
By: **Delegates Costa, Hubbard, Benson, Boutin, Kullen, Murray, Oaks, Pendergrass, ~~Rudolph~~ Rudolph, Bromwell, Donoghue, Elliott, Frank, Mandel, McDonough, Morhaim, Nathan-Pulliam, V. Turner, and Weldon**

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Committee Report: Favorable with amendments
House action: Adopted
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CHAPTER _____

1 AN ACT concerning

2 **Developmental Disabilities Administration - Prioritization System for**
3 **Investigations**

4 FOR the purpose of requiring the Developmental Disabilities Administration, in
5 conjunction with the Office of Health Care Quality, to adopt regulations
6 establishing a certain prioritization system for responding to and investigating
7 certain incidents; requiring the Administration to seek input from certain
8 individuals in developing the regulations; and generally relating to a
9 prioritization system for investigations of licensees of the Developmental
10 Disabilities Administration.

11 BY repealing and reenacting, with amendments,
12 Article - Health - General
13 Section 7-909
14 Annotated Code of Maryland
15 (2000 Replacement Volume and 2004 Supplement)

16 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF
17 MARYLAND, That the Laws of Maryland read as follows:

1

Article - Health - General

2 7-909.

3 (a) In this section, the word "licensee" means a person who is licensed by the
4 Administration under this title to provide services.

5 (b) The Administration or its agent shall inspect each site or office operated by
6 a licensee at least once annually and at any other time that the Administration
7 considers necessary.

8 (c) The Administration shall keep a report of each inspection.

9 (d) The Administration shall bring any deficiencies to the attention of:

10 (1) The executive officer of the licensee; or

11 (2) In the case of an intermediate care facility-mental retardation, the
12 State Planning Council and the State-designated protection and advocacy agency.

13 (E) (1) THE ADMINISTRATION, IN CONJUNCTION WITH THE OFFICE OF
14 HEALTH CARE QUALITY, SHALL ADOPT REGULATIONS THAT ESTABLISH A SYSTEM OF
15 PRIORITIZATION TO RESPOND TO AND INVESTIGATE SERIOUS REPORTABLE
16 INCIDENTS, AS DEFINED BY THE ADMINISTRATION, IN THE AREAS OF ABUSE,
17 NEGLECT, SERIOUS INJURY, AND MEDICATION ERRORS THAT THREATEN THE
18 HEALTH, SAFETY, AND WELL-BEING OF INDIVIDUALS RECEIVING SERVICES FUNDED
19 BY THE ADMINISTRATION IN STATE-OPERATED AND COMMUNITY PROGRAMS
20 LICENSED BY THE ADMINISTRATION.

21 (2) THE ADMINISTRATION SHALL SEEK INPUT FROM INDIVIDUALS WITH
22 DISABILITIES AND THEIR FAMILIES, LICENSEES, AND ADVOCACY ORGANIZATIONS IN
23 DEVELOPING THE REGULATIONS, PRIOR TO PUBLISHING THE REGULATIONS IN THE
24 MARYLAND REGISTER FOR PUBLIC COMMENT.

25 (3) THE REGULATIONS SHALL DEFINE AND ADDRESS:

26 (I) THE PROCEDURES AND TIMELINES THAT PROVIDERS MUST
27 FOLLOW WHEN REPORTING SERIOUS REPORTABLE INCIDENTS AND DEATHS TO THE
28 ADMINISTRATION AND THE OFFICE OF HEALTH CARE QUALITY;

29 ~~(I)~~ (II) ~~THE SYSTEM OF PRIORITIZATION FOR INVESTIGATION OF~~
30 ~~SERIOUS REPORTABLE INCIDENTS AND DEATHS; THE DEPARTMENT'S PROTOCOL TO~~
31 ~~DETERMINE THE NECESSITY TO INVESTIGATE A SERIOUS REPORTABLE INCIDENT~~
32 ~~THAT TAKES INTO ACCOUNT;~~

33 1. THE SEVERITY OF THE INCIDENT;

34 2. THE QUALITY OF THE LICENSEE'S INTERNAL
35 INVESTIGATION; AND

1 3. THE NUMBER AND FREQUENCY OF SERIOUS REPORTABLE
2 INCIDENTS REPORTED BY THE LICENSEE TO THE DEPARTMENT;

3 ~~(II)~~ (III) THE SPECIFIC ROLES AND RESPONSIBILITIES OF EACH
4 GOVERNMENTAL UNIT INVOLVED IN ~~INVESTIGATING LICENSEES~~ ANY FOLLOW-UP
5 INVESTIGATIONS THAT MAY OCCUR DUE TO A LICENSEE'S REPORT OF A SERIOUS
6 REPORTABLE INCIDENT OR DEATH;

7 ~~(III)~~ (IV) METHODS OF INVESTIGATIONS, INCLUDING ON-SITE
8 INVESTIGATIONS;

9 ~~(IV)~~ (V) TIME LINES FOR RESPONSE TO SERIOUS REPORTABLE
10 INCIDENTS AND DEATHS AND INVESTIGATION OF SERIOUS REPORTABLE INCIDENTS
11 AND DEATHS;

12 ~~(V)~~ (VI) TIME LINES FOR ISSUING SPECIFIED REPORTS,
13 INCLUDING CORRECTIVE ACTION PLANS, TO THE ADMINISTRATION, LICENSEE,
14 MORTALITY REVIEW COMMITTEE, MEDICAID FRAUD UNIT, INDIVIDUALS RECEIVING
15 SERVICES FROM THE LICENSEE INVOLVED IN THE INCIDENT AND THEIR GUARDIANS
16 OR FAMILY MEMBERS, AND OTHERS; AND

17 ~~(VI)~~ FOLLOW UP MONITORING REQUIREMENTS AND TIME LINES
18 FOR THE OFFICE OF HEALTH CARE QUALITY AND THE ADMINISTRATION TO ENSURE
19 THAT CORRECTIVE ACTION HAS BEEN IMPLEMENTED BY THE LICENSEE; AND

20 ~~(VII)~~ FOLLOW UP MONITORING METHODS IN THE CASE OF A
21 STATE OPERATED OR COMMUNITY LICENSEE THAT HAS NO DOCUMENTED SERIOUS
22 REPORTABLE INCIDENTS OF ABUSE OR NEGLECT WITHIN A CERTAIN PERIOD OF
23 TIME.

24 ~~(4)~~ THE FOLLOW UP MONITORING MAY INCLUDE AN ON SITE REVIEW
25 TO DETERMINE THAT THERE ARE NO SERIOUS REPORTABLE INCIDENTS OF ABUSE
26 AND NEGLECT, MODIFIED SURVEY SCHEDULES FOR LICENSEES DEMONSTRATING
27 CERTAIN QUALITY STANDARDS OF COMPLIANCE, AND OTHER MEASURES TO ENSURE
28 THE HEALTH, SAFETY, AND WELL BEING OF INDIVIDUALS.

29 (VII) FOLLOW-UP PROTOCOLS FOR THE OFFICE OF HEALTH CARE
30 QUALITY AND THE ADMINISTRATION TO ENSURE THAT CORRECTIVE ACTION HAS
31 BEEN IMPLEMENTED BY THE LICENSEE.

32 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect
33 July 1, 2005.

