



Senate

General Assembly

File No. 101

January Session, 2003

Substitute Senate Bill No. 971

Senate, March 31, 2003

The Committee on Program Review and Investigations reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING DEPARTMENT OF MENTAL RETARDATION CLIENT HEALTH AND SAFETY.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsection (a) of section 17a-210 of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective*
3 *October 1, 2003*):

4 (a) There shall be a Department of Mental Retardation. The
5 Department of Mental Retardation, with the advice of a Council on
6 Mental Retardation, shall be responsible for the planning,
7 development and administration of complete, comprehensive and
8 integrated state-wide services for persons with mental retardation and
9 persons medically diagnosed as having Prader-Willi syndrome. The
10 Department of Mental Retardation shall be under the supervision of a
11 Commissioner of Mental Retardation, who shall be appointed by the

12 Governor in accordance with the provisions of sections 4-5 to 4-8,
13 inclusive. The Council on Mental Retardation may advise the
14 Governor on the appointment. The commissioner shall be a person
15 who has background, training, education or experience in
16 administering programs for the care, training, education, treatment
17 and custody of persons with mental retardation. The commissioner
18 shall be responsible, with the advice of the council, for: (1) Planning
19 and developing complete, comprehensive and integrated state-wide
20 services for persons with mental retardation; (2) the implementation
21 and where appropriate the funding of such services; and (3) the
22 coordination of the efforts of the Department of Mental Retardation
23 with those of other state departments and agencies, municipal
24 governments and private agencies concerned with and providing
25 services for persons with mental retardation. The commissioner shall
26 be responsible for the administration and operation of the state
27 training school, state mental retardation regions and all state-operated
28 community-based residential facilities established for the diagnosis,
29 care and training of persons with mental retardation. The
30 commissioner shall be responsible for establishing standards,
31 providing technical assistance and exercising the requisite supervision
32 of all state-supported residential, day and program support services
33 for persons with mental retardation and work activity programs
34 operated pursuant to section 17a-226. The commissioner shall conduct
35 or monitor investigations into allegations of abuse and neglect and file
36 reports as requested by state agencies having statutory responsibility
37 for the conduct and oversight of such investigations. In the event of the
38 death of a person with mental retardation for whom the department
39 has direct or oversight responsibility for medical care, the
40 commissioner shall ensure that a comprehensive and timely review of
41 the events, overall care, quality of life issues and medical care
42 preceding such death is conducted by the department and shall, as
43 requested, provide information and assistance to the Independent
44 Mortality Review Board established by Executive Order No. 25 of
45 Governor John G. Rowland. The commissioner shall report to the
46 board and the board shall review any death: (A) Involving an

47 allegation of abuse or neglect; (B) for which the Office of Chief Medical
48 Examiner or local medical examiner has accepted jurisdiction; (C) in
49 which an autopsy was performed; (D) which was sudden and
50 unexpected; or (E) in which the commissioner's review raises questions
51 about the appropriateness of care. The commissioner shall stimulate
52 research by public and private agencies, institutions of higher learning
53 and hospitals, in the interest of the elimination and amelioration of
54 retardation and care and training of persons with mental retardation.

55 Sec. 2. Section 17a-227 of the general statutes is repealed and the
56 following is substituted in lieu thereof (*Effective July 1, 2004*):

57 (a) No person, firm or corporation shall conduct or maintain within
58 this state a residential facility which it owns, leases or rents for the
59 lodging, care or treatment of persons with mental retardation or
60 autistic persons unless such person, firm or corporation, upon written
61 application, verified by oath, has obtained a license issued by the
62 Department of Mental Retardation.

63 (b) The commissioner shall adopt regulations, in accordance with
64 the provisions of chapter 54, to insure the comfort, safety, adequate
65 medical care and treatment of such persons at such residential
66 facilities. Such regulations shall include requirements that: (1) All
67 residential facility staff be certified in cardiopulmonary resuscitation in
68 a manner and timeframe prescribed by the commissioner; (2) records
69 of staffing schedules and actual staff hours worked, by residential
70 facility, shall be available for inspection by the department upon
71 advance notice; (3) each residential facility develop and implement
72 emergency plans and staff training to address emergencies that may
73 pose a threat to the health and safety of the residents of the facility; (4)
74 department inspectors verify during licensing inspections, that (A)
75 staff is adequately trained to respond in an emergency, and (B) a
76 summary of information on each resident is available to emergency
77 medical personnel for use in an emergency; and (5) at least half of the
78 inspections conducted by the department after initial licensure are
79 unannounced.

80 (c) After receiving an application and making such investigation as
81 is deemed necessary and after finding the specified requirements to
82 have been fulfilled, the department shall grant a license to such
83 applicant to conduct a facility of the character described in such
84 application, which license shall specify the name of the person to have
85 charge and the location of such facility. Any person, firm or
86 corporation aggrieved by any requirement of the regulations or by the
87 refusal to grant any license may within twenty days of any order
88 directing the enforcement of any provision of such regulations or the
89 refusal of such license, appeal therefrom in accordance with the
90 provisions of section 4-183, except venue for such appeal shall be in the
91 judicial district in which such facility is located. If the licensee of any
92 such facility desires to place in charge thereof a person other than the
93 one specified in the license, application shall be made to the
94 Department of Mental Retardation, in the same manner as provided
95 for the original application, for permission to make such change. Such
96 application shall be acted upon within ten days from the date of the
97 filing of same. Each such license shall be renewed annually upon such
98 terms as may be established by regulations and may be revoked by the
99 department upon proof that the facility for which such license was
100 issued is being improperly conducted, or for the violation of any of the
101 provisions of this section or of the regulations adopted pursuant to this
102 subsection, provided the licensee shall first be given a reasonable
103 opportunity to be heard in reference to such proposed revocation. Any
104 person, firm or corporation aggrieved by such revocation may appeal
105 in the same manner as hereinbefore provided. Each person, firm or
106 corporation, upon filing an application under the provisions of this
107 section for a license for a facility providing residential services for five
108 or more persons, shall pay to the State Treasurer the sum of fifty
109 dollars.

110 [(c)] (d) Notwithstanding any regulation to the contrary, subject to
111 the provisions of this section, the Department of Mental Retardation
112 may contract, within available appropriations, with any organization
113 for the operation of a community-based residential facility, provided
114 such facility is licensed by the [Department of Mental Retardation]

115 department. The department shall include in all contracts with such
116 organizations, provisions requiring the department to (1) conduct
117 periodic reviews of contract performance, and (2) take progressive
118 enforcement actions if the department finds poor performance or
119 noncompliance with the contract, as follows: (A) The organization
120 shall be placed on a strict schedule of monitoring and oversight by the
121 department; (B) the organization shall be placed on a partial-year
122 contract; and (C) payments due under the contract shall be reduced by
123 specific amounts on a monthly basis until the organization complies
124 with the contract. If compliance cannot be achieved, the department
125 shall terminate the contract.

126 [(d)] (e) The department may contract with any person, firm or
127 corporation to provide residential support services for persons with
128 mental retardation who reside in settings which are not licensed by the
129 department. The commissioner shall adopt regulations, in accordance
130 with the provisions of chapter 54, to ensure the safety, adequate
131 supervision and support of persons receiving residential support
132 services.

133 [(e)] (f) Any person, firm or corporation who conducts any facility
134 contrary to the provisions of this section shall be fined not more than
135 one thousand dollars or imprisoned not more than six months or both.
136 Any person, firm or corporation who conducts any facility contrary to
137 the regulations adopted pursuant to subsection (b) of this section shall
138 be fined not more than one thousand dollars.

139 Sec. 3. Subsection (a) of section 46a-11c of the general statutes is
140 repealed and the following is substituted in lieu thereof (*Effective*
141 *October 1, 2003*):

142 (a) The director, upon receiving a report that a person with mental
143 retardation allegedly is being or has been abused or neglected, shall
144 make an initial determination whether such person has mental
145 retardation, shall determine if the report warrants investigation and
146 shall cause, in cases that so warrant, a prompt, thorough evaluation to
147 be made to determine whether the person has mental retardation and

148 has been abused or neglected. In cases where there is a death of a
149 person with mental retardation for whom the Department of Mental
150 Retardation has direct or oversight responsibility for medical care, and
151 there are allegations that such death may be due to abuse or neglect,
152 the director shall conduct an investigation to determine whether abuse
153 or neglect occurred, except as may be otherwise required by court
154 order. The director, in consultation with the Commissioner of Mental
155 Retardation, shall establish protocols for the conduct of such
156 investigations. For the purposes of sections 46a-11a to 46a-11g,
157 inclusive, the determination of mental retardation may be made by
158 means of a review of records and shall not require the director to
159 conduct a full psychological examination of the person. Any delay in
160 making such determination of mental retardation shall not delay the
161 investigation of abuse or neglect or recommendation of provision of
162 protective services. The evaluation shall include a visit to the named
163 person with mental retardation and consultation with those
164 individuals having knowledge of the facts of the particular case. All
165 state, local and private agencies shall have a duty to cooperate with
166 any investigation conducted by the Office of Protection and Advocacy
167 for Persons with Disabilities under this section, including the release of
168 complete client records for review, inspection and copying, except
169 where the person with mental retardation refuses to permit his or her
170 record to be released. The director shall have subpoena powers to
171 compel any information related to [his] such investigation. All client
172 records shall be kept confidential by said office. Upon completion of
173 the evaluation of each case, written findings shall be prepared which
174 shall include a determination of whether abuse or neglect has occurred
175 and recommendations as to whether protective services are needed.
176 The director, except in cases where the parent or guardian is the
177 alleged perpetrator of abuse or is residing with the alleged perpetrator,
178 shall notify the parents or guardian, if any, of the person with mental
179 retardation if a report of abuse or neglect is made which the director
180 determines warrants investigation. The director shall provide the
181 parents or guardians who [he] the director determines are entitled to
182 such information with further information upon request. The person

183 filing the report of abuse or neglect shall be notified of the findings
184 upon request.

185 Sec. 4. (*Effective October 1, 2003*) The Department of Mental
186 Retardation shall transfer to the Office of Protection and Advocacy one
187 investigator position to enable the office to investigate deaths of
188 persons with mental retardation for whom the Department of Mental
189 Retardation has direct or oversight responsibility for medical care
190 where allegations of abuse or neglect are present, as provided in
191 section 46a-11c of the general statutes, as amended by this act.

This act shall take effect as follows:	
Section 1	<i>October 1, 2003</i>
Sec. 2	<i>July 1, 2004</i>
Sec. 3	<i>October 1, 2003</i>
Sec. 4	<i>October 1, 2003</i>

Statement of Legislative Commissioners:

In sections 3 and 4, the phrase "the Department of Mental Retardation had direct or oversight responsibility" was changed to "the Department of Mental Retardation has direct or oversight responsibility" for consistency and accuracy.

PRI *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Type	FY 04 \$	FY 05 \$
Department of Mental Retardation Office of Protection & Advocacy	GF - Transfer	(40,500) 40,500	(54,000) 54,000
Office of Protection & Advocacy; Department of Mental Retardation	GF - Cost	Minimal	Minimal

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill makes changes to the policies and procedures of the Department of Mental Retardation (DMR), its contracted provider agencies and the Office of Protection and Advocacy for Person with Disabilities (P&A) in regards to the health and safety of the individuals that DMR has direct or oversight responsibility for. The following changes are addressed:

Section 1 - DMR Comprehensive and Timely Review

In the event of a death of a person with mental retardation for whom the department has direct oversight responsibility for medical care, the commissioner is required to ensure that a comprehensive and timely review of events and quality of life issues and medical care preceding the death is conducted by the department and provided to the Independent Mortality Review Board (IMRB). Currently, the IMRB (as established by the Governor's Executive Order #25) reviews the medical care and other circumstances surrounding the death of clients (there are local/regional committees that review cases prior to proceeding to the IMRB). In FY 02 there were 178 deaths of DMR clients of which over half were reviewed by the IMRB (including audit

review). Currently, the department provides staffing and technical assistance to the board. The review and reporting responsibility requirements established in the bill are keeping within current practice of the department and their existing relationship with the IMRB. The staff and technical support currently provided by the department to the board may in the future incur a workload increase due to the mandated obligation of a comprehensive and timely review. It is anticipated that no additional resources are required to fulfill this provision in FY 04 and FY 05.

Section 2 - Residential Facilities & Contractual Obligations

The bill requires the commissioner to adopt regulations that include various residential facility requirements. Most of the provisions are current practice or in the process of being implemented and therefore would not result in additional costs. However, there are two provisions that would require additional resources when fully implemented (CPR certification and unannounced inspections).

The bill requires that all residential staff be certified in cardiopulmonary resuscitation (CPR). Currently, only one staff person per shift is required to be certified in CPR although there is a significant number of certified staff in both public and private residential facilities. Although the cost resulting from certification may vary, to provide for in-house certification is \$150 per instructor (staff member) for training with an additional cost of \$6 per staff for each certification (this does not include other training supplies). Due to the effective date of this section (July 1, 2004), the timeframe allowable for implementation and the current number of certified staff (based on existing requirements), cost resulting from the certification provision (including indirect costs resulting from staffing adjustments) are not anticipated to result in FY 04 and to be minimal in FY 05.

The bill further requires that at least half of the inspections conducted by the department after initial licensure are unannounced. There are over 790 Community Living Arrangements (CLA's) that DMR license or certifies (652 private licensed and 138 public certified)

on a biennial basis. In FY 02 there were over 440 inspections conducted (this includes initial inspections, periodic and revisit inspections). As this section is not effective until July 1, 2004 and requires regulatory implementation, any increase to the inspection caseload as a result would not be realized until FY 05. It is anticipated that as a result of additional staff resources needed to complete the required unannounced and return visits, a minimal cost would result. The FY 05 partial year cost attributed to this provision is anticipated to be less than \$12,000 (representing 25% of an annual Inspector position). To the extent that DMR reallocated Inspector staff from within the department, provisions of the bill and current inspection requirements could be met without additional resources.

The bill also places compliance provisions on the organizations that the department contracts with for community-based residential facilities. To the extent that partial funding or termination of a provider contract resulting from the noncompliance provision puts a strain on the funding of the residential service system, a minimal impact may result. However, as reflected above, due to the effective date and implementation process, it is anticipated that this provision will result in no additional cost in FY 04 or FY 05.

Sections 3 & 4 P&A Requirements

The bill requires that in cases where there is a death of a person with mental retardation for whom DMR has direct or oversight responsibility for medical care, and there are allegations of abuse or neglect, the Office of Protection and Advocacy shall conduct an investigation. Currently, P&A has oversight responsibility for the investigations of abuse and neglect. This bill further defines DMR's and P&A's responsibilities in investigating the deaths. In FY 02, there were 12 reported deaths where abuse and neglect were suspected. Section 4 transfers from DMR to P&A one investigator position to handle the investigation of these reported deaths. It is anticipated that a Nurse Investigator position would be established (annual salary of \$54,000) in response to the provision. Other Expenses costs associated

with this position will also result. To the extent that P&A would be required to establish an on-call system in order to respond to the investigation responsibility additional minimal cost would also be incurred. A total annual cost of \$61,700 is anticipated (FY 04 estimated at \$46,275 for nine months) to result from the investigation responsibility. The provision in the bill requires only the transfer of a position (estimated at \$40,500 in FY 04 and \$54,000 in FY 05), however, the additional costs and required resources are estimated at \$6,000 in FY 04 and \$8,000 in FY 05. It is anticipated that the transfer of resources will not diminish the current capacity of DMR's Investigations Unit. To the extent that DMR would be unable to support the transfer of the full investigation responsibility costs to P&A then there would be a need for additional resources.

It should be noted that the full implications as a result of the Early Retirement Incentive Plan are unknown. However, it is anticipated that staffing levels in inspections, investigations and support within DMR will be affected and further expand the bills impact.

OLR Bill Analysis

sSB 971

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING DEPARTMENT OF MENTAL RETARDATION CLIENT HEALTH AND SAFETY**SUMMARY:**

This bill delineates the Department of Mental Retardation's (DMR) and the Office of Protection and Advocacy for Persons with Disabilities' (OPA) responsibilities in investigating the deaths of people for whose medical care DMR is either directly responsible or for which it has oversight responsibility. It also requires DMR to establish graduated sanctions for poorly performing private community-based residential providers with which it contracts and to adopt specific health and safety regulations to govern providers that it licenses.

EFFECTIVE DATE: October 1, 2003, except for the requirement that the DMR commissioner adopt regulations which is effective July 1, 2004.

INVESTIGATING DEATHS OF PEOPLE WITH MENTAL RETARDATION

Current law requires the OPA executive director to determine if a report of abuse or neglect of a person with retardation warrants investigation and, if it does, to provide for that investigation. The law also requires the DMR commissioner to conduct or monitor investigations and file reports if the agency responsible for conducting or overseeing the investigation (e.g., OPA or State Police) asks for them. In addition, Executive Order 25 (2002) created an Independent Mortality Review Board (IMRB) and made it responsible for reviewing the medical care and other circumstances surrounding the deaths of DMR clients when either the commissioner or OPA director believes abuse or neglect caused the death or the board determines a thorough review of the person's care is warranted. This bill delineates DMR and OPA's responsibilities in such cases.

DMR Responsibilities

The bill requires DMR to conduct a comprehensive and timely review when a person for whose medical care it had direct or oversight responsibility dies. These could be people in group homes or other community living arrangements or nursing homes. The review must cover the events, overall care, medical care, and quality of life issues that preceded the death. The bill requires DMR to provide information and assistance to the IMRB at its request.

The bill requires DMR to report to the IRMB on any death (1) involving abuse or neglect, (2) for which the chief medical examiner or a “local medical examiner” has accepted jurisdiction, (3) in which an autopsy was performed, (4) that was sudden and unexpected, or (5) about which the commissioner has questions following his review concerning the appropriateness of care. (The statutes do not refer to “local medical examiners.” The Chief Medical Examiner’s Office conducts medicolegal investigations and may designate pathologists to conduct autopsies.)

OPA Responsibility

Unless a court orders otherwise, the bill requires OPA to investigate to determine the veracity of allegations that abuse or neglected caused the death of a person for whose medical care DMR had direct or oversight responsibility. As noted above, current law does not require OPA to conduct the investigation itself, just to cause it to be conducted. The bill requires OPA’s executive director, in consultation with the commissioner, to establish investigatory protocols.

The bill requires DMR to transfer an investigator position to OPA.

PRIVATE RESIDENTIAL FACILITIES

Contract Requirements

The bill requires DMR contracts with licensed private residential care providers to include provisions requiring it periodically to review contract performance and to impose graduated sanctions on providers that perform poorly or do not comply with their contracts. The sanctions are: (1) placing the provider on a strict monitoring and oversight schedule, (2) placing the provider on a partial year contract, or (3) reducing contract payments by a monthly amount the

deapartment determines until the provider achieves compliance. The bill requires DMR to terminate contracts of providers who cannot achieve compliance. By law, DMR can currently impose a fine of up to \$1,000 on any provider for operating a facility contrary to statute or regulation.

Regulatory Requirements

Current law requires DMR to adopt regulations to ensure the safety and adequate medical care and treatment of people living in residential facilities it licenses. The bill requires these regulations to include requirements that:

1. at least half of DMR's inspections following initial licensing be unannounced (DMR inspects facilities biennially and makes follow-up visits as necessary);
2. DMR inspectors verify during licensing inspections that staff are adequately trained to respond to emergencies and that summary information on each resident is available to emergency medical personnel;
3. records of staffing schedules and actual hours worked, by facility, are available to DMR inspectors following advance notice;
4. each facility develops and implements emergency plans and staff training to address potential threats to residents' health and safety (current regulations require each licensee to train direct-care staff to respond to fire and other life-threatening situations); and
5. all staff are certified in cardiopulmonary resuscitation (CPR) in a way and timeframe that the commissioner prescribes. (Current regulations require (a) direct care staff to complete in-service training in first aid within the first six months of work and every two years thereafter and (b) at least one person with CPR certification to be on duty every shift.)

COMMITTEE ACTION

Program Review and Investigations Committee

Joint Favorable Substitute

Yea 11 Nay 0