



# UNSAFE AND UNPROTECTED:

*Neglect at the Psychiatric Institute of  
Washington*

JULY 2024

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## ABOUT DISABILITY RIGHTS DC

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

Disability Rights DC 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 members 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 inclusion, and the improper use of seclusion, restraint, and medication.

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## I. INTRODUCTION

Many patients at the Psychiatric Institute of Washington (“PIW”) do not feel safe. And for good reason. This is Disability Rights DC’s [third public report](#) in recent years detailing disturbing abuse and neglect at the facility. Disability Rights DC’s investigations continue to find that PIW patients are exposed to sexual and physical abuse and suffer serious injuries. Many patients reported that in addition to feeling unsafe, their admission left them traumatized and distrustful of the mental health system that landed them at PIW. PIW’s lack of adequate reporting, investigations, and follow-up of these incidents results in the status quo and continued suffering.

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.<sup>1</sup> PIW admits and discharges hundreds of patients each month on acute inpatient adult and adolescent units, as well as providing outpatient programs.<sup>2</sup> PIW admits both voluntary and involuntary patients and houses them on locked units.<sup>3</sup> 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.<sup>4</sup>

PIW is one of more than 400 facilities owned by Universal Health Services (“UHS”), a for-profit corporation and one of the largest owners of behavioral healthcare facilities nationally, serving over 3.6 million patients a year.<sup>5</sup> UHS’s revenues increased to over \$14 billion in 2023.<sup>6</sup> While reaping enormous profits, UHS-operated behavioral health facilities have been the subject of numerous investigations and lawsuits, which allege incidents of disturbing abuse and neglect, as well as violations of federal and state regulations.

Complaints of abuse and neglect at UHS facilities are numerous. In February 2018, two employees at UHS-owned North Spring Behavioral Healthcare were arrested and charged with manslaughter after the state medical examiner concluded that a teenage patient, whom they had restrained, died of positional asphyxiation.<sup>7</sup> In 2020, the United States Department of Justice settled with UHS for \$122 million resolving 18 actions against UHS which alleged failure to provide adequate staffing, training, and supervision of staff, improper use of restraint and seclusion, failure to discharge patients when hospitalization was no longer

necessary, failure to develop and/or update treatment plans, and failure to provide adequate individual and group therapy.<sup>8</sup>

*In March 2024, a jury found that a UHS behavioral health facility was negligent in the rape of a 13-year-old patient and awarded the family \$535 million in damages.*

In 2021, a former employee at a UHS-owned Pennsylvania behavioral health facility plead guilty to sexually assaulting a female patient.<sup>9</sup> In November 2023, a local news organization reported that there were dozens of complaints filed against a UHS-owned behavioral health facility in South Carolina “alleging there are bugs, abuse, dangerously low staffing levels, violent fights and blood and vomit smeared throughout the building.”<sup>10</sup> In March 2024, a jury found a UHS behavioral health facility in Champaign, Illinois was negligent in the rape of a 13-year-old patient and awarded the family \$535 million in damages.<sup>11</sup> And according to a news report, a \$387 million lawsuit with claims of sexual abuse and other mistreatment made by dozens of former patients of a UHS-owned Virginia Hospital is set to go to trial in September 2024.<sup>12</sup> Patients’ claims include sexual abuse and battery, sexual or physical abuse, negligence, and the falsification of medical records and diagnoses to prolong their stays.<sup>13</sup>

Similarly, as will be discussed in detail in this report, serious abuse and neglect has also been reported at UHS-owned PIW. According to media reports, in late 2023, D.C. police arrested a male PIW staff person for sexually assaulting a 17-year-old female patient.<sup>14</sup> The staff person, who had worked at PIW for two years, was charged with first-degree sexual abuse of a patient.<sup>15</sup> As reported, the affidavit in the criminal case alleges that, on November 3, 2023, the staff person entered the youth’s room while she was showering to tell her that there were designated times for showering and she needed to finish up.<sup>16</sup> When the adolescent patient got out of the shower and while she was wrapped in a towel, the staff person said he was going to “whoop her a\*\*,” instructed her to place her hands on the bed, and spanked her on the buttocks twice.<sup>17</sup> The affidavit also alleges that the following day, the same staff person told the patient to follow him into the laundry room, which is a restricted area.<sup>18</sup> The patient reported that once inside the room,

the staff person groped her, grabbed her breast, reached into her pants, and touched her genitals.<sup>19</sup> She reported that the staff person then placed her hand on his genitals, pushed her down to her knees, and forced her to perform oral sex on him. She reported that later that same day, the staff person approached her in the common area and demanded that she masturbate in front of him while he watched.<sup>20</sup> PIW suspended the staff member and reported the allegations to Child Protective Services and the DC Metropolitan Police Department for investigation.<sup>21</sup>

Disability Rights DC's investigations into allegations of abuse and neglect at PIW also reveal a disturbing, long-standing pattern of abuse and neglect. In June of 2021, Disability Rights DC released a report, [\*A Disturbing Death: Abuse and Neglect at the Psychiatric Institute of Washington\*](#), which described videotape footage of nursing neglect surrounding the death of a patient, as well as many incidents of serious abuse and neglect. Yet, serious abuse and neglect continued. In July 2022, Disability Rights DC released another report [\*Do No Harm: Multiple Incidents of Abuse and Neglect at the Psychiatric Institute of Washington\*](#), which detailed equally alarming incidents of abuse and neglect at PIW, including videotape footage showing (1) multiple staff persons using unauthorized physical restraint techniques, which caused a patient to fall to the ground and sustain head and arm injuries; (2) a male staff person dragging a crying, frightened female patient across the floor twice, then pushing her into a room; and (3) a chaotic incident on the adolescent unit where multiple patients engaged in physical altercations and staff did not adequately intervene, culminating in a frightening scene in which seven DC Metropolitan Police officers arrived on the unit and arrested one youth. During this incident, an adolescent patient was stabbed in the cheek and sustained a laceration and facial fracture. Another patient was struck in the face and sustained nasal fractures and a laceration.

Disability Rights DC's more recent investigations uncovered equally disturbing incidents. Discussed in detail in this report, Disability Rights DC found evidence of continued staff neglect, including patients being subjected to sexual assaults, physical assaults resulting in fractures and other serious injuries, as well as an overreliance on seclusion and restraint. *These conditions are unacceptable.* D.C. residents with mental health disabilities cannot continue to experience trauma and injuries when seeking care and treatment for their mental health disabilities. The District government and federal oversight agencies must intervene to ensure the safety and wellbeing of every patient admitted to PIW and make certain that PIW is not maximizing profits at the expense of patients.

## II. ABUSE AND NEGLECT AT PIW

Disability Rights DC's most recent investigations of PIW have continued to uncover multiple incidents of staff abuse and neglect. Through a Freedom of Information Act ("FOIA") request to the DC Department of Behavioral Health ("DBH") and DC Department of Health ("DC Health"), Disability Rights DC obtained incident reports and survey reports containing further evidence of abuse and neglect. Moreover, Disability Rights DC learned through record reviews, monitoring, and, importantly, from complaints received from multiple sources, including patients, family members, and stakeholders that many individuals who are taken to PIW do not feel safe.

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### *Many Patients Are Not Safe*

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#### A Violent Assault Caught on Videotape

Kathy Jones<sup>22</sup> was a patient at PIW. During her brief stay, she was violently assaulted. Disability Rights DC obtained and analyzed videotape footage of the incident. The videotape footage reveals that at approximately 1:53 a.m., Ms. Jones was violently punched squarely in the face by a male patient with such tremendous force that it knocked her immediately to the floor.<sup>23</sup> Records indicate that after the assault, Ms. Jones was bleeding profusely from her nose and had a laceration to her upper lip, and she was sent to the emergency room.<sup>24</sup>

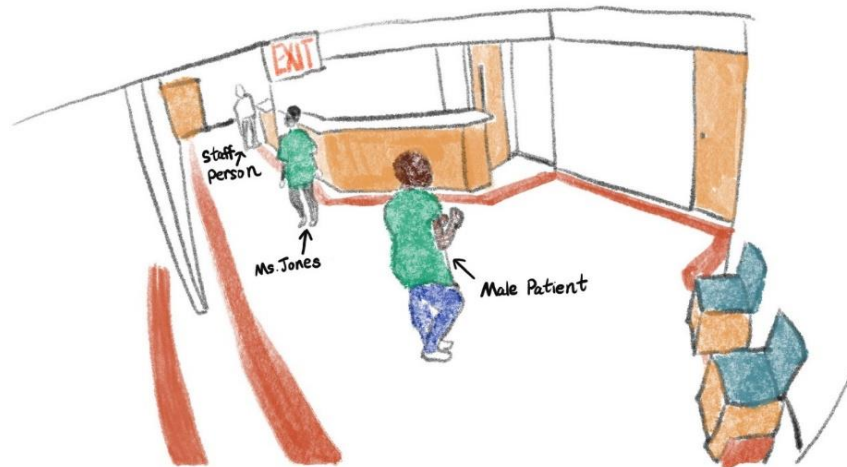
Disturbingly, the male patient had been clearly exhibiting signs of agitation for *at least 33 minutes* prior to the incident, including pacing quickly back and forth across the hallway, balling his fists, and punching into the air.<sup>25</sup> In the silent video, he appears to be expressing his anger verbally. During almost the entire time prior to the assault, the male patient is pacing back and forth and exhibiting these agitated, aggressive behaviors. At the same time, Ms. Jones is calmly pacing up and down the same hallway, where she frequently crosses paths with the male patient.<sup>26</sup> Staff persons can be intermittently seen in the hallway and can be seen observing the male patient's behavior. However, for much of the videotape

footage, no staff persons are visible, including when the incident occurred.<sup>27</sup> Inexplicably, staff failed to intervene to prevent the assault -- even though it was clear that the male patient was in a very agitated state and Ms. Jones was consistently in very close proximity to him. Staff persons failed to escort Ms. Jones away from the agitated male patient or take other action to protect her or to deescalate the male patient.

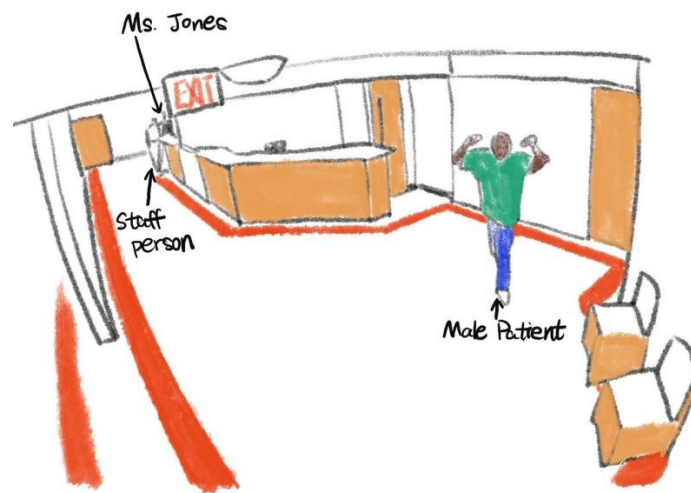
Below are videotape screenshot tracings of the incident.<sup>28</sup>



*The unit at approximately 1:20 a.m. The male patient walks past Ms. Jones. The staff is at the far end of the hallway looking down at paperwork.<sup>29</sup>*

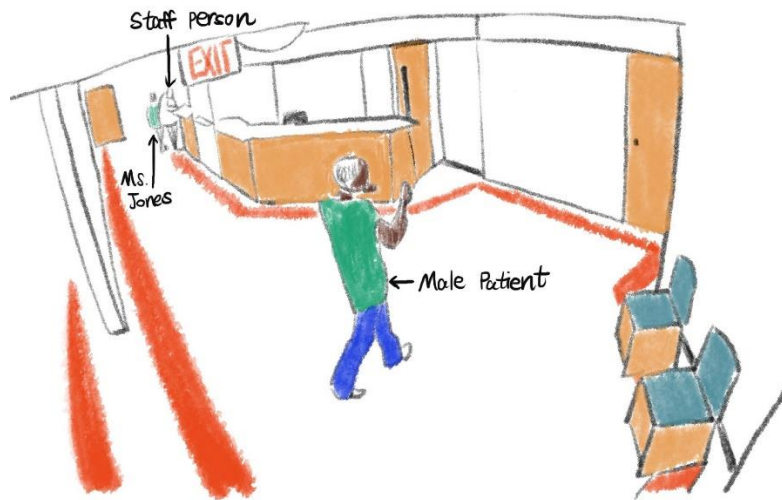


*The male patient is in a fighting stance with his fists clenched. Ms. Jones passes him pacing the hallway. A staff person appears to observe but does not interact with either patient.<sup>30</sup>*

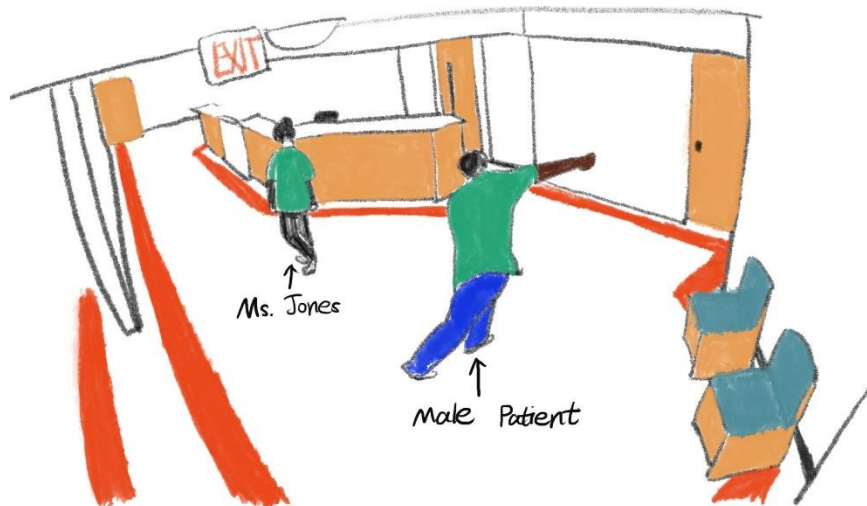


*The male patient is agitated and balling his fists.<sup>31</sup>*

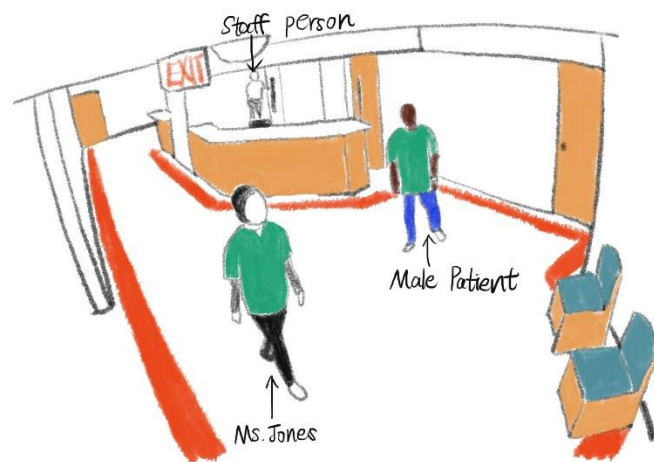




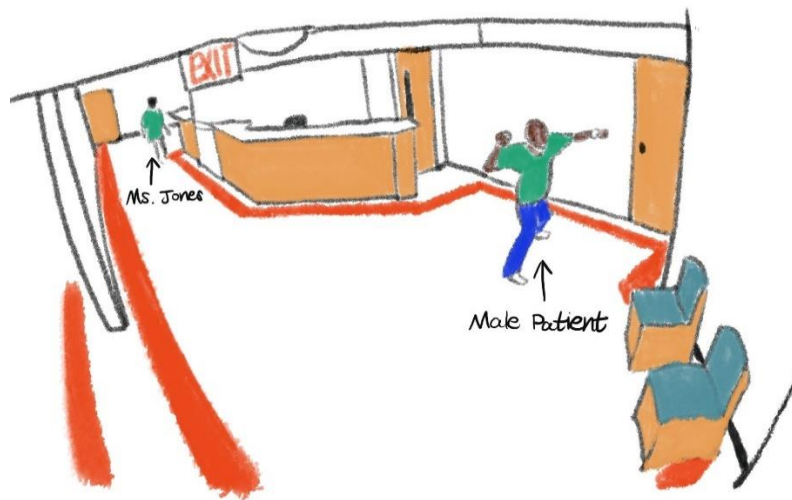
*The male patient jabs punches and throws punches in the air. A staff person is at the far end of the hallway.<sup>32</sup>*



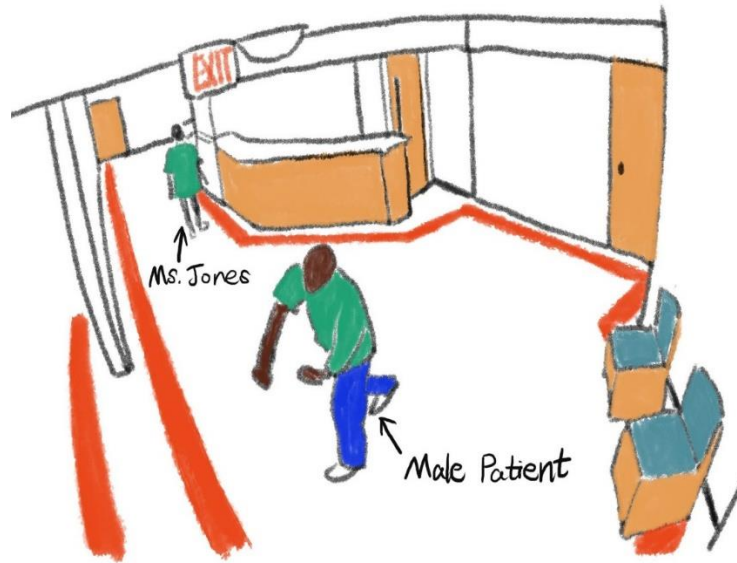
*The male patient again punches forcefully in the air as Ms. Jones passes him, pacing in the hallway. No staff persons are behind the desk or visible on the videotape footage.<sup>33</sup>*



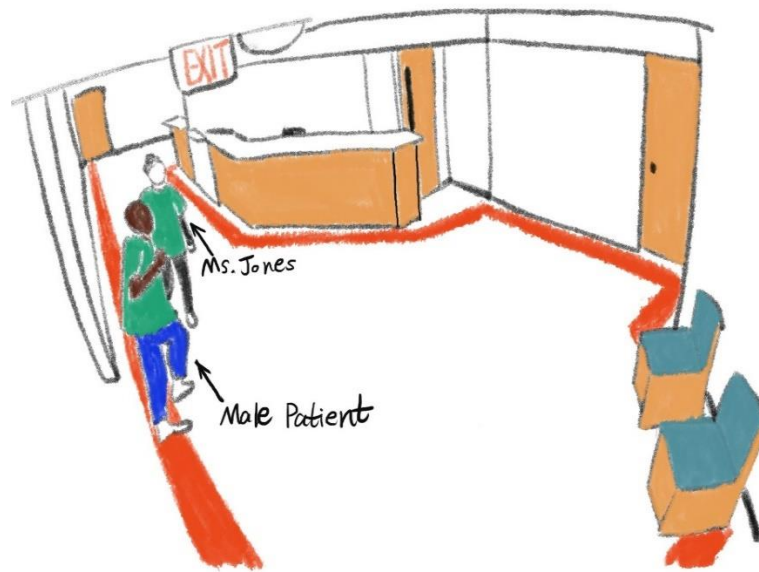
*The male patient stands and looks at Ms. Jones while the staff person leaves the scene through the nurse station.<sup>34</sup>*



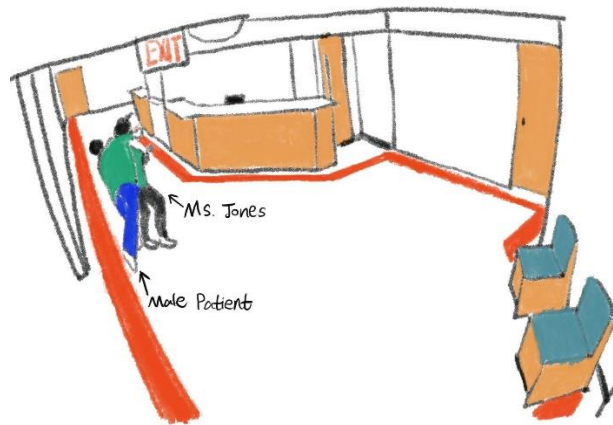
*The male patient winds up to punch near the door. Ms. Jones had passed him again. No staff persons are behind the desk or visible on the videotape footage.<sup>35</sup>*



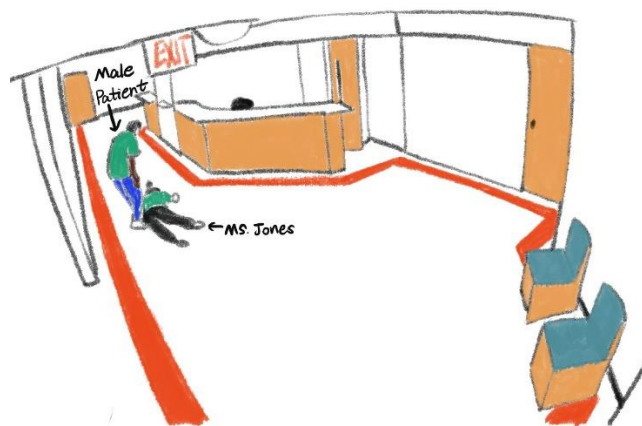
*The male patient continues to appear very agitated and shakes and clenches his fists. Ms. Jones has just passed him again. Again, no staff are behind the desk or visible on the videotape.<sup>36</sup>*



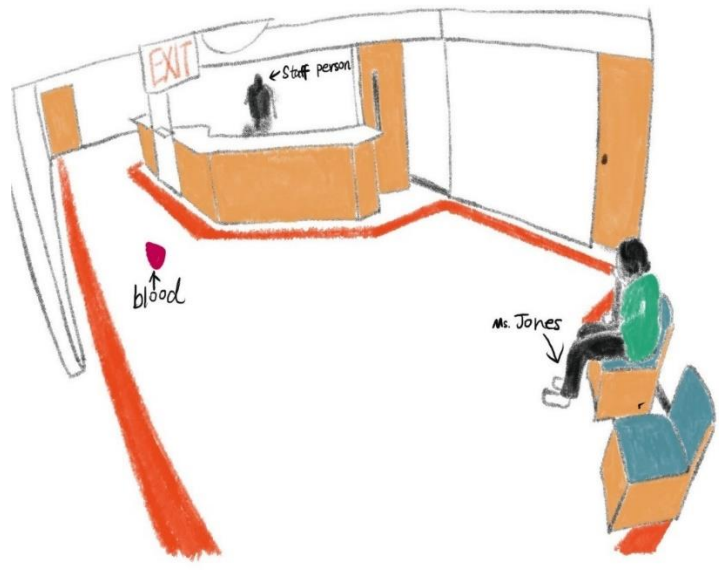
*The male patient pulls his fist back prior to striking Ms. Jones. No staff persons are behind the desk or visible on the videotape footage.<sup>37</sup>*



*The male patient strikes Ms. Jones in the face with tremendous force. No staff persons are behind the desk or visible on the videotape footage.<sup>38</sup>*



*Ms. Jones is knocked to the floor. Still, no staff persons are behind the desk or visible on the videotape footage.<sup>39</sup>*



*Staff have escorted the male patient away. Ms. Jones has been assisted to a chair. Her blood is visible on the floor.<sup>40</sup>*



*Ms. Jones covers her nose with an ice pack. Staff have wiped up the blood.<sup>41</sup>*

In February 2024, Disability Rights DC reported their investigation findings to DBH and DC Health and requested that the agencies investigate.<sup>42</sup> DC Health acknowledge receipt of Disability Rights DC’s findings, however, they have not provided an investigation report or other follow up information.<sup>43</sup> In April 2024, in response to a follow up email from Disability Rights DC to DBH regarding the status of the investigation, DBH indicated that they “do not normally” investigate patient on patient assaults and that since the allegation involved staff failure to respond, it would be “a DC Health issue.”<sup>44</sup> Additionally, though requested,<sup>45</sup> Disability Rights DC received no documentation from DBH that PIW performed its own investigation of the incident though under DBH policies DBH can and should require it.<sup>46</sup> *Adequate oversight from these DC government agencies is essential to prevent future serious incidents and to hold PIW accountable for their failure to protect patients.*

### A Patient’s Arm is Broken During an Assault

In February 2023, a PIW patient, Linda Reed,<sup>47</sup> was assaulted by her roommate and sustained a fracture to her shoulder. According to a PIW incident report, a PIW staff person heard someone yell “stop,” entered Ms. Reed’s room and observed a female peer standing over Ms. Reed “being physically aggressive toward her” and that Ms. Reed was “crying and mumbling” on her bed.<sup>48</sup> However, a DC Health survey report provides much more context about the incident. The survey notes that videotape footage from just prior to the assault shows “five male employees in the hallway outside Ms. Reed’s room.”<sup>49</sup> When questioned as to why they were “standing around” and did not enter the room, an employee stated that they “waited until the RN gave the medication” before they went into the room.<sup>50</sup> Another employee interviewed about the incident stated that Ms. Reed’s roommate “wanted the room to herself” and that she “beats up people – patients and staff, same as always.”<sup>51</sup> Another employee stated that “the scenario was bad,” that Ms. Reed “was weak,” and that her roommate “bullied” her.<sup>52</sup> The PIW incident report does not explain or analyze why staff took no precautionary steps to protect Ms. Reed from her agitated roommate. Nor does it describe any trauma-informed intervention for Ms. Reed’s roommate to address her aggressive and troubled conduct.

Concerningly, the incident report referencing the attack indicated that “no injuries were noted.”<sup>53</sup> However, the next day a contract nurse practitioner at PIW documented that Ms. Reed “screamed” when her left arm was touched, and that

she reported that she was “beaten up” by other patients.<sup>54</sup> The nurse practitioner noted an abrasion to Ms. Reed’s forehead and an abrasion and swelling to her left arm, and ordered an x-ray.<sup>55</sup> The record indicates that two days later, the x-ray results came back negative and that Ms. Reed had a “big bruise” on her left arm “[m]ost likely, from the injury she sustained on 2/18/23.”<sup>56</sup> Five days after the assault, a nurse practitioner noted “purplish discoloration/pain (left arm),” “possibly due to delayed injury from altercation with peers.”<sup>57</sup> It was not until a week after the assault that Ms. Reed was sent to the emergency room by a doctor after noting that she had a “bruised left upper extending to the forearm which is getting bright red.”<sup>58</sup> Ms. Reed was diagnosed with an arm fracture (distal radius bone) and a fracture to her shoulder.<sup>59</sup> It is not clear why PIW staff did not order a follow-up x-ray and/or send Ms. Reed to the emergency room as soon as they noticed that her symptoms of swelling and bruising were getting worse. Again, though requested, Disability Rights DC received no documentation from DBH that PIW performed its own investigation of the incident though under DBH policies DBH can and should require it.<sup>60</sup> Follow-up investigations and implementation of corrective action can prevent future harm to patients and are critical to the functioning of a hospital.

### A Patient Suffers Facial Fractures During an Assault

In May 2023, a PIW patient (Patient #3) was assaulted and sustained serious injuries, including a head injury, a fracture to his nose and facial bones, and a hand injury.<sup>61</sup> A review of the videotape footage by DC Health showed that at approximately 10:17 a.m., Patient #3 hit Patient #4 on the back of the head “by the nursing station.”<sup>62</sup> Moments later, Patient #4 approached Patient #3 with his fists clenched.<sup>63</sup> A few minutes later, Patient #3 entered his assigned room and closed the door.<sup>64</sup> Patient #4 then walked towards Patient #3’s room “with the staff member walking beside them.” Patient #4 entered Patient #3’s room and closed the door.<sup>65</sup> The staff person attempted to open the door. When the door was opened, Patient #3 was laying on the floor.<sup>66</sup> The DC Health survey cited several deficiencies, including that PIW failed to “provide care in a safe setting and provide non-abusive and harassment-free” care to Patient #3 and failed to place the patients on the appropriate monitoring precautions.<sup>67</sup>

An incident report submitted by PIW to the DBH describes that after Patient #4 hit Patient #3 on the back of the head, he told staff that he was experiencing hallucinations and hearing voices telling him to punch people.<sup>68</sup> According to the

incident report, while staff was waiting for “additional support,” Patient #3 went into Patient #4’s bedroom and shut the door behind him.<sup>69</sup> However, the incident report failed to note that a staff person was actually escorting Patient #4 when Patient #4 entered Patient #3’s room as DC Health observed on the videotape footage. The incident report also failed to describe steps staff took to protect Patient #3 or to deescalate Patient #4. Additionally, the incident report indicates that PIW “will continue to investigate,” however, though requested, Disability Rights DC received no documentation from DC Health or DBH that PIW performed its own investigation of the incident though under DBH policy, DBH can and should require it.<sup>70</sup>

### A Patient Suffers Deep Facial Scratches and a Human Bite During an Assault

In late December 2023, PIW patient Mary Green<sup>71</sup> was attacked by her roommate who severely scratched her multiple times on her face and bit her on her breast and arm.<sup>72</sup> She reported that she thought the patient may have used a weapon since the scratches on her face were so numerous and severe. She also reported that she was terrified to go back into her room and slept in the dayroom after the attack.<sup>73</sup> Ms. Green’s son reported that he saw his mother two days after the attack.<sup>74</sup> He described that upon seeing his mother he was greatly alarmed, and that she sustained approximately fifteen scratches over her entire face, including very deep scratches to her right and left cheek, forehead, and below her right eye.<sup>75</sup> Ms. Green’s son also described photographs of his mother taken approximately one month after the attack which show approximately fifteen dark purple scars from two to five inches on her entire face.<sup>76</sup>

Moreover, Ms. Green’s medical records confirm that she sustained a human bite to her left breast and arm, as well as multiple scratches to her entire face.<sup>77</sup> An incident report notes that in addition to these injuries, Ms. Green’s hair was pulled out.<sup>78</sup> In a complaint filed with the DBH dated January 1, 2024, a PIW employee noted, “A patient currently on the unit has scratches so severe it looks like she was attacked by an animal. The scratches are the result of an attack by another patient on the unit.<sup>79</sup> The employee alleged that the unit was understaffed and “recalls being alone on a unit with 19 patients,” and that the patient to staff ratio is supposed to be 1:15, however, a 1:19 ratio is not uncommon.”<sup>80</sup>



On February 12, 2024, Disability Rights DC reported their investigation findings to DBH and DC Health and requested that the agencies investigate the incident.<sup>81</sup> Disability Rights DC has yet to receive an investigation report from either agency. Again, though requested, Disability Rights DC received no documentation from DBH that PIW performed its own investigation of the incident though under DBH policies DBH can and should require it.<sup>82</sup>

### An Eighteen-Year-Old Patient is Attacked

In the Spring of 2024, Disability Rights DC received a complaint that an eighteen-year-old female patient was attacked by another patient. According to the patient, while she was asleep, another patient hit her in the neck and shoulder, and she sustained a bruise on her neck and her clothes were ripped.<sup>83</sup> She reported that she was then transferred to the “detoxification unit,” where a male patient touched her inappropriately on her thigh and shoulder.<sup>84</sup> Nurses’ notes confirm that she was attacked by her roommate while sleeping and that she sustained “visual discoloration” and bruising to her neck and upper chest.<sup>85</sup>

### A Female Patient is Attacked

In November 2023, a female patient reported to Disability Rights DC that she was “jumped” by another patient, who hit her in the face, “busted her lip,” and pulled her hair.<sup>86</sup> PIW staff documented that the altercation occurred; however, the progress notes fail to provide a description of the altercation.<sup>87</sup> Although the progress notes indicate that no injury or pain was reported, the female patient disputes this and alleges that she reported to staff that her face and lip were injured.<sup>88</sup> The records provided the Disability Rights DC contain no evidence that PIW staff reported the incident or that an incident report was filed. And again, though requested, Disability Rights DC received no documentation from DBH that PIW performed its own investigation of the incident though under DBH policies DBH can and should require it.<sup>89</sup>

### Allegations of Sexual Assault

PIW is not adequately protecting vulnerable psychiatric patients from sexual assaults. As outlined below, PIW patients have allegedly experienced sexual assault during their stay at PIW and PIW has not taken steps to address this serious

concern, either to protect the potential victims or to provide needed psychiatric care to other individuals involved.

- In May 2022, A DC Health Survey found that PIW staff failed to order and implement sexual victimization precautions for another patient with a history of sexual trauma.<sup>90</sup>
- A DC Health survey found that in December 2022, a PIW doctor ordered sexual aggression and sexual victimization precautions because of a reported sexual encounter between two patients.<sup>91</sup> Disturbingly, observation monitoring sheets indicated that PIW staff failed to implement the precautions for twelve consecutive days.<sup>92</sup> In addition, during the same time period, PIW failed to implement sexual aggression, sexual victimization, and suicide precautions for a 17-year-old patient on numerous days in December 2022 and January 2023.<sup>93</sup>
- According to PIW incident reporting, in May 2023, a PIW staff person observed two patients engaging in sexual activity.<sup>94</sup> The incident report notes that the physician placed both patients on sexual aggression precautions and ordered testing.<sup>95</sup> Of note, this incident report was not submitted to DBH until January 2024.
- According to PIW incident reporting, in January 2024, a staff person observed a female patient engaging in sexual act with another patient in the middle of the day.<sup>96</sup> The other patient was placed on “sexual aggression precautions,” the patients were reassigned to different units, sexually transmitted disease testing was ordered and a medical evaluation was conducted.<sup>97</sup> However, the incident report does not contain further information about what additional steps staff took to protect the female patient, and the next day at 11:00 a.m., staff again “found the [the same] female patient engaging in sexual act in a separate male room.”<sup>98</sup>
- According to PIW incident reporting, in February 2024, two adult patients were “engaged in sexual activity in the day room,” and that “soon after” the nurse was notified of the “reported sexual abuse.”<sup>99</sup> The incident report notes that the patients were “separated” and the Metropolitan police was called and conducted an investigation.<sup>100</sup>

Some of the incident reports noted that PIW was investigating the incidents. Though requested, Disability Rights DC received no documentation from DBH that PIW performed its own investigation of the incident though under DBH policies DBH can and should require it.<sup>101</sup> These very serious incidents likely caused significant harm to the victims and demonstrate a need for improved care and treatment. Investigations and implementation of corrective action is essential to address such incidents which can result in serious trauma.

## Chaos on the Unit

According to an incident report submitted by PIW to DBH, in April 2022, multiple assaults occurred on a unit. The incident report notes that “staff heard a commotion coming from a male patient’s bedroom” and observed two male patients “having a physical confrontation . . .”<sup>102</sup> A female patient then hit another female patient, who sustained a contusion to her eye and was sent to the emergency room for evaluation.<sup>103</sup> Shortly after that, two other male patients started engaging in a physical confrontation in one of the male patient’s bedrooms.<sup>104</sup>

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## *Problems With Staff*

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In addition to an environment where patients feel unsafe because of multiple documented patient-on-patient assaults, and in which staff fail to implement trauma-informed care strategies to address the needs of agitated patients, there have been multiple incidents of staff misconduct and documented neglect.

## Alleged Staff Misconduct

According to an incident report submitted by PIW to DBH, in January 2022, videotape footage revealed that a staff person used “improper technique” resulting in a patient sustaining swelling on the left side of his face.<sup>105</sup> The incident report states that the staff did not follow PIW policy, was placed on administrative leave and that “PIW will continue to investigate and discipline staff as necessary.”<sup>106</sup> However, though requested, Disability Rights DC did not receive any evidence that PIW completed or submitted the investigation report to DBH as required.<sup>107</sup>

In May 2023, according to another unusual incident report, PIW staff “struggled” with an aggressive patient and used “improper” “Handle With Care techniques” when physically intervening. This resulted in the staff being “removed from the schedule.”<sup>108</sup> The incident report notes that a patient approached a PIW staff person with a clenched fist and started “throwing punches.”<sup>109</sup> The staff person was “removed from the schedule pending investigation.”<sup>110</sup> The unusual incident report does not describe how the staff person used “improper Handle with Care technique,” nor the steps taken to address the staff person’s behavior.<sup>111</sup> This kind of analysis is needed to ensure staff receive proper training going-forward. Again, though requested, Disability Rights DC received no documentation from DBH that PIW performed its own investigation of the incident though under DBH policies DBH can and should require it.<sup>112</sup>

*One PIW patient told Disability Rights DC that “PIW feels like prison. This situation taught me that I should not have reached out for help.”*

## Staff Neglect

Moreover, DC Health reports note multiple instances of staff violating the rights of patients, failing to adequately meet the needs of PIW patients, and failing to provide required reporting. From June 21, 2023, to June 30, 2023, a joint Federal and Licensure complaint investigation was conducted at PIW by the DC Health on behalf of the U.S. Department of Health and Human Services Center for Medicare & Medicaid Services (“CMS”). On June 28, 2023, an “Immediate Jeopardy” was identified. According to the Statement of Deficiencies, PIW violated a patient’s right to receive care in a safe setting after staff failed to communicate a patient’s legal status when he was transferred to a higher level of care (an emergency room) and he subsequently eloped.<sup>113</sup>

Additional staff deficiencies cited in the same report included nursing staff’s failure to: (1) document observations and precautions monitoring per physicians order; (2) consistently document pain reassessments for a patient with a pre-existing wound; (3) consistently document accurate daily skin assessments for a patient with a pre-existing wound; and (4) remove contraband from a patient in a timely manner per hospital policy.<sup>114</sup> Staff also failed to complete the required

transfer documentation for patients requiring a higher level of care in six of nine records reviewed.<sup>115</sup> In an earlier DC Health review in 2022, DC Health found that PIW staff failed to implement suicide precautions ordered by the physician and failed to adequately complete safety checks.<sup>116</sup>

Finally, according to a PIW incident report, in October 2023, a PIW patient reportedly fell and hit his head.<sup>117</sup> The incident report notes that “the fall was not initially reported by the nurse but was discovered via video review,” and that forty-five minutes after the unreported fall, the patient experience seizure activity and was transferred to the hospital where he was admitted and required respiratory intubation.<sup>118</sup> It is unclear if the initial fall was observed by staff and not reported or there were not enough staff available to ensure a safe and quick response to the fall.

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### ***DC Health Reports Understaffing at PIW***

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In addition to patients repeatedly reporting to Disability Rights DC that they do not feel safe at PIW, and that staff do not intervene when other patients threaten them or physically attack them, we have been told by numerous patients that the units are understaffed.

A DC Health survey review confirmed allegations of insufficient staffing. The review looked at staffing levels for a fifteen-day review period, from May 8, 2022, to May 22, 2022. Remarkably, the DC Health Surveyor discovered that many, and sometimes all, of the units were without the requisite staffing personnel *on all fifteen days*.<sup>119</sup>

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### ***PIW Employee Alleges Serious Neglect and Understaffing***

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Revealingly, in January 2024, a PIW employee filed a complaint with DBH about serious and consistent safety and staffing problems, reporting being “disturbed and distressed by what she has seen.” The employee described multiple allegations of abuse and neglect, many related to inadequate staffing.<sup>120</sup> The complaints included:

- Patients are routinely attacked with some patients requiring emergency room care.
- There have been riots on the units.
- Staff do not implement “handle with care” training during a crisis because there are not enough staff to implement it.
- There are inadequate staff to patient ratios on the units.
- It is difficult for staff to implement the required every 15-minute check on all patients due to understaffing.
- The nurses document vital signs when they do not actually take vital signs.
- PIW offers unlimited overtime due to staff shortages.
- Night shift staff have been observed to be asleep.
- Psychiatric patients are placed on the substance abuse unit if psychiatric units are full, “which is very disruptive.”
- Adolescent patients are not taken outside despite extended stays.
- Tutors are not available for adolescent patients.
- There is an inadequate amount of food for patients.
- Ice forms on the windows due to cold temperatures inside the building. The facility runs out of blankets on the weekends.<sup>121</sup>

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## *Numerous Restraints and Seclusions*

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Pursuant to a FOIA request, Disability Rights DC obtained PIW incident reports that revealed that staff are employing restraint and seclusion at an alarming frequency. In February 2024, staff restrained and/or secluded patients twenty-eight times, *averaging one incident per day*.<sup>122</sup>

D.C. law, D.C. regulations, and federal regulations generally prohibit the use of restraint and seclusion in psychiatric facilities such as PIW, carving out narrowly tailored exceptions.<sup>123</sup> These restrictions and requirements are essential to protect the safety and dignity of PIW’s patients.<sup>124</sup> D.C. law allows their use only in an emergency when necessary to prevent serious injury to the consumer or others.<sup>125</sup> Restraint and seclusion must be implemented in accordance with safe and appropriate techniques and only when less restrictive alternatives have been considered and determined ineffective.<sup>126</sup> Federal regulations also allow for restraint and seclusion only to ensure the immediate physical safety of the patient or staff and only when less restrictive interventions have been determined to be

ineffective to protect the patient or staff member or others from harm.<sup>127</sup> PIW policy also has detailed requirements and restrictions related to the use of restraint and seclusion.<sup>128</sup>

The staffs' descriptions of the restraints and seclusions in the incident reports are very brief and do not provide evidence that PIW staff followed all required interventions prior to using such an extreme response. For example, one incident report indicates that a patient was involved in one physical hold and one chemical restraint on February 29, 2024, without providing further details of the incident. The report notes, "These restrictive interventions were in response to immediate danger to self or others. No injuries were sustained as a result of these interventions."<sup>129</sup> There is no further explanation. Similarly, another report simply states that the patient was involved in one chemical restraint on February 28, 2024. This is followed by the identical sentence quoted above. Again, there is no further explanation.<sup>130</sup> This very brief description is repeated almost verbatim in all twenty-eight incident reports related to restraint and seclusion. Disability Rights DC did not have access to the medical records related to these incidents, which may contain more information. Regardless, as noted above, staff can only use restraint and seclusion as a last resort and must employ alternative strategies prior to subjecting patients to the trauma and potential danger of these very restrictive interventions prior to restraining or secluding them.<sup>131</sup> The high frequency of restraint and seclusion suggests that PIW staff are not adequately employing de-escalation techniques or other less restrictive alternatives. Moreover, repeated use of seclusion and restraint can actually make an environment more dangerous for patients and staff. Research shows seclusion and restraint are not effective and "can actually fuel violence," creating a vicious cycle where restraint and seclusion "may cause, reinforce, and maintain aggression and violence on the ward."<sup>132</sup>

Significantly, a DC Health June 2023 review found that on multiple occasions PIW staff implemented physical and chemical restraints and that staff failed to report the incidents. In March 2023, staff subjected a patient to physical and chemical restraint nine times yet failed to report six of the incidents.<sup>133</sup> Another patient was restrained four times, however, staff failed to report two of the incidents.<sup>134</sup> A seventeen-year-old patient was restrained six times and staff failed to report three of the incidents.<sup>135</sup> Another patient was restrained twice yet staff failed to report both incidents.<sup>136</sup> Thus, it is unclear how frequently seclusion and restraint are actually used, reflecting lack of adequate oversight and quality improvement.

The overuse of restraint and seclusion, along with an unsafe environment, can seriously traumatize individuals with mental health disabilities, many of whom have a history of trauma. One PIW patient told Disability Rights DC that “PIW feels like prison. This situation taught me that I should not have reached out for help.”<sup>137</sup> According to an article in the JAMA Health Forum, “inpatient psychiatry that serves individuals in their greatest time of need, is broken.”<sup>138</sup> The authors report disturbing common statements made by inpatient psychiatric patients similar to those expressed to Disability Rights DC by PIW patients, such as “my most recent hospitalization experience felt more like a prison than a place of healing;” “I am terrified of hospitals and have no idea how to get help when I need it;” “I just stay quiet and isolate myself away;” and “I was not suicidal when I entered this unit, but I was when I left.”<sup>139</sup> The authors opine that a “patient-centered care (PCC)” approach, which is “respectful, transparent, and responsive to patients’ needs and preferences,” should be prioritized and is “central to evidence based models for preventing and reducing conflict, trauma, and use of restraint and seclusion.”<sup>140</sup>

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### *Patients Exposed to Construction*

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During several in person visits to various PIW units to meet with clients, the Public Defender Service (“PDS”) noted multiple environmental concerns and reported them to DC Health. PDS reported that on February 6, 2024, during a visit to Unit 3, they observed that the unit was actively under renovation while their client, staff and other patients resided on the unit.<sup>141</sup> PDS observed three painters working on the walls in the common area surround the nursing station, while patients were either in their rooms or walking right by the painters in the hallways, and that the paint fumes were strong.<sup>142</sup> PDS noted that the workers were unlikely to be trained or familiar with individuals in psychiatric crisis.<sup>143</sup>

On February 13, 2024, while visiting a client on Unit 3, PDS observed that the bathroom in the room to which their client was assigned was being renovated, and that workers were actively renovating the bathroom throughout the day.<sup>144</sup> Additionally, PDS noted that there had been ongoing, very loud construction that interferes with the patients’ sleep, groups, and ability to use phones. PDS reported that it is often so loud on the units that their clients cannot hear PDS on the phone or in virtual meetings.<sup>145</sup> PDS informed DC Health that the “renovation undermines



the therapeutic environment to which the patients—some detained against their will—are entitled.”<sup>146</sup>

On March 18, 2024, PDS again reported that during a legal visit, painters were working on a unit in the common room while patients were gathered for group therapy.<sup>147</sup> PDS again expressed concerns that having active construction on the units is not only inappropriate and non-therapeutic, but also it was not safe.<sup>148</sup> Finally, on May 20, PDS was present on both Unit 3 and Unit 9. On Unit 3, PDS observed two crews working where patients were residing.<sup>149</sup> Three painters were working on walls and trim with various tools. Additionally, a worker was vacuuming out the vents in the bedrooms where patients were resting on their beds.<sup>150</sup> On Unit 9, PDS observed a crew with a ladder and tools, working to fix the cameras in the ceiling.<sup>151</sup> Staff on both Unit 3 and 9 expressed their concern about the various tools out in the open and their frustration regarding exposing staff and patients to the ongoing renovation on the units.<sup>152</sup>

After reporting all of these concerns, PDS followed up with DC Health several times after they did not receive a complaint response. It was not until July 5, 2024, that DC Health sent a brief letter (dated July 2, 2024) addressing the February 9, 2024 complaint only and stating that DC Health investigated the February 9, 2024 complaint and no deficiencies were cited.<sup>153</sup> No details were provided. It is not clear how DC Health came to this conclusion since federal regulations require that a “hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.”<sup>154</sup> Nor is it clear why they have not provided PDS with responses to their subsequent complaints. Patients at PIW should not be routinely exposed to active construction and renovation on their units. PIW must close units while major repairs and renovations are completed. Although this may reduce revenue, the priority should be a safe and therapeutic environment for their patients.

### *III. Inadequate Incident Reporting and Investigation Process*

An adequate quality improvement program, which includes reporting incidents and conducting investigations, is essential for maintaining patient safety

and ensuring quality care, as well as for reducing and preventing incidents of abuse and neglect. For these reasons, the Center for Medicaid and Medicare Services requires PIW to have an adequate quality improvement system.<sup>155</sup>

DBH also requires PIW to report major unusual incidents (“MUIs”) to DBH, including restraint, seclusion, suicide attempts, physical assault, sexual assault, physical abuse, physical injury, death, psychological or verbal abuse, neglect, medical emergencies, and falls.<sup>156</sup> DBH policy further provides that MUIs must be reported timely and accurately.<sup>157</sup> However, despite these multiple reporting requirements, *PIW has failed to send the requisite MUIs to DBH for years*, significantly hampering DBH’s critical oversight role. During an investigation in May 2023, DC Health found that PIW “nursing staff failed to ensure timely and accurate reporting and data entry of incidents for three of five patients.”<sup>158</sup> In fact, excluding the incidents of restraint and seclusion previously discussed in this report, for a sixteen-month period, from January 1, 2023, through March 4, 2024, according to records provided by DBH, PIW submitted only seven MUIs to DBH. PIW admits and discharges hundreds of patients every month. These low reporting numbers are quite alarming and raise questions as to whether serious incidents at PIW are going unreported.<sup>159</sup>

Equally as important is a hospital’s internal investigatory process. PIW’s own policy requires that they conduct rigorous investigations, stating that PIW will conduct a “full investigation” for all hospital occurrences “for which all details are not self-evident.”<sup>160</sup> 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.<sup>161</sup> Disability Rights DC has repeatedly requested that PIW provide its internal investigation reports when Disability Rights DC initiates an investigation based on a complaint it has received. In addition, Disability Rights DC has requested that DBH and DC Health provide any PIW prepared investigation reports in their possession as a part of these investigations or through the Freedom of Information Act. Although PIW represents that they conduct investigations into certain incidents, Disability Rights DC has received no such reports.<sup>162</sup> In fact, in August 2021, DC Health found that PIW repeatedly failed to ensure adequate follow-up and investigation of incidents in accordance with their own hospital policy.<sup>163</sup> The DC Health inspection revealed that a total of 50 incidents had not been investigated in the 21 days under review, and there was no additional documented evidence of any follow-up in response to the incidents.<sup>164</sup>

## IV. Conclusion and Recommendations

The long-standing, serious allegations of abuse and neglect at PIW are extremely alarming. At the very least, DBH, DC Health, and PIW must ensure that patients are safe while seeking care at a hospital. PIW represents that their goal is “to provide a stabilizing, healing environment” and that “[e]xcellence in behavioral health programs for children, adolescents and adults has been the mission of [PIW] since it opened nearly 50 years ago.”<sup>165</sup> This is far from how many patients describe their stay at PIW and not consistent with the findings in this report.

The status quo cannot continue. *DBH and DC Health must provide increased and meaningful oversight of PIW, including their quality improvement system of incident reporting and investigatory processes.* Both DBH and DC Health must require PIW to adhere to all legal and policy requirements, including those related to abuse and neglect, incidents and investigations, *and hold them accountable when they fail to do so.* These oversight agencies must also ensure that PIW maintains the staffing at a level that ensures patients are safe from harm and trauma. Moreover, as the oversight agencies, both DC Health and DBH *must* investigate allegations of abuse and neglect in a timely manner when such incidents are reported to them. They cannot continue to “point fingers” at each other but must adequately coordinate investigations of serious allegations, including allegations of physical and sexual harm.

PIW must make changes that put patient care above corporate concerns. Its goal should be to enable healing that results in recovery and community integration. The District of Columbia deserves no less. As Disability Rights DC recommended in our 2022 report,<sup>166</sup> at a minimum, PIW must examine the current staff ratios and increase staffing to levels that ensure a safe environment. The current staffing practices have not been sufficient to keep the units safe.

And PIW staff must use treatment practices that demonstrate care and compassion for those who are hospitalized, upholding the dignity of the patients -  
- creating an environment that does not demand seclusion and restraint but

provides respite and insight. As recommended in our 2022 report, PIW should retain the services of an independent consultant specializing in trauma-informed care and the reduction and elimination of seclusion and restraint and the prevention of dangerous incidents in institutional settings. PIW has stated that it has its own consultants that train its staff. It's not working. PIW should hire an independent consultant with the ability to effectuate the actual change that is needed.

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<sup>1</sup> Psych. Inst. of Washington, *About Us*, <https://psychinstitute.com/about-us/> (last visited April 18, 2024). St. Elizabeths Hospital is also a psychiatric facility located in Washington, D.C. However, in contrast to PIW, it is a nonprofit public facility, not private, and is operated by DC's Department of Behavioral Health. See Dep't of Behav. Health, *Saint Elizabeths Hospital*, <https://dbh.dc.gov/page/saint-elizabeths-hospital> (last visited April 18, 2024).

<sup>2</sup> Psych. Inst. of Washington, *Outpatient and Inpatient Treatment Programs*, <https://psychinstitute.com/treatment-services/> (last visited April 17, 2024).

<sup>3</sup> *Id.*

<sup>4</sup> D.C. Code §§ 7-731(4), 7-1141.06(3).

<sup>5</sup> Universal Health Servs., *UHS Healthcare Facility Locations*, <https://www.uhsinc.com/our-communities/> (last visited July 7, 2022); Universal Health Servs., *About UHS*, <https://uhs.com/universal-health-services-inc-ranks-on-fortune-500-for-21st-year/> (last visited June 12, 2024).

<sup>6</sup> *Id.*, Macrotrends, *Universal Health Services Revenue 2010-2023*, <https://www.macrotrends.net/stocks/charts/UHS/universal-health-services/revenue> (last visited June 12, 2024).

<sup>7</sup> Ellie Silverman, *Second Worker Charged in Teen Patient's Death at Health Care Center*, Washington Post (February 15, 2018, 6:53 pm) [https://www.washingtonpost.com/local/public-safety/second-worker-charged-in-teen-patients-death-at-health-care-center/2018/02/15/cbd0d0ba-129a-11e8-8ea1-c1d91fcec3fe\\_story.html](https://www.washingtonpost.com/local/public-safety/second-worker-charged-in-teen-patients-death-at-health-care-center/2018/02/15/cbd0d0ba-129a-11e8-8ea1-c1d91fcec3fe_story.html) (last visited June 12, 2024); see <https://jobs.uhsinc.com/north-spring-behavioral-healthcare/jobs> ("North Spring Behavioral Healthcare is operated by a subsidiary of Universal Health Services, Inc. (UHS), a King of Prussia, PA-based company...").

<sup>8</sup> U.S. Dep't of Just. Off. of Pub. Affs., *Universal Health Services, Inc. And Related Entities to Pay \$122 Million to Settle False Claims Act* (July 10, 2020), <https://www.justice.gov/opa/pr/universal-health-services-inc-and-related-entities-pay-122-million-settle-false-claims-act> (last visited June 12, 2024). 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

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health claims that are submitted to federal health care programs are to undergo annual reviews performed by an independent review organization.

<sup>9</sup> Chad Pradelli, *Former staffer pleads guilty to sex assault at Fairmount Behavioral Health*, ABC Action News (April 23, 2021) [https://6abc.com/fairmount-behavioral-health-michael-mcintosh-guilty-plea-sex-assault-investigation-action-news/10540747/#:~:text=PHILADELPHIA%20\(WPVI\)%20%2D%2D%20A%20former,Assault%2C%20a%20class%203%20felony](https://6abc.com/fairmount-behavioral-health-michael-mcintosh-guilty-plea-sex-assault-investigation-action-news/10540747/#:~:text=PHILADELPHIA%20(WPVI)%20%2D%2D%20A%20former,Assault%2C%20a%20class%203%20felony) (last visited June 12, 2024).

<sup>10</sup> Katie Kamin, *Bugs, blood and beatings: Docs reveal claims against Summerville youth facility*, Live 5 News (November 30, 2023, 7:07 pm) <https://www.live5news.com/2023/11/30/bugs-blood-beatings-docs-reveal-claims-against-summerville-youth-facility/> (last visited June 12, 2024). See <https://jobs.uhsinc.com/palmetto-summerville-behavioral-health> (“Palmetto Summerville Behavioral Health is operated by a subsidiary of Universal Health Services, Inc. (UHS), a King of Prussia, PA-based company that is one of the nation’s largest and most respected providers of hospital and healthcare services.”)

<sup>11</sup> Samuel Lisec, *Jury renders \$535 million judgment against The Pavilion in 2020 rape of patient*, The News-Gazette (March 29, 2024). The decision has been appealed. [https://www.news-gazette.com/news/local/courts-police-fire/jury-renders-535-million-judgment-against-the-pavilion-in-2020-rape-of-patient/article\\_c36a05f5-e80a-53c6-92ee-9f1f17acafef.html](https://www.news-gazette.com/news/local/courts-police-fire/jury-renders-535-million-judgment-against-the-pavilion-in-2020-rape-of-patient/article_c36a05f5-e80a-53c6-92ee-9f1f17acafef.html). See <https://jobs.uhsinc.com/the-pavilion-behavioral-health-system> (“The Pavilion Behavioral Health System is operated by a subsidiary of Universal Health Services, Inc. (UHS), a King of Prussia, PA-based company that is one of the nation’s largest and most respected providers of hospital and healthcare services.”)

<sup>12</sup> Laura French, *New Information in \$387 million lawsuit against Cumberland Children’s Hospital*, 6 News Richmond (July 31, 2023) <https://www.wtvr.com/news/local-news/cumberland-childrens-hospital-lawsuit-update-07-31-2023#:~:text=NEW%20KENT%20COUNTY%2C%20Va.,Daniel%20Davidow> (last visited June 26, 2024).

<sup>13</sup> Sarah Rankin, *Lawsuit against New Kent County hospital alleging abuse can move forward, judge rules*, The Virginian Pilot, (August 21, 2023) <https://www.pilotonline.com/2023/08/21/virginia-judge-largely-sides-with-ex-patients-in-hospitals-effort-to-pare-down-lawsuit-abuse-claims/> (Last visited June 26, 2024).

<sup>14</sup> Peter Hermann, *Psychiatric health aide in D.C. charged with sexual abuse of a patient*, (Dec. 21, 2023) <https://www.washingtonpost.com/dc-md-va/2023/12/21/sexual-assault-dc-psychiatric/>; Amber Anderson, *Teen patient sexually abused by hospital employee, police say*, WUSA 9 (Dec. 22, 2023, 8:51 am). <https://www.wusa9.com/article/news/local/dc/teen-sexual-abusepsychiatric-institute-washington-man-arrested/65-e6ab89e6-cc9b-4aaa-8725-4803a15f9e24>.

<sup>15</sup> *Id.*

<sup>16</sup> Amber Anderson, *Teen patient sexually abused by hospital employee, police say*, WUSA 9 (Dec. 2, 2023, 8:51 am) <https://www.wusa9.com/article/news/local/dc/teen-sexual-abusepsychiatric-institute-washington-man-arrested/65-e6ab89e6-cc9b-4aaa-8725-4803a15f9e24>.

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<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> *Id.*

<sup>22</sup> Pseudonym used to protect patient privacy.

<sup>23</sup> Videotape, Security Camera Footage at Psych. Inst. of Washington at 01:53:17 am (December 2023, 01:20:01 am to 02:19:33 am).

<sup>24</sup> PIW RN Progress note, dated December 2023, timed at 2:00 a.m.

<sup>25</sup> Videotape, Security Camera Footage at Psych. Inst. of Washington (December 2023, 01:20:01 am to 02:19:33 am).

<sup>26</sup> *Id.*

<sup>27</sup> *Id.*

<sup>28</sup> The still frames featured in this report have been traced and sketched to protect Ms. Jones' and the male patient's identity.

<sup>29</sup> Videotape, Security Camera Footage at Psych. Inst. of Washington at 01:20:54 am (December 2023, 01:20:01 am to 02:19:33 am).

<sup>30</sup> *Id.* at 01:21:23 am.

<sup>31</sup> *Id.* at 01:22:33 am.

<sup>32</sup> *Id.* at 01:23:39 am.

<sup>33</sup> *Id.* at 01:51:32 am.

<sup>34</sup> *Id.* at 01:31:38 am.

<sup>35</sup> *Id.* at 01:49:31 am.

<sup>36</sup> *Id.* at 01:51:36 am.

<sup>37</sup> *Id.* at 01:53:16 am.

<sup>38</sup> *Id.* at 01:53:17 am.

<sup>39</sup> *Id.* at 01:53:17 am.

<sup>40</sup> *Id.*

<sup>41</sup> *Id.* at 02:00:25 am.

<sup>42</sup> DRDC Letter to DBH and DC Health (February 12, 2024).

<sup>43</sup> Email from DC health to DRDC (February 12, 2024).

<sup>44</sup> Email from DBH to DRDC (March 25, 2024).

<sup>45</sup> DRDC sent FOIA requests to DBH and DC Health requesting the following information from January 1, 2023, through March 4, 2024: 1. Any major unusual incident reports received from or related to the Psychiatric Institute of Washington ("PIW"); 2. Any complaints and grievances related to PIW; 3. Any investigation reports issued by DBH, the DC Department of Health ("DOH"), Centers for Medicare & Medicaid Services the Joint Commission, or any other oversight authority or entity, related to PIW; 4. Any investigation reports or any other report describing alleged or confirmed abuse and/or neglect received from, or related to, PIW; 5. Any corrective action plans issued by DBH, or any other entity, including DOH, CMS, the Joint Commission, or any other oversight authority or entity, related to PIW; and 6. Any corrective action plans or other documents requiring action steps in response to a report or findings,

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drafted or created by PIW. No incident or investigation reports related to this incident were provided.

<sup>46</sup> Dep't of Behav. Health Policy No. 480.1A (4), (5b)(5).

<sup>47</sup> Pseudonym used to protect patient privacy.

<sup>48</sup> PIW Incident report, dated February 18, 2023, timed at 10:00 p.m.

<sup>49</sup> DC Health Licensing and Administration Survey, Psych. Inst. of Washington at 16 (June 5, 2023).

<sup>50</sup> *Id.* at 17.

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> PIW Incident report, dated February 18, 2023, timed at 10:00 p.m.

<sup>54</sup> Medical Home Development Group Nurse Practitioner Assessment, dated February 20, 2023, timed at 2:50 p.m.

<sup>55</sup> *Id.*

<sup>56</sup> PIW Physician Progress note, dated February 22, 2023, timed at 5:58 p.m.

<sup>57</sup> Medical Home Development Group Nurse Practitioner Assessment, dated February 23, 2023, timed at 9:46 p.m.

<sup>58</sup> PIW Incident report, dated February 25, 2023, timed at 10:50 p.m.

<sup>59</sup> PIW Physician progress note, dated February 27, 2023, not timed.

<sup>60</sup> *See supra* note 45; Dep't of Behav. Health Policy No. 480.1A (4), (5b)(5).

<sup>61</sup> Dep't of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (May 15, 2023).

<sup>62</sup> DC Health Licensing and Administration Survey, Psych. Inst. of Washington at 18. (June 5, 2023).

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

<sup>65</sup> *Id.* at 19.

<sup>66</sup> *Id.*

<sup>67</sup> *Id.* at 11,12.

<sup>68</sup> Dep't of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (May 15, 2023).

<sup>69</sup> *Id.*

<sup>70</sup> *See supra* note 45: Dep't of Behav. Health Policy No. 480.1A (4), (5b)(5).

<sup>71</sup> Pseudonym used to protect patient privacy.

<sup>72</sup> DRDC interview with Mary Green (January 26, 2024).

<sup>73</sup> *Id.*

<sup>74</sup> DRDC interview with Mary Green's son (January 26, 2024).

<sup>75</sup> *Id.*

<sup>76</sup> DRDC interview with Ms. Green's son (May 17, 2024).

<sup>77</sup> Medical Home Development Group Physician Evaluation, dated December 28, 2023.

<sup>78</sup> Psych. Inst. of Washington Incident Report (December 27, 2023).

<sup>79</sup> Dep't of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (January 1, 2024).

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- <sup>80</sup> *Id.*
- <sup>81</sup> DRDC letter to DBH and DC Health (March 22, 2024).
- <sup>82</sup> *See infra* note 45; Dep't of Behav. Health Policy No. 480.1A (4), (5b)(5).
- <sup>83</sup> DRDC interview with PIW patient (Spring 2024).
- <sup>84</sup> *Id.*
- <sup>85</sup> PIW RN Progress Note, dated Spring 2024.
- <sup>86</sup> DRDC interview with PIW patient (November 20, 2023).
- <sup>87</sup> PIW RN Progress Note dated November 6, 2023, timed at 9:00 a.m.
- <sup>88</sup> DRDC interview with PIW patient (November 20, 2023).
- <sup>89</sup> *See supra* note 45; Dep't of Behav. Health Policy No. 480.1A (4), (5b)(5).
- <sup>90</sup> DC Health Licensing and Administration Survey, Psych. Inst. of Washington at 38 (May 26, 2022).
- <sup>91</sup> Unannounced Survey DC Health Licensing and Administration Survey, Psych. Inst. of Washington at 24, 25 (June 5, 2023).
- <sup>92</sup> *Id.* at 25.
- <sup>93</sup> *Id.*
- <sup>94</sup> Dep't of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (May 11, 2023).
- <sup>95</sup> *Id.*
- <sup>96</sup> Dep't of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (January 2, 202[4]).
- <sup>97</sup> *Id.*
- <sup>98</sup> *Id.*
- <sup>99</sup> Dep't of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (February 25, 2024).
- <sup>100</sup> *Id.*
- <sup>101</sup> *See supra* note 45; Dep't of Behav. Health Policy No. 480.1A (4), (5b)(5).
- <sup>102</sup> Dep't of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (April 6, 2022).
- <sup>103</sup> *Id.*
- <sup>104</sup> *Id.*
- <sup>105</sup> Dep't of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (January 10, 2022).
- <sup>106</sup> *Id.*
- <sup>107</sup> *See supra* note 45; Dep't of Behav. Health Policy No. 480.1A (4), (5b)(5).
- <sup>108</sup> Dep't of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (May 1, 2023).
- <sup>109</sup> *Id.*
- <sup>110</sup> *Id.*
- <sup>111</sup> *Id.*
- <sup>112</sup> *See supra* note 45; Dep't of Behav. Health Policy No. 480.1A (5b)(5).
- <sup>113</sup> DC Health Complaint Survey, Psych. Inst. of Washington at 2 (June 30, 2023).
- <sup>114</sup> *Id.* at 10.



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<sup>115</sup> *Id.* at 17.

<sup>116</sup> DC Health Licensing and Administration Survey, Psych. Inst. of Washington at 36, 37 (May 26, 2022).

<sup>117</sup> Dep't of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (November 11, 2023).

<sup>118</sup> *Id.*

<sup>119</sup> DC Health Licensing and Administration Survey, Psych. Inst. of Washington at 17-22. (May 26, 2022).

<sup>120</sup> Dep't of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (1/24/2024).

<sup>121</sup> *Id.*

<sup>122</sup> Dep't of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (2/10/2024; 2/11/2024; 2/11/2024; 2/12/2024; 2/13/2024; 2/13/2024; 2/13/2024; 2/13/2024; 2/14/2024; 2/14/2024; 2/14/2024; 2/15/2024; 2/15/2024; 2/16/2024; 2/17/2024; 2/20/2024; 2/20/2024; 2/21/2024; 2/21/2024; 2/22/2024; 2/24/2024; 2/23/2024; 2/23/2024; 2/23/2024; 2/24/2024; 2/25/2024; 2/28/2024; 2/29/2024).

<sup>123</sup> D.C. law defines seclusion as “any involuntary confinement of a consumer alone in a room or an area from which the consumer is either physically prevented from leaving or from which the consumer is led to believe he or she cannot leave at will.” D.C. Code § 7-1231.02(24). D.C. law defines restraint as “either a physical restraint or a drug that is being used as a restraint.” D.C. Code § 7-1231.02(23).

<sup>124</sup> D.C. regulations specifically explain the reasons for the multiple legal requirements that staff must follow prior to, during, and after a restraint, noting that their purpose includes: (1) to provide a safe and therapeutic environment to significantly reduce the incidence of emergencies that necessitate the use of restraints and seclusion; (2) to establish positive, trusting relationships among consumers and mental health provider staff; and (3) to reduce and minimize the use of restraints and seclusion in an emergency in favor of less restrictive behavior management techniques. D.C. Mun. Regs. tit. 22A § 500.1. PIW’s own restraint and seclusion policy has similar requirements: that staff (1) use restraint and seclusion only as a last resort; (2) exhaust all less restrictive techniques prior to resorting to restraint and seclusion; (3) use only approved techniques trained through the aggression management program; and (4) in no case may take a patient to the floor. PIW Policy NSG.168.

<sup>125</sup> D.C. Code § 7-1231.09(c).

<sup>126</sup> D.C. Code § 7-1231.09(c)(d). D.C. law also specifies that patients “have the right to be free from seclusion and restraint of any form that is not medically necessary or that is used as a means of coercion, discipline, convenience, or retaliation by staff.” D.C. Code § 7-1231.09(a). D.C. regulations have similar specific documentation requirements staff must follow, including that within one hour of the restraint the registered nurse in charge must document: “(1) the justification for the use of restraints or seclusion; (2) alternative strategies which failed to manage the consumer's behavior or why other strategies were considered but deemed impractical or unsafe; (3) the consumer's current behaviors and mental and emotional status; and (4) the consumer's physical status. D.C. Mun. Regs. tit. 22A § 506.2 (b).

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<sup>127</sup> 42 C.F.R. § 482.13(e). CMS indicates that the intent of their requirements is to “identify patients’ basic rights, ensure patient safety, and *eliminate the inappropriate use of restraint or seclusion.*” CMS Interpretive Guidelines for 42 C.F.R. § 482.13(e), at p. 90 (emphasis added).

<sup>128</sup> See PIW Policy NSG.168. Staff techniques to avoid restraint and seclusion should be deliberate and meaningful, thus the policy provides examples of multiple interventions staff should employ before resorting to restraint or seclusion. PIW Policy NSG.168 at p. 2 (“Examples of less restrictive measures include, but are not limited to: 1. Verbal interventions such as talking quietly with the patient, 2. Environmental intervention through reduction of stimuli causing irritation, 3. Relaxation techniques, 4. Physical activity, 5. Psychoactive medications, 6. Reality Orientation, 7. Seclusion time, 8. Time out/time away.”)

<sup>129</sup> Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (2/29/2024).

<sup>130</sup> Dep’t of Behav. Health Major and Unusual Incident Form, Psych. Inst. of Washington (2/28/2024).

<sup>131</sup> D.C. Code § 7-1231.09(c).

<sup>132</sup> See Amanda Wik, M.A., *Elevating Patient/Staff Safety in State Psychiatric Hospitals*, Nat’l Assoc. of State Mental Health Program Directors Res. Inst. (January 2018), [https://www.nri-inc.org/media/1465/2018-elevatingpatient\\_endnotesfinal.pdf](https://www.nri-inc.org/media/1465/2018-elevatingpatient_endnotesfinal.pdf)

<sup>133</sup> Unannounced Survey DC Health Licensing and Administration Survey at 30. (June 5, 2023).

<sup>134</sup> *Id.*

<sup>135</sup> *Id.* at 31.

<sup>136</sup> *Id.*

<sup>137</sup> DISABILITY RIGHTS DC interview with PIW patient (April 24, 2024).

<sup>138</sup> Morgan C. Shields & Rinad S. Beidas, *The Need to Prioritize Patient-Centered Care in Inpatient Psychiatry as a Matter of Social Justice*, JAMA Health Forum, February 4, 2022 <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2788761>.

<sup>139</sup> *Id.*

<sup>140</sup> *Id.*

<sup>141</sup> Email from PDS to DC Health (February 9, 2024).

<sup>142</sup> *Id.*

<sup>143</sup> *Id.*

<sup>144</sup> Email from PDS to DC Health (March 4, 2024).

<sup>145</sup> *Id.*

<sup>146</sup> *Id.*

<sup>147</sup> Email from PDS to DC Health (March 18, 2024).

<sup>148</sup> *Id.*

<sup>149</sup> Email from PDS to DC Health (May 20, 2024).

<sup>150</sup> *Id.*

<sup>151</sup> *Id.*

<sup>152</sup> *Id.*

<sup>153</sup> DC Health letter to PDS (July 2, 2024).

<sup>154</sup> 42 CRF §482.41(a)

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<sup>155</sup> PIW’s Human Care Agreement with DBH specifies that PIW will conform to “generally accepted standards of care as defined by the Centers for Medicare and Medicaid Services (“CMS”) and the Joint Commission... .” These standards include a requirement that a hospital’s “governing body ... medical staff, and administrative officials are responsible and accountable for ensuring ... that an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.” Contract, Dep’t of Behav. Health, Psych. Inst. of Washington C.3.2.1 (signed Sept. 27, 2013) (first quote); 42 CFR § 482.21 (second quote). Also, as part of its program, a hospital “must set priorities for its performance improvement activities that (i) [f]ocus on high-risk, high-volume, or problem-prone areas; (ii) [c]onsider the incidence, prevalence, and severity of problems in those areas; and (iii) [a]ffect health outcomes, patient safety, and quality of care.” 42 C.F.R. § 483.75(e)(1).

<sup>156</sup> Dep’t of Behav. Health Policy No. 482.1 at Ex.1A; Dep’t of Behav. Health Policy No. 482.1 (7a), (6a).

<sup>157</sup> Dep’t of Behav. Health Policy No. 480.1A (4), (5b)(1), (5b)(2).

<sup>158</sup> DC Health Investigation Intake No: 11928 (not dated).

<sup>159</sup> *Compare with* St Elizabeths reported number of MUIs for March 2024, which was 149 total MUIs and an average daily census of 264. *Performance Related Information for Staff and Managers*, Dept. of Behav. Health (March.2024)

[https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page\\_content/attachments/SEH PRISM Dashboard PDF-Mar%202024.pdf](https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/SEH_PRISM_Dashboard_PDF-Mar%202024.pdf)

<sup>160</sup> Psych. Inst. of Washington Policy No. ADM.041. The policy further provides that “an [i]nvestigation is an inquiry for ascertaining facts” and “consists of a detailed, careful examination of, but is not limited to, staff and patient interviews, review of pertinent documentation, and review of video footage.” The policy requires that PIW produce a written investigation report with detailed findings, stating that “the Risk Manager or designee will review medical records and other pertinent documentation for inclusion into the final investigation report.” Moreover, DBH Policy requires PIW to submit a follow up report or internal investigation report to DBH within ten business days, if requested by DBH, following the provider’s internal procedures for investigations. Psych. Inst. of Washington Policy No. ADM.041 at 1. *See also* Psych. Inst. of Washington Policy No. ADM.143 (stating that the PIW risk manager shall “[w]hen necessary, confidentially investigate serious and critical occurrences”).

<sup>161</sup> Dep’t of Behav. Health Policy No. 480.1A (4), (5b)(5).

<sup>162</sup> Federal regulations allow DISABILITY RIGHTS DC access to all records, which are defined as “reports prepared by any staff of a facility rendering care and treatment or reports prepared by an agency charged with investigating reports of incidents of abuse, neglect, and injury occurring at such facility that describe incidents of abuse, neglect, and injury occurring at such facility and the steps taken to investigate such incidents, and discharge planning records.” 42 U.S.C. § 10806(3)(A).

<sup>163</sup> DC Health Regulation and Licensing Administration Survey, Psych. Inst. of Washington at 5 (August 31, 2021).

<sup>164</sup> *Id.*

<sup>165</sup> Psych. Inst. of Washington, *About Us*, <https://psychinstitute.com/about-us/> (last visited May 17, 2024).

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<sup>166</sup> Do No Harm: Multiple Incidents of Abuse and Neglect at the Psychiatric Institute of Washington, [https://assets-global.website-files.com/65792ba62c7815e2cdc139a2/65f22c754f8fbd542831e786\\_piwreport72022.pdf](https://assets-global.website-files.com/65792ba62c7815e2cdc139a2/65f22c754f8fbd542831e786_piwreport72022.pdf) at 35.