OFFICE OF THE STATE AUDITOR
DIANA DIZOGLIO

Official Audit Report – Issued April 15, 2026

Department of Developmental Services

For the period July 1, 2022 through June 30, 2024

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OFFICE OF THE STATE AUDITOR
DIANA DIZOGLIO

April 15, 2026

Sarah Peterson, Commissioner
Department of Developmental Services
40 Broad Street
Boston, MA 02119

Dear Commissioner Peterson:

I am pleased to provide to you the results of the enclosed performance audit of the Department of Developmental Services. As is typically the case, this report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, July 1, 2022 through June 30, 2024. As you know, my audit team discussed the contents of this report with agency managers. This report reflects those comments.

I appreciate you and all your efforts at the Department of Developmental Services. The cooperation and assistance provided to my staff during the audit went a long way toward a smooth process. Thank you for encouraging and making available your team. I am available to discuss this audit if you or your team has any questions.

Best regards,

Diana DiZoglio
Auditor of the Commonwealth

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LIST OF ABBREVIATIONS

CMR	Code of Massachusetts Regulations
CRT	complaint resolution team
DDS	Department of Developmental Services
DPPC	Disabled Persons Protection Commission
ISP	individual support plan
MAP	Medication Administration Program
PAR	Post-audit Review
MOR	medication occurrence report

EXECUTIVE SUMMARY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor has conducted a performance audit of certain activities of the Department of Developmental Services (DDS) for the period July 1, 2022 through June 30, 2024.

The purpose of our audit was to determine whether DDS implemented the recommendations from our prior audit report (Audit No. 2020-0234-3S), issued on June 29, 2021. Specifically, we determined the following:

- Did DDS complete investigations, including their corresponding action plans and decision letters, within the timeframes required by Sections 9.10(5), 9.13(1)(d), and 9.14(3) of Title 115 of the Code of Massachusetts Regulations (CMR)?
- Did DDS conduct administrative reviews in accordance with the procedures and timeframes established in 115 CMR 9.11(1), 9.11(2), and 9.14(3)(b)?
- Did DDS implement policies and procedures to ensure that medication occurrence reports (MORs) were processed based on the recommendations from our prior audit (Audit No. 2020-0234-3S)?
- Did DDS implement policies and procedures to monitor the accuracy and completeness of incident reports based on the recommendations from our prior audit (Audit No. 2020-0234-3S)?

In addition, we determined the following:

- Did DDS develop individual support plans (ISPs) on behalf of recipients of DDS services to accommodate those who elected the self-determination option in accordance with 115 CMR 6.21 and 6.23(5) and Sections 19(b), (f), and (g) of Chapter 255 of the General Laws?

Below is a summary of our findings, the effects of those findings, and our recommendations, with hyperlinks to each page listed.

Finding 1 **Page 22**	DDS did not always issue decision letters or develop action plans for its investigations within the timeframes required by regulation.
Effect	When investigations are not completed within required timeframes, or extensions are created without reason, there is a greater risk that recipients of DDS services may be subject to safety risks, abuse, and/or mistreatment.
Recommendations **Page 23**	1. DDS should continue to follow its newly updated investigations manual to ensure that all decision letters are issued within the required timeline and ensure that any necessary extensions are properly requested, documented, and approved. 2. As previously recommended in our Audit No. 2020-0234-3S, DDS should properly implement effective monitoring controls to ensure that all action plans are completed timely.

Finding 2 **Page 24**	DDS did not properly manage all administrative reviews.
Effect	When administrative reviews are not completed or are conducted improperly, DDS cannot ensure prompt implementation of actions outlined in resolution letters to address potential harm.
Recommendation **Page 25**	DDS should establish effective policies and procedures to schedule more frequent meetings of the complaint resolution teams in order to ensure that all administrative review reports are submitted and finalized on time.
Finding 3 **Page 26**	DDS did not ensure that medication occurrence reports were created, finalized, and reviewed within the required timeframes.
Effect	Without timely creation, finalization, and review of MORs, there is an increased risk of poor outcomes for recipients of DDS services who could be adversely affected by staff members who do not administer medication, make dosage mistakes, or administer the wrong medication.
Recommendations **Page 26**	1. DDS should continue to follow its newly updated policies and procedures to ensure that providers create and finalize MORs, and that Medication Administration Program (MAP) coordinators review them, within the prescribed timeframes 2. DDS should implement corrective actions related to audit findings in a timely manner.
Finding 4 **Page 28**	DDS did not ensure that its providers submitted and finalized incident reports within the prescribed timeframes.
Effect	As a result, DDS did not act on all incident reports in a timely manner to identify and remediate safety risks for alleged victims.
Recommendation **Page 29**	DDS should continue to work with providers to ensure that all incident reports are submitted and finalized on time.
Finding 5 **Page 30**	DDS did not offer the self-determination option to all its recipients enrolled in ISPs.
Effect	The absence of the required self-determination option calls into question whether the proper quality of care was given to each recipient of DDS services who enrolled in an ISP.
Recommendation **Page 31**	DDS should collaborate with providers and implement standardized policies and procedures to ensure that DDS is aware that all recipients of DDS services have been offered the self-determination option and are aware of who selected the self-determination option.

Post-audit Action

As of summer 2024, after the audit period, DDS reported to us that it had updated its formal policies to monitor the timeliness of investigations in response to our Audit No. 2020-0234-3S, issued on June 29, 2021.

> *DDS routinely conducts internal control and auditing activities to ensure compliance with timeframes for issuing decision letters. The [web-based system's] "Outstanding Case List" is*

available to all investigations staff and contains a list of all outstanding investigations, which may be sorted and/or restricted to investigative region/office/investigator. The list includes the date of assignment, number of days overdue (if applicable), and the investigation/decision letter due date (adjusted according to extension if applicable).

In addition, senior investigators and staff investigators are required to meet "at least bi-weekly" to discuss active investigations/caseload as documented within the "Outstanding Case List". The deputy and director of investigations meet with senior investigators monthly, to discuss active investigations/caseloads as documented within the "Outstanding Case List". These meetings include investigative strategy and prioritization of cases based upon risk, sensitivity, and complexity.

DDS hired Assistant Senior Investigators" ("ASI") for each investigative office. The ASI complete high-profile cases and help the senior investigator, monitor and mentor staff investigators who struggle to keep pace with the high volume of investigations the department receives. To further prioritize efficiency, the senior investigator and staff investigator's performance objectives were updated for the current evaluation period to place more emphasis on timeliness.

A portion (25%) of the senior investigator's responsibility pertains to ensuring efficiency and productivity. Senior investigators ensure the productivity and quality of work for supervisees are at optimum levels through intense supervision and mentoring that include regular meetings, and by providing support, and encouraging professional development opportunities.

As all cases must be completed within the prescribed regulatory timeline or approved extension date, any case remaining open beyond 90 days of assignment, regardless of extension, will undergo increased scrutiny. Senior investigators create and implement a performance improvement plan ("PIP") that includes a dedicated weekly in-office "writing day" for any staff investigator who maintains a case beyond 90 days of assignment, without clearly documented acceptable explanation. The Deputy Director of Investigations and the Director of Investigations shall be the sole arbiters of what constitutes an acceptable explanation.

DDS provided evidence of the updated investigation manual, an example of the "Outstanding Cases List" report, evidence of a senior investigators biweekly meeting, and evidence that it worked with employees to improve agency performance related to these matters.

In addition, to ensure that providers create and finalize MORs, and that MAP coordinators review them, within the prescribed timeframes, DDS reported to us that it took the following actions in 2025, after the audit period:

DDS created and filled a dedicated position of Statewide Director of the Medication Administration Program, with centralized oversight of the Medication Administration Program ("MAP"). The DDS Statewide Director of MAP has become an important leader and participant in MAP training, MAP testing, and MAP communications, together with the other state MAP agencies (Department of Mental Health, Department of Public Health ("DPH"), Department of Children and Families, and

MassAbility, formerly known as Massachusetts Rehabilitation Commission). These activities include updating the MAP Policy Manual (see https://www.mass.gov/lists/map-policy-manual, updated periodically), a joint effort between all state MAP agencies, and issuing an RFR to procure the services of a single qualified vendor to manage the MAP Certification and Recertification Testing Processes (see https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-24-1023-1023C-1023L-91823&external=true&parentUrl=close). The DDS Statewide Director of MAP is also engaged with the DPH-led effort to offer an electronic medication administration record (eMAR) system, free of charge, to all provider agencies, enhancing safe medication administration and documentation.

In January 2025, DDS reorganized the Regional MAP Coordinators to report directly to the DDS Statewide Director of MAP, enhancing standardization and statewide coverage and improving timeliness. The DDS Statewide Director of MAP reviews timeliness requirements with Regional MAP Coordinators during staff meetings and supervision.

DDS, spearheaded by the Statewide Director of MAP, the Assistant Commissioner of Quality Management, and the newly hired Provider Compliance Manager, is developing reporting and monitoring capability of medication occurrences at the site level as part of the overall implementation of a provider compliance management system.

As a matter of practice, DDS Regional MAP Coordinators remind providers of MAP Policy requirements to report Hotline MORs within one day of discovery and other MORs within seven days of discovery, when the Coordinators review the details for MORs in [the web-based system]. Regular ongoing webinars, required for MAP Trainers, also provide reminders about timeliness requirements.

Regarding incident reporting, DDS noted, "DDS recently hired a Provider Compliance Manager who is reviewing, and revising and updating, as necessary, the reporting and monitoring capability for incident reporting."

OVERVIEW OF AUDITED ENTITY

The Department of Developmental Services (DDS) was established by Section 1 of Chapter 19B of the Massachusetts General Laws and falls under the Executive Office of Health and Human Services. According to its website,

> *The Department of Developmental Services provides support for individuals with intellectual and developmental disabilities including Autism Spectrum Disorder to enhance opportunities to become fully engaged members of their community.*

During fiscal year 2024, the agency served approximately 43,000 adults and children with intellectual and developmental disabilities throughout the Commonwealth.

During the audit period, DDS provided these services through 287 community-based state-operated programs that were delivered by two state-operated facilities and approximately 200 contracted service providers, all of which were based in the Commonwealth. DDS had annual appropriations of approximately $2.4 billion for fiscal year 2023 and $2.8 billion for fiscal year 2024. As of July 17, 2023, DDS employed 1,554 staff members in 23 area offices[1] and four regional offices.[2]

As part of its responsibilities, DDS conducts various types of investigations and reviews into alleged abuse or mistreatment, as well as circumstances that may pose a serious risk of harm to recipients of DDS services. DDS is also responsible for reviewing self-reported events from its contracted service providers, which include issues such as deaths of recipients of DDS services, property damage, and incorrectly administered medication. In order to process, review, and monitor alleged abuse, mistreatment, and other incidents during the audit period, DDS used its web-based system that houses all intakes and complaints regarding recipients of DDS services.

1. Area offices, according to DDS's website, "are responsible for managing and monitoring the services we provide, or arrange for individuals served by us, and their families who live in the towns covered by the respective Area Office. Functions performed at an Area Office include: information and referral, service coordination/case management, service planning, prioritization and arrangements, complaint resolution; and citizen and family involvement."
2. Regional offices, according to DDS's website, "provide management of the area offices and perform the following regional functions: intake and eligibility determination, survey and certification of service providers, procurement and contracts business, legal and administration, abuse and mistreatment investigations, informal conferences to resolve disputes about the identification, prioritization, or provision of services."

Processing Alleged Abuse or Mistreatment

Public reporters[3] and mandated reporters[4] disclose alleged abuse or mistreatment to the Disabled Persons Protection Commission (DPPC) via its 24-hour hotline. Once DPPC receives a complaint alleging abuse or mistreatment, DPPC generates an intake form. Upon review, DPPC refers the complaint to the appropriate service-providing agency, including, but not limited to, any of the following:

- DDS;
- the Department of Mental Health;
- the Executive Office of Elder Affairs;
- the Department of Public Health; and
- the Department of Children and Families.

According to data we retrieved from DDS's web-based system, DPPC referred 12,749 complaints to DDS during the audit period.

Once DPPC refers a complaint to DDS, according to Section 9.09(2)(a) of Title 115 of the Code of Massachusetts Regulations (CMR), the assigned DDS senior investigator determines the complaint disposition to be one of the following:

1. *dismissed;*
2. *resolved without investigation;*
3. *referred to the regional director or designee for administrative review;*
4. *referred directly to the [complaint resolution team] for review;*
5. *designated as requiring investigation but deferred pending investigation by outside authorities;*
6. *assigned to an investigator for active investigation; or*

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3. The term public reporter refers to any person who is able to report alleged abuse, but who is not legally required to do so, as a mandated reporter is.
4. Section 1 of Chapter 19c of General Laws defines the term mandated reporter as "any physician, medical intern, hospital personnel engaged in the examination, care or treatment of persons, medical examiner, dentist, psychologist, nurse, chiropractor, podiatrist, osteopath, public or private school teacher, educational administrator, guidance or family counselor, day care worker, probation officer, animal control officer, social worker, foster parent, police officer or person employed by a state agency within the executive office of health and human services as defined by section sixteen of chapter six A [of the General Laws], or employed by a private agency providing services to disabled persons who, in his professional capacity shall have reasonable cause to believe that a disabled person is suffering from a reportable condition."

7. *referred to another state agency for review.*

The table below shows the DDS complaint dispositions that originated during the audit period. Note that this audit looked at administrative reviews, dismissals, DDS investigations, and referrals to the complaint resolution team (CRT). Other data in the table above is provided for informational purposes.

DDS Complaint Dispositions from Fiscal Years 2023 and 2024

Type of Disposition	Number of Dispositions	Percent of Dispositions
Administrative Review	3,515	28%
Dismissal	3,459	27%
DDS Investigation	2,523	20%
Referral to Complaint Resolution Team (CRT)	1,772	14%
Referral to Another State Agency	1,365	11%
Resolved without Investigation	110	1%
Investigation by Outside Authorities	5	<1%
Total	12,749	100%*

* Discrepancy in total is due to rounding.

Investigation Process for Alleged Abuse or Mistreatment

Regional senior investigators work from six DDS offices located in Danvers, Middleborough, Springfield, Waltham, Worcester, and Wrentham. As of June 30, 2024, DDS employed 38 full-time investigators.

DDS receives multiple batches of complaints daily from DPPC in the form of secure CSV files. DDS uploads these files into its web-based system and assigns each complaint to a senior investigator. The assigned investigator is required to make a complaint disposition determination within three days of being assigned the complaint, according to 115 CMR 9.09(2)(a). If the complaint disposition determination results in an active investigation by a DDS senior investigator, then an investigation report and a decision letter must be issued to the regional director within 45 days of an investigator's assignment, according to 115 CMR 9.13(1)(d). Investigators may request an extension for more time to complete the investigation, if necessary, but only if the delay would not pose a threat to the safety of the alleged victim.

Decision letters summarize the evidence and conclusions found in the corresponding official investigation reports. The regional director forwards decision letters to a CRT to develop an action plan. The purpose of an action plan is to ensure that specific steps are taken to reduce the possible reoccurrence of the

situation at the center of the complaint. An action plan must be developed within 30 days of the date the decision letter was assigned to the involved CRT.

If DDS conducts an investigation in accordance with both DPPC and DDS regulations, then DPPC must approve the investigation report before DDS issues the decision letter and before an action plan can be developed. If DDS conducts an investigation in accordance with only its own regulations, then a DDS regional senior investigator must approve the investigation report before DDS issues the decision letter and before an action plan can be developed.

In our previous audit of DDS (Audit No. 2020-0234-3S), our office made the following recommendations related to decision letters and action plans:

- *DDS should formalize the necessary policies and procedures to require that regional senior investigators monitor investigations for timeliness and ensure that any necessary extensions are properly requested, documented, and approved.*
- *DDS should enhance its policies and procedures by implementing effective monitoring controls to ensure action plans are developed within required timeframes.*

To address our recommendations, DDS stated in the Post-audit Review (PAR) that DDS is issuing extension requests when necessary and performing routine audits to ensure compliance with decision letters. In addition, caseloads are monitored biweekly, and this process was formalized in writing.

Furthermore, DDS formed a working group to analyze the process for issuing action plans. DDS created custom reports to help monitor the timeliness of action plans and is looking into hiring additional staff members to monitor this process.

We were able to confirm that DDS did implement our recommendation related to investigations from our previous audit.

Administrative Reviews

The regional director conducts administrative reviews for situations that do not present serious physical or emotional harm to DDS service recipients. These reviews do not involve allegations of abuse, assault, or financial exploitation, which are investigated through a different process.

If a complaint disposition determination results in an administrative review, then the assigned senior investigator refers the complaint to personnel members from the corresponding area or regional office.

DDS regulations require that administrative review reports, which detail the pertinent information found during the course of the review, be submitted to the appropriate CRT coordinator within 15 days of the date of completion of the administrative review. Notably, DDS regulations do not include a timeframe in which the administrative review itself must be conducted. Once the assigned CRT receives the administrative review report, then the CRT is required to prepare a resolution letter, which may, depending on the conclusions reached upon the completion of the administrative review, state the specific action(s) to be taken in response to the administrative review report, the date by when these action(s) must be implemented, and the person responsible for implementing these action(s).

In our previous audit of DDS (Audit No. 2020-0234-3S), our office made the following recommendation related to administrative reviews:

- *DDS should implement policies, procedures, and monitoring controls to ensure that administrative reviews are completed by the regional director or his/her designees.*

To address our recommendation DDS stated in the PAR that it formed a working group to develop best practices, minimum standards, and training tips for performing administrative reviews. In addition, DDS stated that it identified and resolved an issue in its web-based system that was allowing staff members to enter action plans/resolutions letters without completing the section pertaining to the principal findings of the review.

The audit team was able to confirm that DDS did implement our recommendation from our previous audit related to administrative reviews.

Medication Occurrence Report Process

According to the *[Medication Administration Program (MAP)] Policy Manual*, a medication occurrence report (MOR) is submitted by a contracted service provider through DDS's web-based system to DDS when a breach of any one of the following medication checklist procedures (which DDS refers to as the five Rs) occurs:

- *right individual;*
- *right medication;*
- *right time;*
- *right dose; and*
- *right route.*[5]

5. The term right route refers to the mechanism for administering a medication (e.g., orally or intravenously).

In addition to the medication checklist procedures listed above, missing a medication dose entirely would also generate a MOR.

Similarly to how incident reports are handled, MORs are submitted by contracted service providers through DDS's web-based system directly to DDS. For each MOR, a MAP consultant must be contacted by the contracted service provider. A MAP consultant is a healthcare provider, such as a registered nurse, a pharmacist, or an authorized prescriber such as a physician or nurse practitioner. MORs are classified as either a hotline MOR (which indicates that medical intervention was required because illness, injury, or death resulted from the breach of medication checklist procedures) or a regular MOR (which indicates that medical intervention was not required because illness, injury, or death did not result from the breach in medication checklist procedures).

DDS's web-based system documents key milestones regarding the MOR process, from a provider's MOR creation and finalization to a DDS MAP coordinator's MOR review and approval/disapproval. Contracted service providers must finalize a hotline MOR within 24 hours of discovering the breach and a regular MOR within 14 days. Both hotline and regular MORs must be reviewed by a DDS regional MAP coordinator within 14 days of the date of finalization by the contracted service provider.

There were 12,290 MORs submitted by contracted service providers to DDS during the audit period, of which, 213 were hotline MORs and 12,077 were regular MORs. The table below indicates the nature of all MORs submitted during the audit period.

MOR Submissions by All Contracted Service Providers During Fiscal Years 2023 and 2024

Nature of MOR	Number of Submitted MORs	Percent of Submitted MORs
Medication Omission	8,146	66%
Wrong Dose	1,923	16%
Wrong Individual	246	2%
Wrong Medication	543	4%
Wrong Route	8	<1%
Wrong Time	1,424	12%
Total	12,290	100%

In our previous audit of DDS (Audit No. 2020-0234-3S), our office made the following recommendation related to medication occurrence reports:

- *DDS should implement effective monitoring controls in its policies and procedures to ensure that provider-operated group homes create and finalize MORs, and MAP coordinators review them, within the prescribed timeframes.*

To address our recommendations, DDS stated in the PAR that it would update its guidance and training materials related to creating and finalizing MORs and outlining timeliness and responsibilities of providers. In addition, DDS would develop guidance for providers to clarify requirements of hotline MORs. Furthermore, DDS stated that it has worked with the regional MAP coordinators to ensure that all reviews are done within the required timeline.

DDS did not fully implement our recommendations during the audit period from our previous audit (Audit No. 2020-0234-3S). However, after the audit period for our current audit, DDS told us that it had implemented monitoring policies and procedures to ensure that providers create and finalize MORs, and that MAP coordinators review MORs, within the prescribed timeframes after. See Post-audit Action for more details.

Incident Reporting and Review Process

When an incident meets the threshold of a reportable event, a provider must generate an incident report and submit it to DDS through its web-based system. DDS organizes these reportable events into incident categories, which are classified as either minor- or major-level incidents. As examples, minor-level incidents may involve verbal abuse of a victim or property damage, while major-level incidents may involve suspicious or sudden deaths or missing people. For minor-level incidents, an area office management review is required. For major-level incidents, both an area office and a regional management review are required.

There were 57,566 incident reports submitted to DDS by providers during the audit period; 49,714 were minor-level incidents and 7,852 were major-level incidents.

In our previous audit of DDS (Audit No. 2020-0234-3S), our office made the following recommendation related to incident reporting and the review process:

- *DDS should work with provider-operated group homes and establish effective monitoring controls to ensure that all incident reports are submitted and finalized on time.*

To address our recommendation, DDS stated in the PAR that it would create custom reports to send to providers with the number of incident reports open. In addition, DDS senior investigators would use the reports to identify and address concerns directly with those provides.

The audit team determined that DDS did not fully implement our recommendation during the audit period from our previous audit (Audit No. 2020-0234-3S). DDS provided evidence of sending custom reports, showing open incidents at the provider and DDS level to the area and region levels; however, there was no follow-up on the reports until after the audit period. See Post-audit Action for more details.

Individual Support Plans

Individual support plans (ISPs) establish goals with recipients of DDS services based on their unique interests and needs as part of their overall support. ISPs are created using a coordinated process to ensure that those who support the recipients of DDS services have a clear understanding of the individual's current circumstances and the support in place to meet their needs.

In order to create an ISP, collaboration and participation is necessary from multiple parties, including the recipients of DDS services, their family or guardian(s), their designated representative, a service coordinator, and contracted service providers. A service coordinator consults with the aforementioned parties within 15 days of services being provided or at least 45 days before the ISP initial meeting, during which the purpose of the ISP and the process for its development is discussed. According to 115 CMR 6.20, an ISP's goals, objectives, and services must include strategies to advance the following for the recipients of DDS services:

- rights and dignity;
- individual control and freedom of choice relating to self-determination;
- community membership;
- relationships;
- personal growth and accomplishments; and
- personal well-being.

A provider documents assessments, develops objectives and support strategies, and provides all these to the service coordinator at least 15 days in advance of the ISP meeting. In addition, the provider must document and report ISP implementation to the service coordinator, the individual, and the individual's

family or guardian(s). After consulting with the service coordinator, the provider must implement the ISP by providing the agreed-upon services.

A recipient of DDS services also has the ability to participate in self-determination. Self-determination is an approach where a recipient of DDS services is given control and an active role over the decision-making process for services provided to them to support their needs. DDS offers self-determination as an option to all recipients of DDS services who are eligible for services.

Forty-five days after the ISP meeting, the area director or facility director must review the ISP in order to approve or disapprove it. The director may approve or disapprove parts of the plan. If the ISP is disapproved, then that decision must be communicated with the service coordinator.

Once the ISP is created, the service coordinator must then take the lead in coordinating the services to be provided to the recipients of DDS services. The service coordinator must also semi-annually review the ISP to ensure that it has been implemented and tailored to the needs of the recipients of DDS services and their family or guardian(s). Subsequently, a review takes place on an annual basis, at least within one year of the date when the ISP was developed, to reflect any changes in the DDS service recipients’ abilities and circumstances.

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor has conducted a performance audit of certain activities of the Department of Developmental Services (DDS) for the period July 1, 2022 through June 30, 2024.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Below is a list of our audit objectives, indicating each question we intended our audit to answer; the conclusion we reached regarding each objective; and, if applicable, where each objective is discussed in the audit findings.

Objective	Conclusion
1. Did DDS complete investigations, including their corresponding action plans and decision letters, within the timeframes required by Sections 9.10(5), 9.13(1)(d), and 9.14(3) of Title 115 of the Code of Massachusetts Regulations (CMR)?	**No; see Finding 1**
2. Did DDS conduct administrative reviews in accordance with the procedures and timeframes established in 115 CMR 9.11(1), 9.11(2), and 9.14(3)(b)?	**No; see Finding 2**
3. Did DDS implement policies and procedures to ensure that medication occurrence reports (MORs) were processed based on the recommendations from our prior audit (Audit No. 2020-0234-3S)?	**No; see Finding 3**
4. Did DDS implement policies and procedures to monitor the accuracy and completeness of incident reports based on the recommendations from our prior audit (Audit No. 2020-0234-3S)?	**No; see Finding 4**
5. Did DDS develop individual support plans (ISPs) on behalf of recipients of DDS services to accommodate those who elected the self-determination option in accordance with 115 CMR 6.21 and 6.23(5) and Sections 19(b), (f), and (g) of Chapter 255 of the General Laws?	**No; see Finding 5**

To accomplish our audit objectives, we gained an understanding of the internal control environment relevant to our objectives by reviewing applicable policies and procedures and DDS's internal control plan, as well as by interviewing DDS personnel members. We evaluated the design of controls over DDS's investigations, administrative reviews, MORs, and incident reports as part of our substantiative testing.

In addition, to obtain sufficient, appropriate evidence to address our audit objectives, we performed the procedures described below.

Investigations

To determine whether DDS completed investigations, including their corresponding action plans and decision letters, within the timeframes required by 115 CMR 9.10(5), 9.13(1)(d), and 9.14(3), we took the following actions. We selected a statistical[6] sample of 73 investigations from the population of 2,523 investigations that were initiated during the audit period. To select the sample, we used a 90% confidence level,[7] a 50% expected error rate,[8] and a 20% desired precision range.[9] We first determined whether any of these 73 investigations had a documented extension and, if not, whether any investigations were completed after more than 45 business days. We did this by calculating the number of business days between the case date, which represents when DDS received the complaint, and the decision letter date.

Next, we analyzed whether action plans were created within 30 business days after they were assigned to complaint resolution team (CRT) coordinators in accordance with 115 CMR 9. We reviewed the date when the decision letter was issued and the date when the action plan was created. We then calculated the number of business days between these two dates to identify whether any action plans were created after more than 30 business days.

To determine whether the 73 investigations in our sample were conducted in accordance with 115 CMR 9.10, we determined whether investigators took the following actions:

- conducted face-to-face interviews with alleged victims and alleged abusers;
- conducted interviews with people whom the investigator considered appropriate to interview (e.g., complainants or eyewitnesses);
- documented any refusals to be interviewed;

6. Auditors use statistical sampling to select items for audit testing when a population is large and contains similar items. Auditors generally use a statistical software program to choose a random sample when sampling is used. The results of testing using statistical sampling, unlike those from judgmental sampling, can usually be used to make conclusions or projections about entire populations.
7. Confidence level is a mathematically based measure of the auditor's assurance that the sample results (statistic) are representative of the population (parameter), expressed as a percentage.
8. Expected error rate is the number of errors that are expected in the population, expressed as a percentage. It is based on the auditor's knowledge of factors such as prior year results, the understanding of controls gained in planning, or a probe sample.
9. Desired precision range is the range of likely values within which the true population value should lie; also called confidence interval. For example, if the interval is 90%, the auditor will set an upper confidence limit and a lower confidence where 90% of transactions fall within those limits.

- reviewed pertinent documents (e.g., incident reports or medical records); and
- conducted site visits, if deemed necessary by DDS.

In addition, to determine whether DDS implemented our recommendations from our previous audit (Audit No. 2020-0234-3S), we requested and reviewed any routine audits performed during the audit period, evidence of caseloads being monitored biweekly by senior investigators/the deputy director and any action taken as a result. We also requested and reviewed the updated formal written procedures.

Lastly, we requested and reviewed the custom reports created to help monitor the timeliness of actions plans.

For this objective, we found certain issues during our testing; namely, that that DDS did not always issue decision letters or develop action plans for its investigations within the required timeframes. See Finding 1 for more information.

Administrative Reviews

To determine whether DDS conducted administrative reviews in accordance with the procedures and timeframes established in 115 CMR 9.11(1), 9.11(2), and 9.14(3)(b), we took the following actions. We generated a statistical sample of 74 administrative reviews from the population of 3,515 administrative reviews that were initiated during the audit period. To select the sample, we used a 90% confidence level, a 50% expected error rate, and a 20% desired precision range.

We reviewed the date when each administrative review was finalized and the date when the resolution letter was created. We then calculated the number of business days between these two dates to determine whether any resolution letters were created after more than 15 business days.

Next, we determined whether administrative reviews were conducted in accordance with the procedures in 115 CMR 9.11. We reviewed each administrative review report from our sample. Information in each report included, but was not limited to, an allegation summary, immediate actions taken, and principal findings of the review. We then reviewed the information and determined whether each administrative review report was complete, whether each report was reviewed by the CRT, and whether each resolution letter was generated upon review by the CRT based on the administrative review report. To determine whether resolution letters were developed by CRTs within 30 business days in accordance with CMR 9.14(3), we obtained and reviewed the date when each resolution letter was created and the date when

it was issued. We then calculated the number of business days between these dates to determine whether any resolution letters were issued after more than 30 business days.

In addition, to determine whether DDS implemented our recommendations from our previous audit (Audit No. 2020-0234-3S), we requested and reviewed any documentation related to the development of best practices, minimum standards and training tips for performing administrative reviews. Furthermore, we determine whether all principal findings were completed as evidence that DDS resolved the issue in its web-based system.

For this objective, we found certain issues during our testing, namely that DDS did not manage all administrative reviews properly. See Finding 2 for more information.

MORs

To determine whether DDS implemented policies and procedures to ensure that MORs were processed based on the recommendations from our prior audit (Audit No. 2020-0234-3S), we took the following actions. We requested and reviewed updated guidance and training materials and evidence of DDS working with the Medication Administration Program (MAP) coordinators to resolve any issues with MORs.

Furthermore, we generated a statistical sample of 75 non-hotline MORs from the population of 12,077 non-hotline MORs. To select the sample, we used a 90% confidence level, a 50% expected error rate, and a 20% desired precision range. We also generated a nonstatistical[10] sample of 35 hotline MORs from the population of 213 hotline MORs.

DDS MAP coordinators are required to review non-hotline MORs within 14 calendar days after providers finalize them. We reviewed the date when each of the 75 non-hotline MORs was finalized by the provider and the date when it was reviewed by a MAP coordinator in DDS's web-based system. We calculated the number of calendar days between these two dates to determine whether any MORs took more than 14 calendar days to be reviewed after they were finalized.

DDS MAP coordinators are required to review hotline MORs within 14 calendar days after the providers finalized them. We reviewed the date when each of the 35 hotline MORs was finalized by the provider, as

10. Auditors use nonstatistical sampling to select items for audit testing when a population is very small, the population items are not similar enough, or there are specific items in the population that the auditors believe require review.

well as the date when it was reviewed by a MAP coordinator. We calculated the number of calendar days between these two dates to determine whether any MOR reviews by MAP coordinators exceeded 14 calendar days.

To determine whether providers met submission timeframes for non-hotline MORs, we reviewed the date when each MOR event[11] occurred and the date when the MOR was created in DDS's web-based system. We calculated the number of calendar days between these two dates to determine whether any MORs took more than the allowed seven calendar days to be created. To determine whether providers met finalization timeframes for non-hotline MORs, we reviewed the date when each non-hotline MOR was created and the date when it was finalized by the provider. We then calculated the number of calendar days between these two dates to determine whether any non-hotline MORs took more than seven calendar days to be finalized after their creation.

To determine whether providers met submission timeframes for hotline MORs, we reviewed the date when each MOR event was discovered and the date when the MOR was finalized. We calculated the number of calendar days between these two dates to determine whether any hotline MORs were finalized after more than the allowed 24 hours.

For this objective, we found certain issues during our testing; namely, that DDS did not ensure that MORs were created, finalized, and reviewed within the required timeframes. See Finding 3 for more information.

Incident Reports

To determine whether DDS implemented policies and procedures to monitor the accuracy and completeness of incident reports based on the recommendations from our prior audit (Audit No. 2020-0234-3S), we took the following actions. We requested and reviewed new custom reports that DDS sends to providers and evidence of senior investigators using the reports to identify and address concerns directly with providers.

Furthermore, we generated a statistical sample of 75 from the population of 7,852 major-level incidents. To select the sample, we used a 90% confidence level, a 50% anticipated rate of occurrence, and a 20% desired precision range.

11. The term MOR event refers to a situation that results in the creation of a MOR (i.e., missing a medication dose entirely or violating one of the five Rs).

For our sample of major-level incidents, we conducted testing based on the timeframes for providers to submit and finalize major-level incident reports. We first reviewed the date when each incident was discovered and the date when the incident report was submitted in DDS's web-based system. We calculated the number of calendar days between these two dates and determined whether any incident reports were submitted after more than the allowed 24 hours. We also reviewed the date when each incident report was submitted and the date when it was finalized. We then calculated the number of calendar days between these two dates to determine whether providers finalized their reports within the allowed seven calendar days after incident reports were submitted.

To determine whether providers submitted minor-level incident reports within the required timeframes, we generated a statistical sample of 75 from the population of 49,714 minor-level incidents. To select the sample, we used a 90% confidence level, a 50% expected error rate, and a 20% desired precision range.

For our sample of minor-level incidents, we conducted testing to determine whether providers met DDS's timeframes for providers to submit and finalize minor-level incident reports. We first reviewed the date when each incident was discovered and the date when the corresponding incident report was submitted. We calculated the number of business days between these two dates and determined whether any incident reports were submitted after more than three business days. We also reviewed the date when each incident report was initially submitted and the date when it was finalized. We calculated the number of calendar days between these two dates to determine whether there were any incident reports that were finalized after more than the allowed seven calendar days.

Within our samples of major-level and minor-level incidents, we identified incident reports that were submitted to the Disabled Persons Protection Commission (DPPC) and incident reports that staff members noted were going to be reported to DPPC. We followed up with DDS about these incidents and determined whether all incidents that should have been reported to DPPC had been reported.

For this objective, we found certain issues during our testing; namely, that DDS did not ensure that its providers submitted and finalized incident reports within the required timeframes. See Finding 4 for more information.

ISPs

To determine whether DDS developed ISPs on behalf of recipients of DDS services to accommodate those who elected the self-determination option in accordance with 115 CMR 6.21 and 6.23(5) and Sections 19(b), (f), and (g) of Chapter 255 of the General Laws, we took the following actions. We generated a statistical sample of 75 recipients of DDS services with ISPs from the population of 22,593 recipients of DDS services with ISPs. To select the sample, we used a 90% confidence level, a 50% expected error rate, and a 20% desired precision range.

For our sample of recipients of DDS services with ISPs, we reviewed dates to determine whether the service coordinator collaborated with the aforementioned parties before the initial ISP meeting as well as whether providers satisfied their responsibilities 15 days before the initial ISP meeting for each of the 75 recipients of DDS services. We then calculated the number of calendar days between these dates to determine whether service coordinators and providers met timeframes before the first ISP meeting.

In addition, to determine whether ISPs were reviewed by the area director or facility director within 45 days after the initial ISP meeting in accordance with 115 CMR 6.23(5), we obtained from DDS's web-based system, and reviewed, the date when the ISP meeting was held and the date when the area director or facility director approved or disapproved the ISP for the recipient of DDS services.

Lastly, to determine whether the self-determination option was offered to each recipient of DDS services, we determined whether the self-determination option was present within the web-based system. In addition, we also reviewed the samples within the web-based system to see whether the provider documented the DDS service recipients' interest in the self-determination option.

For this objective, we found certain issues during our testing, namely that DDS did not offer the self-determination option to all recipients of DDS services enrolled in ISPs. See Finding 5 for more information.

We used a combination of statistical and nonstatistical sampling methods for testing, and we did not project the results of our testing to any corresponding populations.

Data Reliability Assessment

To determine the reliability of the data within DDS's web-based system, we gained an understanding of the system and its controls, and we reviewed information security policies and procedures from DDS and the Executive Office of Health and Human Services. We also tested certain information system general

controls, including security management, access controls, configuration management, contingency planning, and segregation of duties for DDS's web-based system.

DPPC provided us with us a list of intakes that it sent to DDS through the web-based system for the audit period. From this list, we selected a random sample of 25 intakes from the data provided by DPPC and then traced the DPPC intake number, screen date, and investigating/referral agency fields to the system to determine whether they matched.

Additionally, for investigations, administrative reviews, incident reports, medication MORs, and ISPs, we tested these items to ensure that they did not contain certain record issues (i.e., duplicate records, missing values in necessary data fields, dates that did not flow logically in the data).

Based on the results of the reliability assessment procedures described above, we determined that the data was sufficiently reliable for the purposes of our audit.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. The Department of Developmental Services did not always issue decision letters or develop action plans for its investigations within the timeframes required by regulation.

During the audit period, the Department of Developmental Services (DDS) did not always issue decision letters for its investigations within required timeframes with adequate documentation. Specifically, for 2 (3%) out of 73 investigations in our sample, an extension was created for the decision letter after the 45-day timeframe for the decision to be issued.

Further, DDS complaint resolution teams (CRTs) did not consistently develop action plans within the required 30-business-day timeframe. Specifically, 27 (37%) of the 73 completed investigations in our sample had action plans that were not developed within 30 business days. We also identified that 3 of these cases did not have any action plans at all.

When investigations are not completed within required timeframes, or extensions are created without reason, there is a greater risk that recipients of DDS services may be subject to safety risks, abuse, and/or mistreatment.

Authoritative Guidance

Section 9.13(1)(d) of Title 115 of the Code of Massachusetts Regulations (CMR) states,

> *The results of the investigation shall be reported and a decision letter delivered to the regional director or designee within 45 [business] days of the investigator's assignment.*

According to 115 CMR 9.10(5),

> *The senior investigator or investigator may submit a request for an extension of a time limit set forth in 115 CMR 9.00 upon a showing of necessity and that the delay will not pose a threat to the safety of the individual involved. A staff investigator shall submit such request to the senior investigator; a senior investigator shall submit such request to the director of investigations or designee. A request for an extension shall be in writing, explain why an extension is needed, and propose a new time limit which does not unreasonably postpone a final resolution of the matter. If approved, the extension request shall be forwarded to the director of investigations by the senior investigator or designee. The senior investigator or designee shall then send a notice of extension to the parties.*

According to 115 CMR 9.14(3), CRTs must develop action plans "within 30 [business] days of an assignment to the CRT coordinator" for complaints investigated by DDS.

Reasons for Issue

DDS did not implement effective monitoring controls within its policies and procedures to ensure that decision letters and action plans were developed and issued on time.

However, it should be noted that, as of summer 2024, after the audit period for this audit, DDS reported to us that it had updated its formal policies and procedures to monitor the timeliness of investigations. See Post-audit Action for more information.

Recommendations

1. DDS should continue to follow its newly updated investigations manual to ensure that all decision letters are issued within the required timeline and ensure that any necessary extensions are properly requested, documented, and approved.
2. As previously recommended in our Audit No. 2020-0234-3S, DDS should properly implement effective monitoring controls to ensure that all action plans are completed timely.

Auditee's Response

DDS agrees . . . with Finding 1 to the extent that the Department did not always issue decision letters or develop action plans within the requisite timeframes in 100% of cases. . . .

. . . Most recently DDS updated the investigator and senior investigator's performance expectations, to highlight corrective actions to be taken when performance measures are not met. DDS' commitment to increasing efficiency and adherence to these regulatory requirements is evidenced in the difference between the two audits: In 2021, 38% of the decision letters were late beyond extension. In 2025, 2% of the cases were late before an extension was entered. . . .

While DDS agrees with the recommendations and has implemented effective monitoring controls, DDS acknowledges that it can further improve its processes to ensure that all action plans are completed within 30 business days. DDS intends to issue guidance with clear timelines and will ensure all four regions and 23 area offices follow this guidance by standardizing the forms, retraining the field, and conducting regular spot checks. DDS reiterates that pursuant to 115 CMR 9.07, the DDS investigator notifies the regional director immediately if protective services are required to ensure the health and safety of an individual (or individuals) as a result of a complaint allegation. This point simply cannot be overemphasized, particularly with regard to whether an action plan is not completed within 30 business days. Please also note that with respect to the reference [in the "Investigation Process for Alleged Abuse or Mistreatment" section of the Overview] related to DDS' plan to hire additional staff to address timeliness of action plans, DDS wishes to clarify that since the 2021 audit (2020-0234-3S), DDS has created and filled four

> *Administrative Review Manager ("ARM") positions who oversee each region's timely completion of action plans and administrative reviews. . . .*
>
> *Finally, the foremost priority of DDS investigations is risk mitigation, which begins at assignment and continues throughout the investigative process, regardless of duration. Open cases are reviewed by investigators and senior investigators at least bi-weekly, and monthly by the deputy, director, and senior to make certain there are no significant risk factors that have not been addressed. For screened-in ([Chapter 19C of the Massachusetts General Laws] cases), DPPC oversight also monitors the cases for elements of risk and is in frequent (consistent) communication with DDS investigations. In situations where DDS discovers significant risks, DDS documents such and issues written requests for protective services; DDS Investigations works with DDS Operations, DDS providers, and parties to the complaint to eliminate the significant risk and maintain such throughout the process.*

Auditor's Reply

Based on its response, DDS continues to take measures to address our concerns regarding this matter. As part of our post-audit review process, we will follow up on this matter in approximately six months.

2. The Department of Developmental Services did not properly manage all administrative reviews.

During the audit period, 9 (12%) of the 74 administrative reviews in our sample were not provided to the CRT coordinator within 15 business days.

When administrative reviews are not completed or are conducted improperly, DDS cannot ensure prompt implementation of actions outlined in resolution letters to address potential harm.

Authoritative Guidance

According to 115 CMR 9.11(2), "After conducting the review, the regional director or his or her designee shall issue a report of his or her findings and provide the report to the CRT coordinator within 15 days."

Reasons for Issue

DDS stated in a response to the issue that "[Administrative Review] was completed in the required timeframe. The Resolution Letter was issued after the CRT meeting, which in some cases is held monthly and not bi-weekly depending on citizen availability."

Recommendation

DDS should establish effective policies and procedures to schedule more frequent meetings of CRTs in order to ensure that all administrative review reports are submitted and finalized on time.

Auditee's Response

DDS agrees with OSA's finding and agrees with OSA's recommendation to the extent that DDS should establish effective policies and procedures to ensure that all administrative review reports are submitted and finalized on time. However, DDS is cognizant of the practical considerations involved with holding more frequent meetings given the regulatory requirement for citizen participation in the CRT and does not agree that holding more meetings would be a feasible recommendation to implement. DDS acknowledges that it must review and improve the administrative review process to ensure that administrative review reports are provided to the CRT coordinator within 15 business days, unless an extension request is made and approved per 115 CMR 9.11(3). DDS also notes that the volume of administrative reviews has increased significantly since the 2021 audit (2020-0234-3S).

As part of the administrative review process that is currently in place and was implemented two years ago as a result of the 2021 OSA audit, harm mitigation is the very first step when an administrative review is assigned to a regional director. DDS process specifies that upon assignment of a new administrative review, the regional director or designee must first determine if any immediate protective measures are needed to ensure the safety of the alleged victim. If the answer is yes, the regional director or designee should take all steps necessary with all involved parties to ensure the safety of the alleged victim and all individuals in that location. This is an important point, particularly with regard to whether an administrative review is not provided to the CRT coordinator within 15 days. Although a late administrative review is not ideal, it does not automatically mean the health and safety of individuals is put at risk.

DDS will also review, clarify and reissue the administrative review process to all involved regional and area office staff. This updated Administrative Review Process guidance will clarify that if the 15-business day deadline cannot be met, the regional director or designee must request an extension from the Deputy Commissioner for Operations. If approved, the regional director or designee will send a notice of extension to all involved parties.

Auditor's Reply

Based on its response, DDS has taken measures to address our concerns regarding this matter. As part of our post-audit review process, we will follow up on this matter in approximately six months.

3. The Department of Developmental Services did not ensure that medication occurrence reports were created, finalized, and reviewed within the required timeframes.

DDS did not ensure that medication occurrence reports (MORs) were created, finalized, and reviewed by DDS Medication Administration Program (MAP) coordinators within the required timeframes. Sixteen (21%) out of 75 non-hotline MORs that we reviewed were created after the established seven-calendar-day timeframe. Also, 5 (6%) out of 75 non-hotline MORs were not finalized by the provider within the required seven-calendar-day timeframe. DDS MAP coordinators did not review 3 (4%) out of the 75 non-hotline MORs within the established 14-calendar-day timeframe.

In addition, 21 (60%) of 35 hotline MORs we reviewed were created after the established 24-hour timeframe. Finally, DDS MAP coordinators did not review 3 (9%) of these 35 hotline MORs within the established 14-calendar-day timeframe.

Without timely creation, finalization, and review of MORs, there is an increased risk of poor outcomes for recipients of DDS services who could be adversely affected by staff members who do not administer medication, make dosage mistakes, or administer the wrong medication.

Authoritative Guidance

DDS's *MOR Overview Guide* requires all providers to create and finalize non-hotline MORs within seven calendar days after MOR events are discovered and hotline MORs within 24 hours after events are discovered. Once a provider finalizes either a non-hotline or hotline MOR, it must be reviewed by a DDS MAP coordinator for approval within 14 calendar days.

Reasons for Issue

DDS did not fully implement our recommendations during the audit period from our previous audit (Audit No. 2020-0234-3S). However, after the audit period for our current audit, DDS reported to us that it had implemented monitoring policies and procedures to ensure that providers create and finalize MORs, and that MAP coordinators review MORs, within the prescribed timeframes. See Post-audit Action for more details.

Recommendations

1. DDS should continue to follow its newly updated policies and procedures to ensure that providers create and finalize MORs, and that MAP coordinators review them, within the prescribed timeframes.

2. DDS should implement corrective actions related to audit findings in a timely manner.

Auditee's Response

DDS agrees with the finding related to timely medication occurrence reports and appreciates the recommendations given by the OSA to improve and strengthen the medication occurrence reporting process. However, it is important to note that MAP operates in concert with a number of DDS risk management systems, procedures, and processes (including DPPC allegations and investigations, incident reporting, and site monitoring), so the effect of any one medication occurrence report not being timely submitted may be mitigated by coexisting processes.

DDS takes its responsibility to safeguard the welfare of individuals it supports seriously and will carefully consider the recommendations to enhance MAP's ability to monitor, address, and prevent medication occurrences.

As noted earlier in the draft report, DDS has already initiated several strategic and structural improvements related to MAP and medication occurrences. Some of these were implemented during the audit period (for example, the hiring of a Statewide MAP Director), while others occurred after the current audit period (the restructuring of the reporting relationships of the regional MAP Coordinators). The initial effects of some of these strategies can be seen in comparison of the 2021 audit findings to the 2025 audit findings, in which there was an increase in compliance rates for regional MAP Coordinators as well as for providers across both hotline and non-hotline MOR review and submission.

Specifically, DDS created and filled a dedicated position of Statewide Director of MAP, with centralized oversight of MAP. In January 2025, DDS reorganized the Regional MAP Coordinators to report directly to the DDS Statewide Director of MAP, enhancing standardization and statewide coverage and improving timeliness.

DDS will continue to follow newly updated policies and procedures to ensure that providers create and finalize MORs, and that MAP coordinators review MORs, within the prescribed timeframes. Further, DDS is in the process of developing and implementing the following additional corrective actions related to the audit findings in a timely manner:

- *DDS regional MAP Coordinators will document reminders in non-timely MORs in the MOR itself for the provider to review;*
- *DDS plans to create a quarterly report on compliance with timelines for MORs at a provider level. These quarterly reports, once created, will be used by the MAP Director to monitor, flag, and inform providers and DDS staff on areas of noncompliance;*
- *DDS plans to create a quarterly report on compliance with timelines for MORs at the regional MAP coordinator level. These quarterly reports, once created, will be used by the MAP Director to monitor, flag, and inform DDS staff on areas of noncompliance; and,*
- *Regular ongoing webinars, required for MAP Trainers, also provide reminders about timeliness requirements. DDS is exploring other communication strategies to assure that all appropriate MAP-related staff are reminded of timeliness requirements.*

Auditor's Reply

Based on its response, DDS has taken measures to address our concerns regarding this matter. As part of our post-audit review process, we will follow up on this matter in approximately six months.

4. The Department of Developmental Services did not ensure that its providers submitted and finalized incident reports within the prescribed timeframes.

During the audit period, DDS did not ensure that its providers met the timeframes for submitting and finalizing incident reports. Specifically, of the 75 major-incident reports we sampled, 27 (36%) were submitted late, after the one business day allowed. In addition, 23 (35%) out of the 75 major-incident reports were not finalized after the established seven-calendar-day timeframe.

Furthermore, 13 (17%) minor-incident reports out of our sample of 75 minor-incident reports submitted by providers to DDS during the audit period were submitted late, after the three business days allowed. Also, DDS did not ensure that providers finalized 22 (29%) of the 75 minor-incident reports that we sampled within the seven calendar days allowed.

As a result, DDS did not act on all incident reports in a timely manner to identify and remediate safety risks for alleged victims.

Authoritative Guidance

Section VI(A)(1) of DDS's *Incident Management Guidelines* states,

> *[An] Initial Report [is] to be completed and submitted to the appropriate state agency either on a paper incident report form or electronically in one (1) business day for incidents initially classified as major review incidents or three (3) business days for incidents initially classified as minor review incidents. . . .*
>
> *The Final Report for most incident categories is to be completed by the provider and submitted to the involved state agency within seven (7) calendar days following the discovery of the incident.*

Reasons for Issue

DDS did not fully implement our recommendation during the audit period from our previous audit (Audit No. 2020-0234-3S). DDS provided evidence of sending custom reports, showing open incidents at the provider and DDS levels to the area and region levels; however, there was no follow up on the reports until after the audit period. See Post-audit Action for more details.

Recommendation

DDS should continue to work with providers to ensure that all incident reports are submitted and finalized on time.

Auditee's Response

DDS agrees with the finding related to timely incident reports and appreciates the recommendations given by the OSA to improve and strengthen the incident reporting process. Incident reporting is an important risk management process; however, it is important to note that it is not the sole reporting and monitoring process for sentinel events and/or emerging safety risks. For example, any unsafe situation, at any time, may be identified by families/guardians; DDS service providers; other public agencies (courts, schools, child protection agency, elder services); other internal staff (e.g., licensure and certification surveyors, area office nurses, human service coordinators, DDS investigators); and external stakeholders such as neighbors, police, or health care providers. As such, DDS is able to identify, mitigate, and prevent safety risks using a holistic proactive approach.

Incident reporting at DDS operates together with a number of DDS risk management systems, procedures, and processes, such as general risk screening and formal individual clinical risk plan development and tracking at the area, region, and central office levels. Routine risk management reports, DPPC complaint and investigation outcome summaries, site monitoring, and ongoing "real time" communication between individuals, providers, and DDS staff operate in an integrated, systemic manner, so the effect of any one incident report not submitted as timely as required may be mitigated.

DDS takes its responsibility to safeguard the safety and welfare of the individuals it supports very seriously and will carefully consider the recommendations to enhance DDS' ability to monitor, address, and mitigate risks presented in incident reporting. Ongoing DDS improvement efforts since the 2021 audit period have already resulted in an increase in compliance rates for the timeliness of major and minor incident submission and finalization by providers. While DDS is gratified to see improvement, as noted by the OSA, there is more work to be done. To that end, DDS agrees with and will be implementing the recommendation that DDS continue to work with providers to ensure that all incident reports are submitted and finalized on time.

DDS has been meeting regionally with staff to identify root causes of delays and determine potential strategies and resources to address the challenges with timely reporting of incidents. Specific strategies and resources may include reporting/data analytics, training/job aids and web application improvements. Concurrently, the DDS Director of Risk Management is implementing enhancements to the DDS Comprehensive Risk Management System, of which incident reporting and incident management are integral. These revisions will include an evaluation of workflow barriers to achieving quality, timely incident reporting. As these streams of activities progress, DDS will be implementing specific action steps to ensure that providers submit and finalize all incident reports on time.

Auditor's Reply

Based on its response, DDS has taken measures to address our concerns regarding this matter. As part of our post-audit review process, we will follow up on this matter in approximately six months.

5. The Department of Developmental Services did not offer the self-determination option to all its recipients enrolled in individual support plans.

DDS did not ensure that necessary policies and procedures were in place to ensure that all recipients of DDS services enrolled in individual support plans (ISPs) have the opportunity to elect the self-determination option. Specifically, for 16 (21%) of the 75 recipients of DDS services in our sample, the self-determination option was not present within DDS's web-based system.

The absence of the required self-determination option calls into question whether the proper quality of care was given to each recipient of DDS services who enrolled in an ISP.

Authoritative Guidance

Section 19 of Chapter 255 of the Massachusetts General Laws states,

> *(b) The department shall offer self-determination as an option to all individuals eligible for services through the department. Self-determination shall be based on the participant's judgment and preferences as set forth in the participant's person-centered plan. . . .*
>
> *(f) Participation in self-determination shall be available to any individual who receives services from the department. . . .*
>
> *(g) Participation in self-determination shall be voluntary. An individual may choose to take part in or seek other department services at any time; provided, that the individual budget shall follow a participant who seeks other department services. The department shall not require or prohibit participation in self-determination as a condition of eligibility for, or delivery of, services, supports or goods otherwise available.*

Reasons for Issue

There are DDS providers that do not have access to DDS's web-based system, so self-determination cannot be documented. While some providers have their own procedures for documenting the self-determination options, DDS is unaware of those recipients.

Recommendation

DDS should collaborate with providers and implement standardized policies and procedures to ensure that DDS is aware that all recipients of DDS services have been offered the self-determination option and are aware of who selected the self-determination option.

Auditee's Response

DDS agrees with OSA's recommendation to implement standardized policies and procedures to ensure that all recipients of DDS services who are eligible for self-directed services and not already engaged in self-direction have been offered the opportunity to self-direct their services.[3] DDS acknowledges that it was not able to produce documentation in a number of the OSA sample cases, either from [DDS's web-based system] or other DDS information systems, that confirmed an individual was informed (or re-informed) of the self-direction option during the audit review period. In response to this finding, DDS will reissue guidance to all service coordinators detailing the requirement to share information about self-directed services when sending the ISP invitation letters to all individuals on their caseload who are eligible for but not already self-directing services. DDS will maintain documentation of the requirement to discuss self-directed service options in its information system of record.

At present, all DDS staff are mandated to take annual training about self-determination and the value of self-directed services for eligible individuals who are interested. Offering self-direction to all eligible individuals is a high priority for the Department, in addition to growing the self-directed services that operationalize self-determination.

While DDS agrees with the overall audit finding, DDS would like to offer the following clarifications. First, [in the introduction section of Finding 5], OSA concludes that, "[t]he absence of the required self-determination option calls into question whether the proper quality of care was given to each recipient of DDS services who enrolled in an ISP." DDS disagrees with OSA's conclusion. On the contrary, there is no evidence that this one factor indicates the presence of the other. Person-centered planning and completing the ISP process at a high level of quality are a central part of the DDS service coordination work mandated by DDS regulations and the 1915c Home and Community Based Services waivers.

Second, [in the "Reasons for Issue" section of Finding 5, OSA finds that, "[t]here are DDS providers that do not have access to DDS's web-based system, so self-determination cannot be documented." DDS disagrees with this finding and reiterates that [Section 19 of Chapter 19B of the General Laws] requires DDS, not the service provider, to provide individuals with information about self-direction.

[Footnote:]

3. *As a point of clarification, DDS notes that self-determination happens throughout our interactions with the individual in person-centered planning, development and implementation of the ISP. "Self-direction" is the service model that operationalizes self-determination.*

Auditor's Reply

In its response, DDS disagrees with the reason that led to this finding as stated in the "Reasons for Issue" section. However, the reason reported in this section was stated to us by DDS in two separate meetings, one on April 9, 2025 and the other on June 2, 2025. In addition, DDS disagrees that the absence of the required self-determination option calls into question whether the proper quality of care was given to each recipient of DDS services who enrolled in an ISP. To clarify, we are not stating that DDS delivered poor quality of care, but rather, we are stating what the possible effect of this issue could be and the importance of offering the self-determination option to all its recipients enrolled in ISPs.

Nevertheless, DDS agrees with the remainder of our finding and is taking measures to address our concerns regarding this matter. As part of our post-audit review process, we will follow up on this matter in approximately six months.