients. All seven patients were returned to PIW the following day, at which point they were all “medicated for agitation.”

---

127 Id. at 2.
128 Dep’t of Behav. Health Policy No. 480.1A §§ 4, 5b(5).
129 Freedom of Information Act Request from Disability Rights DC to Dep’t of Health (June 17, 2020).
130 Freedom of Information Act Request from Disability Rights DC to Dep’t of Behav. Health (Jan. 21, 2021).
131 Email from Asst. Gen. Counsel at DBH to Staff Attorney at Disability Rights DC (July 21, 2020, 2:07 PM) (FOIA response attached) (on file with author).
132 See Dep’t of Behav. Health Policy No. 480.1A, Ex. 2. (Full MUI form sample available here: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/480.1A%20TL-324_0.pdf).
133 Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington 1 (June 7, 2020, 11:30 AM).
134 Id.
135 Id.
Because law enforcement was notified, both PIW and DBH should have conducted an investigation in order to ascertain how such a serious incident could have occurred and whether there were actions the staff could have employed to prevent or better de-escalate the situation. Yet, Disability Rights DC obtained no evidence that DBH investigated or that PIW submitted an investigation to DBH.

2) According to another incident report, on February 10, 2020, patients on the adolescent unit were being aggressive and disruptive in the middle of the night. The incident report indicates that staff “isolated patients for privacy and safety and were able to medicate” two of the patients “without any restrictive interventions.” The report states that the third patient “became combative and aggressive and was placed in a physical hold for safety” during administration of the medication. One patient alleged that she was “punched in the chest area by a staff member” during medication administration. 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.

The MUI notes that all staff involved were interviewed. The staff member alleged to have engaged in physical abuse denied the allegations and was removed from the schedule pending investigation. In addition, the MUI indicated that MPD was notified and arrived at the scene but determined that no crime had occurred after reviewing video footage and interviewing staff. According to the MUI, the staff member in question would remain off of the Youth Services unit.

Because this was a serious incident involving allegations of physical abuse by staff for which law enforcement was notified, this incident should have been fully investigated. Pursuant to PIW’s own policy, which requires an investigation report and a “detailed, careful examination of ... staff and patient interviews, review of pertinent documentation, and review of video footage,” a single paragraph summarizing the investigatory steps taken and the conclusions reached is not sufficient documentation of the investigation. Nor is there any evidence that DBH required, or that PIW acted to submit, a follow up report or internal investigation report to DBH. There is also no evidence that DBH conducted an investigation of this incident even though it should have based on its own policy because law enforcement was notified and the incident implicated consumer health and safety. Again, investigations into such serious allegations of staff abuse are critical, not only to

---

136 Dep’t of Behav. Health Policy No. 480.1A §§ 5c(2), 5c(7); Psych. Inst. of Washington Policy No. ADM.143; Psych. Inst. of Washington Policy No. ADM.041.
137 Id.
138 Id.
139 Id.
140 Id.
141 Id.
142 Id.
143 Id.
144 Id.
145 Id.
146 See generally Psych. Inst. of Washington Policy Nos. ADM.041, ADM.143.
147 Dep’t of Behav. Health Policy No. 480.1A §§ 4, 5b(5).
148 Dep’t of Behav. Health Policy No. 480.1A §§ 5c(2), 5c(7).
ensure abusive staff are removed from the unit, but also to examine the entirety of the incident to ascertain what steps staff could have employed to deescalate the situation and ensure this type of incident does not occur in the future.

3) An MUI dated November 5, 2019, notes that an adolescent patient alleged that a staff person sexually assaulted her. The MUI indicates that MPD was notified, interviews were conducted, and the videotape was reviewed. The MUI concludes that “[d]ue to inconsistencies in statement and video footage” it was determined that allegations were unfounded. Again, a paragraph briefly describing PIW follow up of an MUI does not constitute a complete investigation, yet there is no evidence that PIW submitted an investigation report to DBH. And due to the serious nature of sexual assault allegations and the notification of MPD, DBH should have also investigated.

**Incidents Involving Alleged Staff Abuse and Neglect on the Adult Unit**

1) An MUI with the date redacted indicates that a patient alleged being sexually assaulted by staff during admission. The patient then denied being touched by staff but “did not agree with being asked to comply with a safety search.” The MUI notes that MPD was notified and arrived at PIW, but the patient “declined MPD’s services.” The MUI has no follow up information, nor is there evidence that DBH requested or that PIW submitted an investigation report to DBH even though MPD was notified.

2) An MUI report dated December 30, 2019, indicates that a patient filed a complaint about a physical hold and reported that “he was held down and choked by staff” in a seclusion room. The MUI states that video footage was reviewed and concludes that the “technique during restraint was safe and technically sound,” thereby finding the allegation unsubstantiated. This is another serious allegation of a physically abusive restraint. A conclusory statement that the restraint used was “safe and technically sound,” without a further description of the technique used and further discussion of the allegations does not constitute an adequate investigation. Again, Disability Rights DC has no evidence that DBH requested or that PIW submitted an investigation report to DBH. Nor does Disability Rights DC have evidence that DBH investigated the incident despite the fact that it concerned the health and safety of a consumer, as required by DBH policy.

3) An incident report dated June 14, 2020, indicates that a patient alleged that she was sexually abused by staff at PIW, reporting “that the counselor offered her snacks for oral

---

149 Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington 1 (Nov. 5, 2019, 9:30 AM).
150 Id. at 2.
151 Id.
152 Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington 1 (date redacted, Labeled 1 by author).
153 Id.
154 Id.
155 Id.
156 Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington 1 (Dec. 30, 2019, 2:35 PM).
157 Id.
158 Dep’t of Behav. Health Policy No. 480.1A § 5c(7).
sex.” 159 According to the incident report, MPD was notified, those involved were interviewed, and the video footage was reviewed. PIW noted that the videotape footage showed that the staff member entered her room “to perform patient observation checks, had no snacks in his hands and did not close the door,” and that he “was in [the] bedroom for 20 seconds and 28 seconds.” 160 PIW thus concluded that the patient’s reported allegation was unfounded. 161 Again, there is no evidence that DBH requested or that PIW submitted a complete investigation report to DBH, and no indication that DBH investigated the incident even though MPD was notified, and the incident involved an alleged risk to consumer safety. 162

4) An MUI report dated June 1, 2020, indicates that a patient, who “required chemical restraint and seclusion,” reported that staff twisted her stomach and stepped on her foot during injection administration. 163 PIW categorized this as an allegation of “physical assault” and indicated that the DBH Accountability Administration was notified. 164 Although this was indeed an allegation of physical assault, PIW should have additionally categorized this as an incident of both restraint and seclusion. 165 Again, Disability Rights DC received no evidence that DBH requested or that PIW submitted an investigation report to DBH, nor that DBH investigated even though the incident raised concerns about consumer health and safety.

5) An MUI indicates that on December 6, 2019, a patient was physically held by staff, placed in seclusion, and administered a chemical restraint. 166 The patient later reported that he was attacked and grabbed by staff “for no apparent reason.” 167 The MUI states that PIW “will investigate,” however, there is no evidence that they submitted an investigation report to DBH.

6) According to an MUI, on December 11, 2019, a patient was involved in a physical altercation with another patient. 168 After being separated by staff, one patient was punched in the face. 169 The patient was placed in a physical hold and administered a chemical restraint, sustained a laceration and bruise to the eyebrow, and was transferred to the emergency room. 170 Even though MPD was notified, Disability Rights DC obtained no evidence that DBH investigated, even though law enforcement was involved, and the incident raised

159 Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington 1 (June 14, 2020, 2:00 PM).
160 Id. at 2.
161 Id.
162 Dep’t of Behav. Health Policy No. 480.1 §§ 4, 5c(7).
163 Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington 1 (June 1, 2020, 2:00 PM).
164 Id.
165 Dep’t of Behav. Health Policy No. 480.1A, Ex 1A §§ 12a, 12b (defines the MUI category of “Restraint” as “any manual or physical method, use of drugs as a restraint, mechanical device, material, equipment that immobilizes or reduces the ability of a consumer to move his or her arms, legs, body, or head freely.” This policy also states that “Seclusion” is an MUI category) (emphasis added).
166 Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington 1 (Dec. 6, 2019, 9:30 AM).
167 Id.
168 Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington 1 (Dec. 11, 2019, 1:00 PM).
169 Id.
170 Id.
concerns about consumer health and safety. Nor is there evidence that DBH requested, or that PIW submitted, an investigation or a follow up report to DBH.\textsuperscript{171}

7) An incident report with the date redacted indicates that a patient, who sustained a scratch to his right eye during a physical hold by staff, alleged that he was pushed to the ground prior to the physical hold.\textsuperscript{172} MPD was notified, arrived and took a report.\textsuperscript{173} However, Disability Rights DC received no evidence that DBH investigated the incident even though law enforcement was notified. Nor is there evidence that DBH requested, or PIW submitted an investigation or a follow up report to DBH, even though this incident involved the intervention of law enforcement.\textsuperscript{174}

8) An MUI report with the date redacted indicates that a patient who was admitted involuntarily “was able to push the stairwell door open and exit through the back stairs.”\textsuperscript{175} Staff were unable to locate the patient, the MDP was notified, and a “request for Emergency Detention was also filed by the facility.”\textsuperscript{176} The MUI also notes that “PIW will investigate.”\textsuperscript{177} However, the MUI contains no follow up information, nor does it indicate if the patient was located. Again, there is no evidence that DBH investigated, nor is there evidence that DBH requested, or PIW submitted, an investigation report to DBH.\textsuperscript{178}

9) An MUI dated June 22, 2020, indicates that housekeeping staff left a cleaning solution unattended in the bathroom and that a patient reported drinking the solution in an attempt to harm himself.\textsuperscript{179} The patient required transport to the emergency room for evaluation.\textsuperscript{180} Again there is no evidence that DBH requested or that PIW submitted an investigation to DBH, nor that DBH investigated even though the incident raised concerns about a consumer’s health and safety.\textsuperscript{181}

In addition to the MUIs described above, a recent alleged incident involving the alleged stabbing of a patients highlights the crucial role of oversight and protection for patients at PIW. A news report initially stated that “patients at the Psychiatric Institute of Washington went after fellow patients,” and that “D.C. police said they arrested three suspects in the attack and “[t]hree victims went to a hospital with minor injuries.”\textsuperscript{182} Based on the news report, Disability

\begin{enumerate}
\item \textsuperscript{171} Dep’t of Behav. Health Policy No. 480.1 § 5b(5); Psych. Inst. of Washington Policy No. ADM.143.
\item \textsuperscript{172} Id.
\item \textsuperscript{173} Id.
\item \textsuperscript{174} Psych. Inst. of Washington Policy No. ADM.0143.
\item \textsuperscript{175} Id.
\item \textsuperscript{176} Id.
\item \textsuperscript{177} Id.
\item \textsuperscript{178} Id.
\item \textsuperscript{179} Id.
\item \textsuperscript{180} Id.
\item \textsuperscript{181} Id.
Rights DC opened an investigation and requested that DBH and DC Health investigate. PIW subsequently informed Disability Rights DC that that one patient was stabbed and that the news report was not correct. Regardless, such serious allegations must be thoroughly investigated.

**E. DBH Reply to FOIA Request Contained Relatively Few MUI Reports.**

In addition to concerns about inadequate investigatory processes, DBH’s FOIA responses raise concerns that PIW is also not adequately documenting and reporting MUIs. 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.” DBH policy further provides that MUIs must be reported timely and accurately. 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.” Among the categories that DBH identifies as MUIs are restraint, seclusion, suicide attempt, physical assault, sexual assault, physical abuse, physical injury, death, psychological or verbal abuse, neglect, medical emergencies, and falls.

PIW’s own policies also require the hospital to report certain incidents or occurrences to DBH. The policy requires that any incidents of “[d]eath, physical injury (self-induced, accidental, or the result of assault) ... any emergency admission to general hospital, sexual assault, exploitation of a patient by staff, or elopement” be communicated to DBH within one hour. This policy also requires that “the Risk Manager or designee will send the required written reports to the relevant external agencies within 24 hours or the next business day.”

Despite these reporting requirements, as noted above, the DBH FOIA responses contained only thirty-three (33) MUIs submitted by PIW-- twenty-three (23) MUIs for the period between November 1, 2019, through June 17, 2020, and ten (10) for the period between July 1, 2020, through January 21, 2021. By contrast, during the same one-year period from November 1, 2019, through October 31, 2020, St. Elizabeths Hospital’s published data indicates an average daily census of 225 patients and reported that 1,029 MUIs, occurred. Moreover, of the 33 PIW MUIs PIW reported, thirteen (13) involved transfers to medical hospitals for medical condition and five (5) involved elopements. Only six (6) MUIs involved restraint and seclusion. Again, by contrast, during the first three months of 2021, St. Elizabeths Hospital’s MUI reports indicate that

---

183 Email from Staff Attorney at Disability Rights DC to DBH, DC Health (May 11, 2021, 4:06 PM) (formal complaint allegations attached).
184 Email from Representative for Quality Management Director at PIW to Staff Attorney at Disability Rights DC (May 12, 2021, 11:34 AM) (on file with author).
185 Dep’t of Behav. Health Policy No. 482.1 § 7(a).
186 Id. at § 6b.
187 Dep’t of Behav. Health Policy No. 480.1A §§ 4, 5b(1), 5b(2).
188 Id. at § 12.
189 Id. at Ex.1A.
190 Psych. Inst. of Washington Policy No. ADM.143.
191 Id.
staff employed seclusion and restraint approximately 80 times, excluding chemical restraint. 193 Such a significant disparity should be addressed by DBH to ensure that PIW is adequately documenting and reporting all major unusual incidents as policies require.

Additionally, DBH policy states that “a follow-up report shall be submitted by the provider within ten (10) business days from the date of the initial submission of the written MUI report to DBH ... when more information is needed in the MUI report.” 194 However, the follow-up sections on most of the MUIs provided to Disability Rights DC by DBH are blank, thus there is no evidence that PIW submitted follow-up information or investigation reports, nor is there evidence that DBH is requesting follow up information for serious instances of alleged abuse and neglect.

VI. DC Health Survey Findings

A robust quality improvement system, which includes adequate incident reporting and investigations, is essential in maintaining patient safety and ensuring quality care, as well as preventing incidents of abuse and neglect from reoccurring. In addition to the District’s obligations to ensure that PIW’s quality improvement system is adequately functioning and protecting its patients, the District, specifically DC Health, licenses and certifies health care facilities for compliance with state and federal health and safety by scheduling and conducting on-site surveys of the applicant’s services to determine whether the applicant satisfies the certification standards. 195 According to its website, DC Health conducts surveys to identify “deficiencies that may affect state licensure or eligibility for federal reimbursements under the Medicare and Medicaid programs.” 196 These regular, on-site surveys allow DC Health “to ensure health, safety, sanitation, fire, and quality of care requirements.” 197

Disability Rights DC received several surveys from 2019 and 2020 in response to a separate FOIA request to DC Health. 198 These surveys reveal serious and concerning deficiencies at PIW that violate multiple CMS Conditions of Participation, including serious nursing deficiencies. Notably, one survey attributes PIW’s lack of an effective monitoring system and failure to ensure an effective quality assurance program as contributing to many of the deficiencies. 199

---

193 Disability Rights DC analyzed redacted MUI reports from St. Elizabeths Hospital from January 1, 2021 through March 31, 2021, of which approximately 80 involved incidents of seclusion and/or restraint, excluding chemical restraint.
194 Dep’t of Behav. Health Policy No. 480.1A § 5e(1).
198 Freedom of Information Act Request from Disability Rights DC to DC Health (May 18, 2020).
September 23, 2019 Complaint Survey

The survey indicates that there was not documented evidence that quality improvement staff “implemented quality improvement activities to address medical errors or adverse events; medication safety and security; medication preparation and administration” and that the review “lacked evidence of quality improvement activities related to environmental safety and infection control precautions, during construction repair.”

The DC Health review confirmed the lack of an effective quality improvement system at PIW, raising serious concerns that PIW’s quality improvement and risk management failures place patients at risk of harm and fail to keep them safe. Deficiencies cited in the September 23, 2019, survey include:

1) Nurses administered medication in violation of multiple Hospital policies and regulations, including that the nurses left the medication room “with the windows open, narcotics on the counter and within reach of passersby,” and video footage revealed two adolescent patients reached in the medication window and took narcotics. It was determined that “25 Adderall tablets and nine Focalin tablets were missing,” and that one patient “ingested an undetermined amount of Adderall” and was transferred to Children’s Hospital. The surveyor noted that a nurse continued to fail to secure the medication carts which contained controlled substances and failed to sign out narcotics and ensure the correct narcotic medication count even though the Risk Manager assured the surveyor that this no longer took place.

2) A contracting staff was conducting repairs in an adolescent patient’s room, who was on suicidal precautions, and left a hand saw and a drill unattended and unsecured. At that time, ten patients on the unit were on suicidal and/or homicidal observation status.

January 15, 2020, Licensure Survey

In this annual licensure survey, DC Health identified a number of serious deficiencies related to patient care, medical record-keeping, and facility sanitation and maintenance. Deficiencies cited include:

1) PIW staff “failed to provide necessary care and services for a patient that was admitted with a lower extremity wound that medical staff assessed as gangrenous, discolored with drainage and infected.” Specifically, the nurse practitioner who conducted an admission History and Physical documented that the patient had a left lower leg bandage and noted “[w]ill follow up later,” but “[t]here was a six day delay for the wound consult for [the

200 Id. at 38.
201 Id. at 11.
202 Id. at 19.
203 Id. at 12.
205 Id. 23.
patient’s] left lower leg wound." A physician ordered that the patient have a dressing change and one application of topical medication; however, there was “no evidence ... to reflect that the nursing staff completed [the patient’s] dressing changes in accordance with the physician’s orders.” In addition, nursing staff failed to administer 28 doses of an antibiotic medication that were ordered by the physician and failed to identify the patient’s medical diagnoses on the medical treatment plan. In violation of the hospital’s policy of abstaining from admitting patients with advanced wounds, the attending physician “failed to review the consult findings, resulting in the patient remaining in the hospital with a wound that required further medical evaluation from a higher level of care.”

2) The surveyor concluded that “hospital staff failed to follow acceptable standards to prevent the spread of infection in four of five medical record reviews.” This was based on Tuberculosis screening forms for four patients that either lacked evidence that nursing staff completed the form or that a screening had been conducted.

3) The survey indicates that “social worker staff failed to conduct a psychological assessment for five of five records reviewed,” in violation of Hospital policy stating that comprehensive psychosocial evaluations should be completed within 72 hours of admission.

4) The surveyor found that “nursing staff failed to provide individualized patient care plans” for four patients. For three patients admitted for alcohol and/or heroin abuse, nursing staff failed to identify substance abuse as part of their nursing treatment plans. Nursing staff also failed to identify suicidal/self-injurious and mood disturbance as part of the nursing treatment plan for one of those three patients. For a patient with a history of elopement, nursing staff “failed to follow the physician’s order relative to elopement monitoring” and “did not develop a plan of care, with goals and intervention, to address the patient’s history of elopement.”

5) PIW staff “failed to complete the consent for the administration of psychotropic and non-psychotropic medications, in four of six patient records reviewed,” as evidenced by blank informed consent sections in these patients’ medical records.

6) For a patient diagnosed with Gingivitis, “the psychiatrist failed to write orders to administer [antibiotic and non-steroidal anti-inflammatory] medications, as recommended by the
medical team,” resulting in a delay of 29 days before the patient received the recommended medications.\textsuperscript{220}

7) The survey noted a number of deficiencies related to sanitation. For example, the surveyor found that “dietary services were not adequate, to ensure that foods are prepared and served in a safe and sanitary manner.”\textsuperscript{221} On one occasion, “hospital staff failed to secure a soiled linen cart as required by hospital policy” when a dirty linen cart was left unattended and without a covering in the hallway.\textsuperscript{222} Overall, the surveyor found that “housekeeping and maintenance services were not adequate,” as evidenced by conditions such as soiled shower walls; cracked window sills and gaps between window sills and window frames; soiled toilet bases; damaged walls, baseboards, and floor tiles; and rusty exhaust vent surfaces.\textsuperscript{223}

**March 4, 2020, Complaint Survey**

The DC Health surveyor investigated PIW’s compliance with a hospital policy pertaining to “Sexual Acting Out Precaution” (SAOP), requiring that a patient whose “behavior is considered to be at risk of sexually acting out” be placed in a private room.\textsuperscript{224} The surveyor reviewed an Unusual Incident Report dated February 28, 2020, which showed that a patient who had been placed in a room with two other patients was involved in sexual misconduct with another patient.\textsuperscript{225} Following this incident, the patient was designated as a sexual aggressor by a PIW psychiatrist.\textsuperscript{226} However, the surveyor found no evidence that the patient was placed in a single room without other roommates.\textsuperscript{227} On March 4, 2020, the date this survey was completed, no patient rooms were blocked for one patient only, and the employee interviewed stated “[t]here are no patients that are diagnosed with SAOP on the floor today”\textsuperscript{228} even though one of the patients had been designated as a sexual predator by the psychiatrist three days before. Moreover, “[a]ll of the Patient Observation sheets lacked documentation for sexual predator, with the sexual Aggressor indicator boxes as blank.”\textsuperscript{229} The surveyor concluded that there was no evidence that PIW staff “provided care as directed by a physician, and hospital policy, to ensure a patient diagnosed as a sexual predator was given a single room, protecting other patients from potential harm.”\textsuperscript{230}

\textsuperscript{220} Id. at 27.
\textsuperscript{221} Id. at 38.
\textsuperscript{222} Id. at 39.
\textsuperscript{223} Id. at 40-55.
\textsuperscript{224} Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington 1, 2 (Completed: Mar. 4, 2020).
\textsuperscript{225} Id. at 3 (stating the patient who was the sexual aggressor “went to another female patient room, kissed her and proposed to have sex”).
\textsuperscript{226} Id.
\textsuperscript{227} Id. at 2.
\textsuperscript{228} Id.
\textsuperscript{229} Id. at 3.
VI. Conclusion

Disability Rights DC’s investigation uncovered what appear to be multiple disturbing deficiencies in PIW’s quality improvement program and the District’s oversight of the Hospital. The apparent shocking staff neglect after a patient became unresponsive and appeared to have stopped breathing, multiple allegations of disturbing incidents on both the adult and adolescent wards, and neglect cited by DC Health surveys, all raise serious concern for the safety of patients admitted to PIW. Equally concerning is the District’s apparent lack of oversight of PIW, and, specifically, PIW’s quality improvement program. A robust incident and investigation review process is essential to keep patients safe, protect patients’ rights, improve the quality of services, and protect patients from abuse and neglect.

As discussed throughout this report, DBH, DC Health, and PIW all have policies in place to ensure that serious incidents are reported, and when necessary, investigated. These “checks and balances” in the system, including robust oversight and enforcement of corrective actions, are critical to ensure that patients are safe, that abuse and neglect will not reoccur, as well as ensure ongoing improvement in patient care. As described herein, Disability Rights DC has serious concerns about whether PIW is dedicating adequate resources to its quality improvement and risk management systems. PIW, DBH, and DC Health must ensure that all policies and practices related to care and treatment, including requirements for incident reporting and investigations of abuse and neglect, are meaningfully implemented and that patients are protected.

Disability Rights DC Recommendations

1. DBH and DC Health must provide increased and meaningful oversight of PIW’s quality improvement system, including incident reporting and investigatory processes. Both DBH and DC Health must require PIW to provide a robust risk management response to major unusual incidents at PIW and require more in-depth follow-up and investigations that will ensure improved patient care. The District must also ensure that PIW is adhering to all DBH and DC Health/CMS requirements.

2. PIW should provide DBH, DC Health and Disability Rights DC with a corrective action plan describing (a) how they will ensure that they are adhering to all DBH, DC Health and PIW requirements related to incident reporting and follow-up investigations, and (b) how they will ensure that PIW’s risk management and quality improvement is adequately resourced. DBH and DC Health must ensure the plan is implemented.
3. Disability Rights DC requests a meeting with DBH, DC Health and PIW to discuss the issues raised in this report.
Attachment I: Summary of Videotape Footage

The video tape footage begins at 11:30 AM where Mr. Grant is asleep, lying on his back, on top of a thin mattress in a seclusion room with the door open. The door opens into a hallway, where another doorway is visible. It appears that a staff member (staff #1) is sitting on a chair in the other doorway with the chair facing away from Mr. Grant. Mr. Grant is naked with a single sheet partially covering his lower body as he continues to sleep, occasionally moving, while his chest and stomach visibly move up and down with his respirations. Soon thereafter the staff person disappeared from the doorway.

At about 12:30 PM, he rolls on his side and his respirations seem to become shallower, elevated and he appears to be in some respiratory distress. At about 12:33 PM, his legs are off the mattress on the floor, and he rolls over more on his stomach.

---

232 Id.
233 Id.
234 Id. at 12:32:19 PM.
235 Id. at 12:33:48 PM.
Mr. Grant occasionally tries to move the sheet to cover his body, while continuing with what appear to be labored respirations.\textsuperscript{236}

\textit{Image 3 at 12:24:42 PM: Mr. Grant tries to move the sheet to cover more of his body.}

At about 12:37 PM, he is almost completely on his stomach.\textsuperscript{237} At around 12:37 PM, he convulses five times.\textsuperscript{238}

\textit{Image 4 at 12:38:01 PM: Mr. Grant is laying on his side with his arm underneath his stomach and convulses 5 times.}

\textsuperscript{236} \textit{Id. at 12:34:05 PM, 12:34:45 PM.}
\textsuperscript{237} \textit{Id. at 12:37:06 PM.}
\textsuperscript{238} \textit{Id. at 12:37:49 PM to 12:38:18 PM}
At around 12:38 PM, Mr. Grant appears to stop breathing as there is no movement in his chest and stomach. 239

Throughout the videotape footage thus far, staff member #1 can sometimes be seen through the open seclusion room door sitting in a chair, but his face is obscured by the daylight (see image 1). 240 Staff #1 gets up from the chair for most of the videotape. 241 At no point does Staff #1, nor any other staff enter the seclusion room where Mr. Grant is laying from the start of the video at 11:30 AM until approximately 12:40 PM. At around 12:40 PM, Staff #1 comes in the room. 242

---

239 Id. at 12:38:21 PM.
240 Id. at 11:30:56 AM to 12:39:56 PM.
241 Id. at 11:33: 52 AM, 11:38:44 AM, 11:57:12 AM, 12:03:34 PM, 12:08:12 PM, 12:30:06 PM.
242 Id. at 12:40:03 PM.
Staff #1 appears to attempt to speak to Mr. Grant and moves his arm out from underneath him.\textsuperscript{243} Mr. Grant does not move at all, is unresponsive and appears to not be breathing.\textsuperscript{244}

At around 12:41 PM, Staff #1 turns on the light, squats down and looks at Mr. Grant while holding a clipboard.\textsuperscript{245}

\textsuperscript{243} \textit{Id.} at 12:40:26 PM.
\textsuperscript{244} \textit{Id.}
\textsuperscript{245} \textit{Id.} at 12:41:14 PM.
At around 12:42 PM, another staff member (Staff # 2) comes into the room. Staff # 2 is gesturing to Staff # 1, his clipboard, and around the room. Staff #1 and Staff #2 engage in an animated discussion for seven minutes. All the while, Mr. Grant is on the mat, appears to not be breathing and appears to be dead.

During this time, Staff #1 nudges Mr. Grant and moves his arms three times. Again, Mr. Grant appears to be completely unresponsive, does not move at all and does not appear to be breathing.

---

246 Id. at 12:42:08 PM.
247 Id.
248 Id. at 12:42:24 PM to 12:48:40 PM (at 12:48:40 Staff #1 leaves the room, presumably to get a nurse, and Staff #2 also leaves the room at 12:48:53 PM).
249 Id. at 12:46:01 PM, 12:47:47 PM, 12:48:25 PM.
Image 11 at 12:47:26 PM: Staff #2 is gesturing to his clipboard while Staff #1 squats down next to Mr. Grant. The two staff are still engaged in conversation.

Image 12 at 12:48:26 PM: Staff #1 and #2 squat down next to Mr. Grant, more than 8 minutes after Staff #1 first found him appearing to be unresponsive and not breathing.
At around 12:49 PM, a third staff member (Staff #3), presumably the nurse, follows Staff #1 into the room. She stands in the room with her hands on her hips for 1 minute 34 seconds and does not touch Mr. Grant, feel for a pulse, or assess him in any way.

Staff #3 talks with Staff #1 and #2, then walks over and looks at Mr. Grant’s face. At around 12:51 PM -- now twelve minutes after Mr. Grant appears to stop breathing and eleven minutes after staff have come into the room, Staff #3 walks out of the room and comes back in with a vital signs machine. Staff #2 places the blood pressure cuff around Mr. Grant’s forearm and turns the machine on, while Nurse #1 faces the machine. She still has not touched Mr. Grant or checked for a pulse even though Mr. Grant continues to appear unresponsive, appears to be not breathing, not moving and appears to be dead.

---

250 ld. at 12:49:11 PM.
251 ld. at 12:49:17 PM.
252 ld. at 12:50:33 PM.
253 ld. at 12:51:24 PM.
254 ld. at 12:52:40 PM.
255 ld.
Staff #1 places one hand on Mr. Grant’s right hip and one hand on his right shoulder and pushes Mr. Grant, who still does not respond. Staff #1 then leaves the room, as Staff #2 and Staff #3 remain in the room, standing up. Another staff member comes in with a different blood pressure cuff. Staff #3 places the new cuff on Mr. Grant’s arm and turns on the machine. Staff #2 lifts Mr. Grant’s head and looks at his face, appearing to check his eyes, before returning Mr. Grant’s head to the face down position.

Staff #1 and Staff #3 leave the room. Staff #2 continues to adjust the blood pressure cuff until about 12:56 PM, when Staff #1 returns to the room and Staff #1 and Staff #2 turn Mr. Grant over. Mr. Grant’s face appears to be cyanotic, or blue in color, he still does not appear to be breathing and remains unresponsive.
Staff #1 leaves the room, Staff #2 turns Mr. Grant back onto his side, and Staff #3 reenters the room with a cell phone in her hands, before appearing to make a phone call. \footnote{Id. at 12:56:44 PM.} Staff #3, who appears to be the nurse, does not touch Mr. Grant. \footnote{Id.} At around 12:57, Staff #1 and Staff #2 turn Mr. Grant onto his back again, and another staff member appears to bring a cart into the room. \footnote{Id.}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{image17}
\caption{Image 17 at 12:56:44 PM: Staff #3 returns to the room with a cell phone in her hands and makes a phone call, while Staff #2 continues to adjust the blood pressure cuff.}
\end{figure}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{image18}
\caption{Image 18 at 12:57:30 PM: Staff #1 and #2 turn Mr. Grant onto his back. Staff #3 appears to look at his face, but still does not touch Mr. Grant.}
\end{figure}
Staff #3 takes an Automated External Defibrillator (AED) off of the cart and is alone in the room with Mr. Grant. Staff #3 fiddles with the machine for over one minute while Staff #1 and #2 stand by the doorway.

Staff #3 gets up and walks over to the cart and searches the cart for something. Two more staff members enter the room and Staff #3 appears to be directing them, giving Staff #4 a breathing mask. Staff #4 appears to struggle to remove the mask from the bag, while staff #5 and Staff #3 slide Mr. Grant off of the mattress.

---

267 Id. at 12:57:58 PM.
268 Id. at 12:59:20 PM.
269 Id. at 12:59:56 PM.
270 Id. at 1:00:25 PM.
271 Id. at 1:00:58 PM.
At around 1:01 PM, 21 minutes after Staff #1 first came into the room, Staff #1 begins chest compressions\(^{272}\) and Staff #3, the presumed nurse, places a manual breathing mask over Mr. Grant’s face and begins to ventilate him.\(^{273}\)

![Image 21 at 1:01:17 PM: Staff #3 gestures to other staff, while Staff #1 begins chest compressions, 21 minutes after first finding Mr. Grant unresponsive appearing to not be breathing. Another staff stands the mattress up against the wall.](image)  

Staff #4, #5, and staff #6 enter the room to assist with CPR, which continues for several minutes until EMTs arrive at 1:11.\(^{274}\)

![Image 22 at 1:02:02 PM: Staff #4, #5, and #6 join staff #1 and #3 in the seclusion room to assist with CPR.](image)

\(^{272}\) *Id.* at 1:01:13 PM.  
\(^{273}\) *Id.* at 1:01:39 PM.  
\(^{274}\) *Id.* at 1:01:28 PM to 1:11:13 PM.
Resuscitation efforts continue until about 1:40 PM. All staff and EMT leave the room. The videotape footage ends.

---

Image 23 at 1:11:15 PM: An EMT arrives while staff continue resuscitation efforts on Mr. Grant.

Image 24 at 1:40:35 PM: Mr. Grant is dead and is left alone in the room.

---

275 Id. at 1:40:05 PM.
276 Id. at 1:40:37 PM.
277 Id. at 1:40:41 PM.