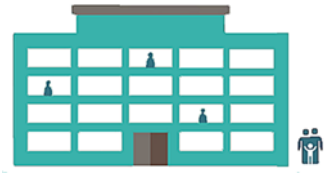
Annual Report on Activities SFY 2026
Office of Developmental Disabilities Ombuds

The Office of Developmental Disabilities Ombuds advocates for the rights, dignity, and humanity of people with developmental disabilities living in Washington-State.

"The Legislature finds and declares that the prevalence of the abuse and neglect of individuals with developmental disabilities has become an issue that negatively affects the health and well-being of such individuals." SB 6564 (2016)








Office of Developmental Disabilities Ombuds

Members of the Legislature
Governor Bob Ferguson
Angela Ramirez, Department of Social and Health Services
Bee Rector, Home and Community Living Administration
Dana Phelps, Developmental Disabilities Administration

November 2, 2026

The legislature in 2016 created the Office of Developmental Disabilities Ombuds (DD Ombuds) program in response to abusive and neglectful conditions for people with developmental disabilities. In SFY 2026, the DD Ombuds completed another year of complaint resolution, monitoring, outreach and training, and systemic change policy work.

With 5.5 full-time staff, DD Ombuds reached more than 3,964 people at 2215 events to talk about our services, show our videos about DD Ombuds and self-advocacy, and give presentations about rights and responsibilities. We opened 114 new individual complaint investigations this year and closed 122 complaints. We conducted 227 monitoring visits, including 132 visits to people receiving supported living services. Monitoring visits are conducted across the state to review facilities, residences, and programs where people with developmental disabilities receive services.

We analyzed trends and used information gathered to bring attention to issues of concern. We brought those issues forward in meetings with state agencies and through the legislative process. We worked with The Developmental Disabilities Administration (DDA), as well as the Residential Care Services (RCS) on system improvements for people with developmental disabilities.

The DD Ombuds remained focused on systemic change for adults and youth stuck in the hospital. Following legislation to repeal the DDA Community Protection Program (CPP) statute, we also focused on monitoring DDA's transition of people from CPP to appropriate supports.

We reached people who may not otherwise had access to an advocate and looked to find new ways to reach people who have concerns about, or experiences with, abuse and neglect. We continue to engage in policy work to address the prevention of, and response to, abuse and neglect of people with developmental disabilities.

Thank you for this opportunity to advocate for and with people with developmental disabilities.

Betty Schwieterman, Developmental Disabilities Ombuds Director
Office of Developmental Disabilities Ombuds

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Policy Recommendations to the Washington State Legislature, Governor, and State Agencies

The Legislature created an independent Office of Developmental Disabilities Ombuds (DD Ombuds) to monitor and report on services to people with developmental disabilities. The DD Ombuds also has the duty to make recommendations for service improvement to State agencies, the Governor, and the Legislature. Policy recommendations from the DD Ombuds are below, followed by a summary of the work of the DD Ombuds for the state fiscal year 2026.

Proposal 1 – Ensure everyone graduating or transitioning out of the Community Protection Program receive the services they need in the community using a person-centered process and have their needs met with other waiver services.

Problem: CPP is the most restrictive community program administered by Developmental Disabilities Administration (DDA). In 2021, the DD Ombuds wrote a report focused on areas of concerns with CPP including lax adherence to policies that protect the rights of people with disabilities. In addition, our report outlines how people in the CPP routinely experience punishment in violation of the prohibition on punishment when using federal Home and Community Based Services (HCBs) funds. As a result of DD Ombuds advocacy, DDA proposed agency request legislation, which passed in 2026 to remove the CPP from state statute. The program will eventually be eliminated, most likely by 2028, and people need a smooth transition to new services.

Recommendations: The legislation passed to eliminate the CPP and ensure people have their needs met through the existing waivers. The DDA must include these actions during the transition process:

- **a.** DDA communicates and collaborates with every person in CPP to create a person-centered service plan to transition them to other services to meet their needs.
- **b.** DDA finds and develops resources to meet the needs of young people with developmental disabilities who are identified as having possible "community protection issues," within current waivers or develop new service types to meet their needs without restrictive programming.
- **c.** DDA ensures each person who is still in CPP during the transition process has a clear path to graduation from CPP using a person-centered planning process.
- **d.** DDA ensure they, and their contracted providers, meet all federal, state and policy requirements to guarantee that people are not subjected to unwarranted restrictions of their civil and human rights.
- **e.** End the CPP exemption from regional oversight. DDA must remove the provision in Policy 5.15 that exempts people eligible for CPP services from regional oversight of restrictions on their rights.

Proposal 2 - Prevent inappropriate hospitalization of children and adults with developmental disabilities.

Problem: Community hospitals continue to be used as crisis placements for children and adults with developmental disabilities across the state. Since July 2018, DD Ombuds has worked with children and adults with developmental disabilities who were, or are, stuck waiting in a hospital without any medical need because Developmental Disabilities Administration (DDA) did not provide them with appropriate services in the community. The DD Ombuds released two reports about this issue our Youth report, "I Want to Go Home" in SFY 2023 and our Adult report, "Stuck in the Hospital" in 2018.

DDA now collects data on people with developmental disabilities who are taken to the hospital and tracks demographics, the reason why the person was taken to the hospital, where they were living before hospitalization, and why they are stuck there. Tracking includes people of all ages, and people coming out of residential service settings and private homes.

According to DDA SFY 2026 data shows these trends.

Region 1 Trends: There were 78 total clients with 27 new admissions. Of the 24 patients awaiting discharges, 21 waited for more than 7 days after cleared for discharge. There were 4 patients waiting to be discharged after 100 days of being medically cleared.
70% of the adults were in the hospital for 30 days or longer (not necessarily cleared).
82.14% of the minors were in the hospital for 30 days or longer (not necessarily cleared).
The majority of the patients were white, with American or Alaskan Natives being the second largest racial group.

Region 2 Trends: There were 121 total clients with 65 new admissions. Of the 51 patients awaiting discharges, 43 waited for more than 7 days after cleared for discharge. There were 5 patients waiting to be discharged after 100 days of being medically cleared.
60% of the adults were in the hospital for 30 days or longer (not necessarily cleared).
42.62% of the minors were in the hospital for 30 days or longer (not necessarily cleared).
The majority of the patients were white, with American or Alaska Native and Black or African American being the second largest racial groups.

Region 3 Trends: There were 99 total clients with 43 new admissions. Of the 39 patients awaiting discharges, 30 waited for more than 7 days for discharge. There were 4 patients waiting to be discharged after 100 days of being medically cleared.
63.64% of the adults were in the hospital for 30 days or longer (not necessarily cleared).
48.48% of the minors were in the hospital for 30 days or longer (not necessarily cleared).
The majority of patients were white, with Black or African American being the second largest racial group. There were no reported American or Alaskan Native patients, although there were 4 patients who identified as two or more race, which may include American/Alaskan Native.

The data shows that statewide 94 patients waited for more than 7 days for discharge after being medically cleared. And statewide a total of 13 patients were waiting to be discharged after 100 days of being medically cleared. Hospitals are not residential service providers and no one should have to wait for services and supports while languishing in a hospital.

Recommendations:

- **a.** The legislature can ask DDA to present the data regarding children and adults stuck in the hospital, DDA efforts to reduce hospital usage for crisis services, and their recommendations for appropriate services for this population.
- **b.** To prevent further or extended hospitalization, ensure that people currently waiting for placement are prioritized to receive services, have assessments and person-centered service plans that comply with all state and federal requirements, do not contain demeaning language, and meet the person's medical and behavioral support needs.
- **c.** Expand the number and types of specialized providers such as psychologists and behavioral support specialists. DDA should analyze the number and type of specialized providers needed to meet the current demands for service in each region. Using this data, DDA should employ or contract directly with specialists who can provide the following services throughout the state: Psychological assessments; Consultation on behavior supports for family caregivers, staff, and medical providers; Behavior supports for people with developmental disabilities living in hospitals; and specialized habilitation services.
- **d.** Direct DDA to identify and remove barriers to utilization of behavioral support, such as in-home consultation, for children and adults who reside with parents.
- **e.** Fund additional community diversion beds, emergency respite or other community bed capacity to meet the current need for crisis services so children, youth and adults with developmental disabilities have an appropriate community placement available.
- **f.** Continued increase in funding for complex transition care-coordinators or teams, mobile diversion rapid response, Intensive Habilitation Services, youth peer mentors, provider development, 24-hour personal care and state operated personal care, smaller caseloads, and enhanced support to providers to prevent unnecessary hospitalization and out of state placement.
- **g.** Follow the recommendations of the Complex Discharge Task Force July 2025 Report.
- **h.** Ensure behavioral health service providers are trained and equipped to serve youth with developmental disabilities.
- **i.** Ensure DDA and DCYF case managers and hospitals know about and use the 1580 Children and Youth Multi-System Care Rapid Care Team Complex Case Escalation Referral process.

Proposal 3 - Identify and close gaps in mental health/behavioral health services for children and youth with developmental disabilities.

Problem: The integration of Medicaid health care and behavioral health care created gaps in mental health services for children and youth with developmental disabilities. This major overhaul of the

health care system did not adequately prepare to address the multifaceted needs of people with developmental disabilities.

Proposal: Create a behavioral/mental health service system inclusive of children and youth with developmental disabilities.

a. Invest in non-institutional supports and services as opposed to institutional settings.
b. Monitor facility-based services and eliminate isolation and restraints.
c. Support Children & Youth Behavioral Health Work Group generated recommendations regarding proposals to identify and examine current gaps in mental health services for children and adults with developmental disabilities.
d. Examine and follow recommendations from the WA Developmental Disabilities Council Bridge Forward report Crossing Barriers to Improved IDD and Behavioral Health Systems in Washington https://cdn.prod.website-files.com/60bd96815ffd0919e385b4ed/68c1d131ddaf70d4f37bbbee_Bridge%20Forward%202025_Final%20Report_V4%20DIGITAL%20(1).pdf
e. Ensure funding for recommendations from the Children & Youth Behavioral Health Work Group for improvements to community based services for individuals with developmental disabilities.
Link for Workgroup https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/children-and-youth-behavioral-health-work-group-cybhwg
Priority recommendations include:

- Mandatory training for WISe to support youth with Autism/IDD
- Maintain state investments in school based Behavioral Health Services
- Expand the RUBI parent provider training program to reach more families with children with Autism and developmental disabilities with co-occurring behavioral health needs.
- Require reimbursement from commercial insurance for pediatric Community Health Workers.

Proposal 4 - Increase investment in quality community supports and services for children and adults with developmental disabilities to reduce use of crisis services.

Problem: The long-term care system in Washington State is ranked as one of the best in the country. Not so for individuals with developmental disabilities: Washington State ranked 41st in the country for fiscal effort for services for people with developmental disabilities according to the 2019 State of the State Report. The staff turnover rate has made modest improvement since 2022 but is still unacceptably high at close to 40% in residential supported living services. The DD Ombuds sees a pattern of both children and adults with identified behavioral supports needs who are unable to access services to stay in their own home or at home with a parent. The DD Ombuds also sees a pattern that people currently in crisis don't have service plans that meet the minimum requirements to prevent crisis.

Recommendations:

a. Increase direct service workers wages in supported living to reduce turnover and increase retention of well-trained staff.
b. Expand the number of out of home respite services for people living with their families.
c. Expand the number of State-Operated Living Alternatives (SOLAs) across the state.
d. Continue focus on the needs of clients DDA has identified who asked for services but are waiting (no paid services caseload) by increasing availability of waiver services. Restore case management for this group. Identify children and youth on the no paid services caseload, under the age of 21 and on Medicaid and determine if there are unmet needs and whether those can be met under the state Medicaid plan through EPSDT.
e. Ensure that DDA and contracted support providers have more training in developing individual and person-centered service plans that meet state and federal requirements to prevent crisis and comply with the Federal Home and Community Based Settings (HCBS) Rules.
f. Support HCA efforts to provide dental services tailored for people with developmental disabilities.

Proposal 5 - Identify and fix systemic gaps with Washington's abuse investigations.

Problem: The DD Ombuds reported concerns to both DDA and RCS about lack of adherence to HCBS rules and client rights. DDA and RCS must train personnel to identify violations of DDA client rights as possible abuse or neglect. Although RCS and DDA leadership has disputed whether these violations may require a mandatory report, effective prevention requires investigators and evaluators to take each person's account seriously to avoid further under-reporting of abuse and neglect.

Recommendations:

a. Recognize and report suspected abuse or neglect - DSHS leaders and employees must recognize that violations of DDA client rights require a mandatory report when there is "reason to suspect" abuse or neglect under RCW 74.34
b. Review how RCS enforces HCBS rules and client rights in residential settings.
c. Expand experience-based training - RCS and DDA leaders must provide additional abuse and neglect training grounded in the actual experiences of people who rely on DSHS services.
d. DDA must ensure that all required safeguards are in place before restricting a person's rights. Person-Centered Service Plans (PCSPs) must document every safeguard required by the Home and HCBS Settings Rule before any restriction is imposed. DDA must train personnel to identify violations of client rights as possible abuse or neglect.
e. Review how DDA enforces residential quality standards for contracted providers. Create and fund increased quality assurance mechanisms for DDA to use with residential providers.
f. Ensure the END HARM line is a 24/7 line for reporting abuse of people with developmental disabilities.

Proposal 6 - Strengthen RCS Oversight of Positive Behavior Support Plans (PBSP)

Problem: Failure to identify and enforce minimum PBSP standards

Complainants told the DD Ombuds that staff restricted their rights by requiring them to remain in their rooms, limiting internet access, and preventing them from going places or seeing people of their choice. These individuals were required to have Positive Behavior Support Plans (PBSPs) intended to prevent challenging behavior and teach replacement skills. Although complainants asked RCS to enforce applicable requirements, RCS found no problems with PBSP's that failed to meet minimum standards.

Recommendations:

a. **Implement Positive Behavior Support training -** RCS must provide effective Positive Behavior Support training for its personnel. Training should help complaint investigators and certification evaluators distinguish punitive practices from reinforcement-based strategies and recognize punishment as a form of abuse.
b. **Strengthen evaluation of behavioral objectives -** Train complaint investigators and certification evaluators to determine whether behavioral objectives in PBSP's contain the elements needed to measure behavior reliably and credibly. Reviews should address these questions:

- Were relevant data collected?
- Do the data correspond to the stated objective?
- Did the problem behavior decrease?
- Did the replacement behavior increase?
- If outcomes did not improve, did the provider use the data to evaluate its approach and make necessary changes?

c. **Recognize rights violations as potential abuse or neglect -** RCS must train personnel to treat violations of DDA client rights as possible abuse or neglect. Although RCS leadership has disputed whether these violations may require a mandatory report, effective prevention requires investigators and evaluators to take each person's account seriously to avoid further under-reporting of abuse and neglect. RCS must also end training that directs staff to cite providers when client rights are not restricted.

Proposal 7 – Identify and fix gaps in reporting suspicious deaths and mortality reviews.

Problem: There are numerous systemic gaps with how the DDA and RCS approach abuse investigations and investigate suspicious deaths. In SFY 2024 DDA made improvements in their policies concerning reporting and responding to suspicious deaths. It is difficult to know if deaths that could be suspicious are identified and reported to the coroner or medical examiner. DD Ombuds will continue to monitor this issue.

Recommendations:

a. Mandate RCS to create a suspicious death investigation and review protocol and track their reports of suspicious deaths to the coroner or medical examiner.
b. DDA must monitor their mandatory reporting requirements for DDA staff to report suspicious deaths to the medical examiner or the coroner's offices.
c. Continue monitoring implementation of mortality review processes to identify suspicious deaths.

Proposal 8 -Improve services for youth with developmental disabilities in foster care.

Problem: There are children and youth with developmental disabilities in the foster care system. The DD Ombuds gathered information about how other states serve children with developmental disabilities in foster care in its report "Improving Services for Youth with Intellectual/Developmental Disabilities in Foster Care." Children and youth in foster care have gained access to DDA waiver services. DD Ombuds continues to see problems with access to DDA services and coordination among agencies. We are concerned that DCYF dependent youth with developmental disabilities are being admitted to the state RHCs.

Recommendations:

a. Direct the DDA and DCYF to evaluate if children and youth with developmental disabilities in foster care are receiving DDA waiver services as required.
b. DDA identify gaps in services, including crisis stabilization services, for these children and report back to the legislature with a plan to improve services for children and youth with developmental disabilities.
c. Divert youth with developmental disabilities from RHCs into community based residential services.
d. Track and report numbers of DCYF dependent youth served in RHCs.

Office of Developmental Disabilities Ombuds Annual Report SFY 2026

Introduction

In 2016, the Washington State Legislature declared, “The prevalence of the abuse and neglect of individuals with developmental disabilities has become an issue that negatively affects the health and well-being of such individuals.” The legislature created an independent Office of Developmental Disabilities Ombuds (DD Ombuds) to investigate complaints and monitor and report on services for people with developmental disabilities.

History

The DD Ombuds began its operations across the state of Washington on May 25, 2017. The Washington State Department of Commerce awarded the nonprofit Disability Rights Washington, through competitive bid, the contract to administer DD Ombuds program. Disability Rights Washington created a separate program to fulfill the contract. The DD Ombuds operates under the authority of RCW 43.382.

Services for People with Developmental Disabilities in Washington State

Developmental Disabilities Administration (DDA) is part of Washington State’s Department of Social and Health Services (DSHS). DDA administers programs for children and adults with developmental disabilities and their families to obtain services and supports based on individual assessments, needs, and preferences. According to DDA data, there were 70,796 enrolled clients as of June 2026. Of the enrolled clients, 35,037 were receiving paid services. DSHS and other state agencies also administer services to children and adults with developmental disabilities. DD Ombuds has the duty and authority to investigate complaints and monitor and report on these services to resolve complaints and make recommendations to state agencies, the Governor, and the legislature.

Powers and Duties of DD Ombuds

DD Ombuds has the authority and duty to carry out the following:

- Provide information on the rights and responsibilities of people receiving DDA services or other state services and on the procedures for providing these services.
- Investigate, upon its own initiative or upon receipt of a complaint, an issue related to a person with developmental disabilities. However, DD Ombuds may decline to investigate any complaint.
- Monitor procedures as established, implemented, and practiced by the department to carry out its responsibilities in the delivery of services to people with developmental disabilities.
- Review the facilities and procedures of state institutions, state-licensed facilities, and residences which serve persons with developmental disabilities.
- Recommend changes, at least annually, to procedures for addressing the needs of people with developmental disabilities to service providers, the department, and legislators.
- Establish procedures to preserve the confidentiality of records and sensitive information to ensure the identity of any complainant or person with developmental disabilities is protected.

- Maintain independence and authority within the bounds of DD Ombuds duties; and
- Carry out such other activities as determined by contract.
- The legislature added a duty to the DD Ombuds in the 2025 session. By November 1, 2028, and in compliance with RCW 43.01.036, the office of the developmental disability ombuds shall submit a report to the appropriate committees of the legislature that includes summaries of resident, parent, and guardian feedback regarding transition of residents out of the Rainier school following the effective date of this section, July 2025

Budget and Staffing SFY 2026

State appropriation: $797,000

Commerce Administration fee $39,850

DD Ombuds contract budget: **$757,150**

Staffing - The Office of DD Ombuds operates with 5.5 full-time equivalent staff statewide.

Director - Betty Schwieterman

Region 1 DD Ombuds and Staff Attorney - Lisa Robbe

Region 2 DD Ombuds - Leigh Walters

Region 3 DD Ombuds - Noah Seidel

Self-Advocacy Educator - Tim McCue

Office Assistant – Trang Le

DD Ombuds Program Approach

The 2016 legislature considered a proactive approach to DD Ombuds services. They recognized some people with developmental disabilities are isolated and do not have the resources or support to reach out for assistance. Therefore, DD Ombuds' approach is to provide services and take complaints in person as much as possible. Even in our very advanced technology dependent society, many people with developmental disabilities do not have access to a phone or the internet, or if they do, other people may control their use.

During 2026, DD Ombuds continued in-person visits although at times, had to cancel because of COVID or flu outbreaks. DD Ombuds continues to take complaints by phone, email, and through a website complaint form.

DD Ombuds resolves complaints at the lowest possible level. DD Ombuds protects choice, autonomy, and ensures people with developmental disabilities have access to advocacy. DD Ombuds promotes the well-being of people with developmental disabilities who receive state services. All DD Ombuds services are resident-directed and person-centered. DD Ombuds operates within strict confidentiality protocols.

DD Ombuds provides information on rights and responsibilities through presentations, trainings, at planning meetings, community events, videos, social media, and website at www.ddombuds.org. DD Ombuds and people with developmental disabilities create these publications, videos, and website content.

DD Ombuds collects information through community engagement from diverse stakeholders such as self-advocacy groups, parent groups, provider organizations, and others to guide its work. DD Ombuds convenes an advisory committee 5 times a year, with a membership comprised of majority people with developmental disabilities. The committee meets virtually to review stakeholder input and advise DD Ombuds on priority setting, topics for systemic issue reports, organizational structure to ensure a person-centered, resident-directed program, and program expansion.

DD Ombuds participates in state-led workgroups and regularly meets with state agencies to exchange information and recommend policy and practice changes to improve services for people with developmental disabilities. The DD Ombuds continues to see increased responsiveness by DDA to address concerns raised by the DD Ombuds. DD Ombuds recognizes larger culture change at DDA is necessary to prevent and remedy harm and we support DDA in this effort.

Each year, the DD Ombuds publishes this annual report on the work of the office, including the types of complaints received and resolved, facilities and residences visited, systemic issues addressed, recommendations formulated and achieved, and community engagement, outreach and trainings presented.

DD Ombuds Mission

The Office of Developmental Disabilities Ombuds advocates for the rights, dignity, and humanity of people with developmental disabilities living in Washington State.

DD Ombuds Vision

We envision people living joyful and unrestricted lives, free from abuse and neglect. We envision a service system by and for individuals with developmental disabilities that:

- Protects and empowers the rights of disabled people
- Trusts people when they say what they need
- Is individualized and responsive to peoples' needs
- Encourages people to come forward with their concerns
- Believes those who come forward with reports of abuse and neglect
- Is culturally responsive to the diverse needs of its population
- Is accessible for everyone
- Prioritizes community over isolation
- Promotes meaningful social relationships
- Uplifts the opinions and needs of disabled people
- Has a robust network of service providers that can meet a wide variety of needs
- Trains and empowers everyone who is providing services to support self advocacy for those they serve

Disability Justice Principles

DD Ombuds examines our work with disability justice principles in mind. People can experience oppression as a direct result of the DDA service system. DD Ombuds brings issues to DDA that highlight that oppression and amplifies a narrative where people with developmental disabilities are free from abuse and neglect and able to live the life of their choosing. When creating work plans and attending meetings with DDA, disability justice principles inform and guide our work. Here are some examples of those principles:

- **Intentional Language** - DD Ombuds uses intentional language that centers individuals with disabilities as the ones who know best. There often is coded language used in oppressive systems and DD Ombuds questions this language when used by people working in the service system to bring them back to person-centered practices and the principle of "nothing about us without us."
- **Intersectionality** - DD Ombuds is mindful of intersectionality framework as we do our work, create our agendas and as discussions occur in meetings. DD Ombuds recognizes that people have multiple identities that make them whole and cannot be separated from the person.
- **Leadership of the Most Impacted** - DD Ombuds centers the leadership of people with intellectual and developmental disabilities. To do our work, we seek out opinions and listen to individuals with developmental disabilities. People who use services and supports must be involved in creating and evaluating those services.

Priorities

The Washington State Legislature created DD Ombuds because of the high rates of abuse and neglect against people with developmental disabilities. All people have the right to be free from abuse and neglect. DD Ombuds program visits people where they live to listen to their concerns as well as find and fight abuse against people with developmental disabilities.

DD Ombuds prioritizes issues related to abuse and neglect of individuals with developmental disabilities, including physical and sexual abuse; personal and financial exploitation; physical, mechanical, and chemical restraint; and verbal abuse, neglect, and self-neglect. This includes individuals who are stuck in the hospital, and people in, or at risk of entering restrictive settings such as the Community Protection Program or institutions.

The Work of DD Ombuds

Information on Rights and Responsibilities

DD Ombuds has the duty to provide information on the rights and responsibilities of individuals with developmental disabilities, including the right to access DD Ombuds services. Information is provided in a variety of formats and locations across the state.

1. Training, Education, Outreach and Community Engagement - DD Ombuds reached 3,964 people with information about DD Ombuds services, trainings on topics such as how to navigate the service systems, voting, self-advocacy and problem solving, and responding to abuse, neglect, and sexual assault through presentations, outreach, and engagement at 215 events.

Some examples of events and presentations and community engagement:

- The DD Ombuds attended a Pierce County Long Term Care Ombuds meeting where we presented about the work of the DD Ombuds and explained how our work is similar but different to the Long Term Care Ombuds. We then had a conversation about how we handle complaints and the DDA system. We talked about when we can refer people to each other and how we could work together on individual and systemic advocacy. Both offices agreed it is helpful to have this conversation and planned for future collaborations.
- The DD Ombuds office collaborated with Open Doors for Multicultural Families for its fifth year, giving information to the youth with developmental disabilities about the DD Ombuds office and tips for self-advocacy.
- DD Ombuds continued Emerging Leaders presentations during the 2026 Legislative Session over Zoom. Emerging Leaders support self-advocates with developing plans for legislative advocacy, such as providing them with information on the current state of legislation and helping them figure out who their legislators are and how to meet them.
- The DD Ombuds participated in another year's Tools 4 Success conference at Tacoma Community College, put together by PAVE, giving a presentation on advocacy at the workplace to youth in transition programs.
- The DD Ombuds also participated in resource fairs at all the state RHCs. The DD Ombuds participated in the People First Annual Convention in Spokane, the 2026 Spokane Disability Pride Event for the third consecutive year, and the Sunnyside Transition Family Picnic in Sunnyside, WA, where the DD Ombuds provided a Spanish-speaking interpreter familiar with the DD system to answer community questions.
- The DD Ombuds have continued our commitment to support self-advocacy by participating in the Allies in Advocacy board meetings and trainings. Allies in Advocacy is an organization governed and staffed by people with developmental disabilities. They advocate for policies and programs in all aspects of society that increase the power of people with developmental disabilities to make the decisions to live the lives they choose. The DD Ombuds have assisted in creating and offering trainings around Supported Decision Making across Washington State to family members, providers and self-advocates in different settings. We have started the process to train first responders and emergency services to better interact with people with disabilities. The DD Ombuds will continue in this effort during the next year.

2. Information and Referral (Self-Advocacy Support) - DD Ombuds provided 117 detailed self-advocacy support services to people to assist them in resolving their issue. This type of service is more than just providing referrals. Examples of this type of service include providing explanations about and referrals to services, processes for applying for or requesting services including types of

DDA services, the DDA eligibility process, the types of DDA service plans, the process for applying for civil legal aid services, and explanation and referral to the complaint resolution unit for abuse and neglect complaints.

3. Resource Development - Work was completed on the brand-new self-advocacy resource, Making My Own Decisions, a booklet that contains tips and tricks for self-advocacy, including information on supported decision making. It is something that can be used by people with disabilities and by their supporters to help make the lives of people with disabilities more person-centered.
The DD Ombuds also developed several updated presentations for this year, such as enhancing Supporting Self Advocacy with a new voting component, reimagining several presentations in the form of interactive activities and quizzes, and a new presentation on healthy relationships to be delivered to individuals with disabilities in transition programs.

DD Ombuds has resources to inform people with developmental disabilities, their families, service providers, and the community about DD Ombuds and rights and responsibilities. A tri-fold brochure and two videos about DD Ombuds are used in presentations and outreach. One video explains the services of DD Ombuds, and the other covers the importance of self-advocacy. The videos are available on DD Ombuds website in ASL and with subtitles available in English and other languages: Chinese (Simplified and Traditional), Korean, Somali, Spanish, and Vietnamese. The tri-fold brochure is available in 8 languages and Braille. DD Ombuds partnered with People First of Washington to translate and caption 5 videos on client rights in five different languages.

4. Website and Social Media – The DD Ombuds website (ddombuds.org) posted 10 posts to the blog on a variety of subjects. DD Ombuds social media has 2.2k followers. For the period of July 1, 2025, to June 30, 2026, the website had 7,765 unique visitors. Those users engaged in a total of 9,688 individual sessions, or individual times they went to the website. Many of the visitors to the website over that period were new to the website, which means they had never visited before, which means that many new people are learning about DD Ombuds office and services.

Complaints

People with developmental disabilities and who receive services from the state are eligible for services from DD Ombuds. Individuals with developmental disabilities, staff or providers, family members, guardians, or other interested individuals may make a complaint. DD Ombuds keeps the identity of those who make a complaint confidential.

Complaints are generated during community engagement, in-person monitoring visits, and from individuals with developmental disabilities, parents or other family members, community members, or service providers. DD Ombuds receives complaints in person, by phone calls, or through DD Ombuds online complaint form.

DD Ombuds reviews, and may investigate, complaints on behalf of people with developmental disabilities who receive state services. Complaints may relate to abuse, neglect, exploitation, the quality of services, or access to services. Complaints regarding abuse or neglect, including restrictive settings and services, are prioritized for services.

In response to a complaint, DD Ombuds may take steps to resolve the issue by talking with others involved, monitoring a facility or residence, researching DDA policies or practices, reviewing records, and interviewing witnesses, or advocating on behalf of an individual or group to resolve a complaint. Only issues where DD Ombuds acted on an individual complaint are listed below. DD Ombuds addresses other issues by providing information or referral services and self-advocacy support. DD Ombuds uses information gained during complaint investigations to address larger systems issues and advocate for change to improve services and people's lives.

Complaints worked on in SFY 2026

SFY 2026 Complaints	
Complaints from SFY 2025 carried over into SYF 2026	36
New complaints opened July 1, 2025 through June 30, 2026	114
Complaints Closed July 1, 2025 through June 30, 2026	122
Number of complaints carried over into SFY 2026	28

New Complaints in SFY 2026 concerned people with the following issues

Note the number of complaints in each issue category does not necessarily correlate to the seriousness of the issue system wide. For example, research shows that abuse and neglect occur at a high rate for people with developmental disabilities and it is underreported.

Most new complaints opened in SFY 2026 concerned:

- Administration including discharge/transfer planning from hospitals and residential services;
- individual care including access to DDA services;
- autonomy and exercise of rights; and
- abuse, neglect, and exploitation.

Complaints by Issue

Abuse, Neglect, Exploitation - 11 complaints concerning: Verbal abuse 2 financial Exploitation 3, Neglect 2, Personal safety Planning 2, Other Abuse/neglect 2.

Access to Information - 3 complaints concerning: Access to Visitors 3.

Autonomy and Exercise of Rights - 25 complaints concerning: Dignity/Respect 4, Right to Refuse Care/Treatment 1, Care Planning 6; Guardianship 6; Response to Complaints 1, Retaliation 1, Personal Funds 2, Personal Property 1, Other autonomy/exercise of rights 3.

Individual Care - 34 complaints concerning: Care plan individual assessment 7, Assistive devices or equipment 3, Access to communication 1, Mental Health Services 1, Therapies 1, Access to DDA Services 17, Access to other state services 2, and Healthcare 2.

Quality of Life - 2 complaints concerning: Active integration into community 2.

Administration – 40 complaints concerning: Administrator unresponsive 2, Inappropriate or illegal administration 5, and Discharge/transfer planning (33).

Staffing - 2 complaints concerning: Shortage of staff 1, Staff training 1

Civil/Legal - 1 complaint concerning: Civil commitment (1)

Criminal Legal -1 complaint concerning: Criminal Justice issues (1)

Complaint Data – Summary, Analysis, and Identification of Systemic Issues

DD Ombuds resolves individual complaints and looks for patterns that may indicate a systemic issue. Categories with the highest number of complaints include:

Discharge/Transfer. The number one type of complaint DD Ombuds assisted with were Administration issues, primarily discharge/transfer. DD Ombuds continues to assist people who were in a hospital and unable to discharge into community services this fiscal year. DD Ombuds identified this as a significant systemic issue in 2018, published a report, "Stuck in the Hospital" and made specific recommendations to address this issue. Toward the end of SFY 2022, DD Ombuds received an increase in the number of referrals of both children and adults stuck in the hospital. DD Ombuds researched the issues with children stuck in the hospital and published a report "I Want To Go Home" in SFY 2023. Although the state has made efforts to address this issue, we continue to have significant concern for both children and adults with developmental disabilities. SFY 2026 data shows statewide 94 patients waited for more than 7 days for discharge after being medically cleared (this may include repeats). Statewide a total of 13 patients were waiting to be discharged after 100 days of being medically cleared. Hospitals are not residential service providers. No one should have to wait for services and supports while languishing in a hospital.

Individual Care. Most of the individual care complaints were about access to DDA services. DD Ombuds has identified access to behavioral supports, access to mental health care, need for increased waiver funding for clients waiting for service, the wait times for assessments and the simplification and timeliness of the eligibility process as systemic issues to be addressed.

Autonomy and exercise of rights, which includes dignity and respect. DD Ombuds helped individuals and their families' problem solve with their service providers and their case managers to address these issues. DD Ombuds identified Preference, Rights, and Choice as issues to address systemically. DD Ombuds has worked with many people who have restrictions in their plans that do not follow the rules for restrictions. They often do not have a copy of their program plan or know what they need to do to challenge the restrictions. This continues to be a significant area of advocacy.

Abuse/neglect. DD Ombuds assisted people who had complaints about abuse, neglect, or exploitation. The DD Ombuds works with the person to explain their rights and ways to complain. Often people want to complain but do not know how or where to complain. Sometimes people are

afraid to complain for fear of retaliation. DD Ombuds identifies gaps or problems in the abuse response system and advocates for systemic improvements.

Complaint Resolution - Examples of assistance provided by DD Ombuds in SFY 2026

1. Summary of complaint: The DD Ombuds received a complaint about a person who was having ongoing issues with their Adult Family Home and the level of care they were receiving**.**

Outcome: The DD Ombuds worked with the person, their family and their DDA Case Resource Manager to review their DDA assessment and care plan. It was found that the person could qualify for the Core Waiver and Supported Living services. The person found a Supported Living Provider that could meet their care needs. The DD Ombuds then visited the Adult Family Home to meet the other residents and visit with them to see if they were getting their service needs met, and to inform them about the DD Ombuds work.

2. Summary of complaint: The DD Ombuds received a complaint from parent who was having a difficult time accessing Specialized Clothing and Equipment/Supplies.

Outcome: The DD Ombuds met with the parents and reviewed the clothing and equipment they requested. We then worked with the DDA Case Manager to review the request and find out what is needed to have the request approved. The family was able to get the correct documentation needed to submit to the request. The person was approved for Specialized Clothing and Equipment.

3. Summary of complaint: The DD Ombuds received a complaint about a person who was in and out of the hospital because their residential provider was calling emergency services to help de-escalate conflicts.

Outcome: The DD Ombuds met with the person and provider and worked to update their Positive Behavioral Support Plan and how they will work their staff. Then we met with their DDA Case Manager to update their assessment and bring more supports to that person's home to avoid involvement of emergency services and hospitalization.

4. Summary of complaint: A person receiving DDA services contacted the DD Ombuds after learning from DSHS that their eligibility for services was at risk because they did not respond to a request for more detailed information. This eligibility section within DSHS only provides a general phone line for people to call in and verbally answer questions or provide information. The person communicates primarily in writing as their disability affects their ability to be understood verbally. The person could not provide necessary information by phone and did not want to rely on others to do it for them.

Outcome: The DD Ombuds reached out to DSHS leadership to explain that some people receiving services cannot communicate verbally by phone because of their disability. We discussed the importance of accommodating communication needs, and the frustration people experience when forced to rely upon others to provide information on their behalf. After learning more about communication access needs, the DSHS employees offered to provide a direct email address, allowing the person to communicate the necessary details independently.

5. Summary of complaint: The DD Ombuds received a complaint from a person receiving DDA residential services who had experienced years of unresolved conflict with their roommate. The conflict escalated to police involvement, assault charges, restraining orders, and risk to the person's housing. When the person raised concerns about failed individual services plans and ongoing problems with the service provider and DDA. The provider terminated services instead of working to resolve the issues.

Outcome: The DD Ombuds requested a meeting with DDA to understand why services were terminated and why the conflict had remained unaddressed for so long. After reading the termination letter, the provider's failure to implement a Positive Behavior Support Plan (PBSP) was obvious and the language they used to describe the person was derogatory and misleading. The DD Ombuds made a complaint to RCS. The DD Ombuds learned that abuse and neglect concerns between the roommates had been reported for years to DDA, RCS, and Adult Protective Services. Although some concerns were investigated, none resulted in findings of abuse or neglect. DDA case managers and supervisors had long known about the difficulties between the roommates, but the issues persisted. DDA's plan was to keep the roommates isolated from each other in their shared home. The person's PBSP and incident reports showed that, rather than preventing challenging behaviors and teaching alternative skills as required, the person was provoked, including through name-calling, and then punished for reacting. The DD Ombuds met with DDA and RCS leadership to highlight the violations of the plans and the failures to hold contractors accountable to provide the service they were being paid to provide. DDA acknowledged that they didn't read the plans and that there was an absence of quality reviews or a culture to hold providers to account. RCS did not agree with the DD Ombuds concerns and found that there was "no failed provider practice." The DD Ombuds will continue to illustrate the presence of punishment and name calling in plans to both RCS and DDA with the hope that their ability to recognize it as abuse will increase.

6. Summary of complaint: The DD Ombuds received a complaint that youth transitioning from a nursing facility were not being enrolled in DDA services in time for their discharge. Despite DDA being made aware of the delays in intake and eligibility months prior to the youth's discharge date, the youth discharged from the nursing facility without access to vital DDA services they needed in order to live in a non-nursing facility environment at home with their families.

Outcome: DD Ombuds communicated with DDA regarding the communication issues between intake and eligibility versus transitional case management that were leading to exceedingly vulnerable youth to discharge from a nursing facility without vitally needed services. DD Ombuds is still working with DDA so that they have a systematized process to ensure medically vulnerable youth discharging from facility settings have access to services

7. Summary of complaint: A transgender person at a state psychiatric hospital was transitioning to DDA's community residential services program. Many on the person's transition team were supportive of their gender identity, however, there was still a broad lack of knowledge and stereotypes that prevented the person from receiving gender affirming services they needed.

Outcome: With DD Ombuds supporting the person's advocacy, the person was able to transition to a community supported living provider that helped the person access gender affirming healthcare. DD Ombuds was also able to work with the state psychiatric hospital, DDA, and their supported living provider to support them all receiving technical assistance so they received training on gender identity and the queer community.

8. Summary of complaint: The DD Ombuds received a complaint that someone at a state psychiatric hospital needed access to Substance Use Disorder (SUD) services as part of their discharge requirements. However, no outpatient SUD providers would offer them services because providers claimed to not serve intellectually and developmentally disabled people. Healthcare Authority (HCA) did not consider this discriminatory against developmentally disabled people. Because this person could not leave the state hospital until they had access to an outpatient SUD provider, the person was not able to transition to the community.

Outcome: After attending the person's transition planning meetings, DD Ombuds successfully advocated for DDA and the person's insurance to work with a local mental health provider to provide wraparound mental health and SUD services in the community. The person was able to discharge from the hospital. In the future, DD Ombuds will continue to monitor discriminatory standards that bar intellectually and developmentally disabled people from receiving SUD services.

Monitoring

DD Ombuds engaged the community through 227 in-person monitoring visits, including 132 visits to people receiving supported living services, across the state in SFY 2026. We talked with individuals with developmental disabilities and reviewed facilities, residences, and programs. Monitoring visits accomplished several purposes. People who receive services, their families, their staff, and provider administrations receive information about DD Ombuds. DD Ombuds provides materials such as refrigerator magnets, door hangers, and coasters that have information about DD Ombuds and client rights. DD Ombuds observes living conditions and staff interactions and responsiveness to the residents they support. DD Ombuds listens to the concerns of the people and also receives complaints, initiates complaints, and identifies locations for follow-up monitoring.

DD Ombuds made 227 visits in person to the following facilities, residences, and programs:

Certified Residential Services Settings	**Number of visits**
Supported Living	**101**
Supported Living Community Protection Program (CPP)	**16**
State Supported Living – SOLA	**15**
Group Training Home	**0**
Total Visits	**132**

Licensed Residential Settings	Number of visits
Adult Family Homes	**15**
Assisted Living Facilities	**7**
DD Group Home	**0**
Nursing Home	**3**
Enhanced Respite Children & Youth	**1**
Enhanced Services Facility	**1**
Total Visits	**27**

State Residential Habilitation Centers	Number of visits
Fircrest Intermediate Care Facility ICF	**12**
Fircrest NF	**1**
Lakeland ICF	**5**
Lakeland NF	**4**
Rainier	**20**
Yakima NF	**12**
Total visits to cottages or programs at RHCs	**54**

Hospitals and Community Psychiatric Facilities	Number of visits
Adult Community Psychiatric	0
Eastern State Psychiatric Hospital	3
Western State Psychiatric Hospital	2
General Hospital	1
Total visits	**6**

Youth Transitional Facility	Number of visits
Lake Burien	5
Total visits	**5**

Parent, Other Relative Home, or Own Home	
Parent Home	2
Other Relative Home	1
Total visits	**3**

Total monitoring visits in SFY 2026	227

Systemic Change Outcomes

DD Ombuds identified numerous systemic issues through monitoring visits and complaints, and recommended system improvements. As a result, the following policies, procedures, or practices were changed or progress made toward improvement.

1. Eliminate the harm caused by DDA's Community Protection Program (CPP).

Problem: The Community Protection Program has resulted in segregation, prolonged hospitalization, and denial of community living for some people. DDA has often not followed eligibility criteria which resulted in people getting swept into the program. Although against the federal Home and Community Based Services rules, many people in DDA's Community Protection Program have been isolated for decades with their most basic human rights restricted. Many people in the program complain of having "no way out."

The DD Ombuds has long advocated for eliminating CPP while ensuring that people in the program do not lose needed services. The Legislature's decision to end CPP, and the Governor's approval of the bill, marked important progress. However, problematic CPP training remains required for all staff and continues to teach that people in CPP are manipulative, dangerous, and not credible.

DDA stated that it sought legislation to end CPP because the program restricts people's rights, limits their choices about services, and isolates them from the community, but once the legislation was signed, the people heard nothing.

Outcome: The DD Ombuds has long called for the elimination of the CPP and for DDA to guarantee that the people in it do not lose services as a result. DDA committed to agency request legislation to eliminate the CPP which was introduced in the 2025 session and passed in the 2026 session! However, DD Ombuds immediately began getting complaints from several people receiving CPP services who had not heard from DDA about how their services would change when the law changes. They reported that their DDA Case Resource Managers did not have information and told them that nothing should change. Some said their staff did not believe them when they explained that CPP was ending. Others lost access to necessary therapy, with no apparent urgency or action from DDA to address the problem. The DD Ombuds has repeatedly raised concerns with DDA about the need to communicate directly with people in the program about what is happening. DDA has failed to share information with the people most affected and has responded with vague assurances rather than

meaningful updates. CPP providers raised similar concerns about DDA's failure to communicate or implement plans, which puts services and housing at risk.

The DD Ombuds continues to attend meetings at the request of people in CPP who still must advocate for basic dignity and respect, or prove they should be allowed ordinary rights such as having an email address, a cell phone, or visits with friends.

2. Improve services for youth with developmental disabilities and behavioral health needs.

Problem: Children and youth with developmental disabilities have difficulty accessing behavioral support services which has led to hospitalization, institutional care, and youth being sent to out of state facilities. Outcomes for Youth in state run facilities have been poor.

Outcome: DD Ombuds visits state run facilities to build relationships with youth and their guardians. DD Ombuds participated in the Children and Youth Behavioral Health Workgroup. Within the group the DD Ombuds shared concerns about youth going to institutional settings and lack of access to community based services for youth with developmental disabilities. The DD Ombuds collaborated with other members of the group to work on solutions. New legislation and policy changes were created based on the recommendations of the workgroup.

3. Identify and fix systemic gaps with Washington's abuse investigations and mortality reviews. Problems: Mortality Reviews; the END HARM line; and RCS Lack of Enforcement

3a. Mortality Reviews

Problem: In SFY 2024, The DD Ombuds uncovered numerous systemic gaps with how suspicious deaths are reported and investigated by DDA and RCS. These gaps lead to suspicious deaths not being reported and abuse/neglect investigations being unfairly biased towards service-providers. This lack of accountability could put disabled people at-risk for increased abuse and neglect.

Outcome: The DD Ombuds advocated for DDA and RCS to change their policies so that they would not be biased towards service-providers and clarified the definition of suspicious death. In response to the DD Ombuds criticisms, DDA made significant changes to their policies related to suspicious deaths, and abuse and neglect. The DD Ombuds are still in conversation with RCS about what they can do to improve how they respond to suspicious deaths.

3b. END HARM Line

Problem: There is a toll-free phone number established by DSHS and the then Children's administration to have one place for the community to report to a live person 24/7 abuse of children or vulnerable adults (seniors and people with disabilities in facilities, people with developmental disabilities.) The DD Ombuds assisted someone with making a call to the END HARM line and discovered it was very confusing and shuffled the caller to a line that was not answered by a live person. The instructions also referred the caller to a website URL.

Outcome: The DD Ombuds raised this issue with DDCs, RCS and HCLA. At first people were sure the line was a resource for people to report abuse of vulnerable adults – until they called the line themselves. All agreed the line needed to change and we learned DCYF oversaw its operation. HCLA

arranged for a meeting with DCYF. The initial meeting was to outline the problem. Since it was decided it was a multi administration issue, there is a need to take it higher up in the agencies. DDA changed its website and materials concerning END HARM line, so they are accurate. The END HARM line is still not a good resource for reporting vulnerable adult abuse 24/7. We will continue to work on this issue.

3c. Residential Care Services Lack of Enforcement

Problem: DSHS and a DDA certified residential provider settled a lawsuit alleging that a person was abused and neglected while in their care. During the period the person was receiving residential care, there were numerous complaints filed and investigated. However, only one citation was issued by RCS, the DSHS agency responsible for rule enforcement, and it was unrelated to the issues raised in the lawsuit. The DD Ombuds has long-standing concerns about the failures of RCS to enforce client rights and HCBS rules. If the agency responsible for rule enforcement found no failed provider practices, yet DSHS settled the lawsuit concerning abuse and neglect, this highlights a significant gap in rule enforcement and puts people at further risk of harm.

Outcome: We continue to monitor RCS's response to complaints and enforcement of rules and make recommendations for improvement.

4. Reform DDA's assessment language and advocate for reforms.

Problem: The DD Ombuds continues to report that DDA's assessment requires everyone to be assessed using harmful terms and subjective language.

- DDA's assessment uses subjective and harmful labels, including *attention-seeking*, *over-reactive*, *obsessive*, and *uncooperative*.
- This judgment-based approach affects tens of thousands of people who rely on DDA services.
- Such language can cause support staff and emergency responders to question the credibility of people with developmental disabilities.
- When people at high risk of abuse or neglect are not believed, they become more vulnerable to further harm.

Outcome: Continued advocacy and documented harms - DDA leadership has acknowledged to the DD Ombuds that its assessment contains subjective and harmful language. However, in waiver amendments and renewals submitted to CMS, DDA has denied that the assessment raises concerns and, to date, has not removed the language. Much of the harmful language appears in a separate Washington DDA section added to the nationally normed assessment.

The DD Ombuds continues to show DDA leadership how harmful, judgmental assessment language causes real-world harm. We have identified numerous Person-Centered Service Plans written by DDA personnel and Positive Behavior Support Plans written by contractors that contain exaggerated or derogatory statements about the people they should support. We have reminded DDA of its responsibility to ensure that these plans use positive interventions and exclude name-calling and other punitive practices.

5. Improve education about Supported Decision Making

Problem: Washington State enacted Supported Decision Making, but it is not widely known or used.

Outcome: The DD Ombuds has presented on Supported Decision Making and is working with DDA, the Developmental Disabilities Council and Advocates about how to expand the use of Supported Decision Making. The DD Ombuds worked with self-advocacy groups to develop a Supported Decision Making training that has been given to DDA providers, parents, and other self-advocates. The DD Ombuds will continue to advocate for access to this service.

6. Monitor DDA's implementation of Home and Community Based Settings (HCBS) Rule

Problems:

Ongoing violations and inadequate oversight - In FY23, the DD Ombuds highlighted DDA's failure to implement the HCBS Settings Rule and monitored the rollout of new policies and training for staff and providers. Since then, we have continued monitoring these critical safeguards. People receiving DDA services continue to report that DDA employees and service providers exert control over their lives in ways that violate the rule.

Insufficient safeguards and enforcement - The DD Ombuds continues to urge DDA leadership to take stronger action to prevent these violations. Thousands of DDA contracted providers across Washington agree to uphold client rights and comply with state and federal law. We have reported numerous apparent violations, particularly PCSPs that do not document required safeguards. Yet we have seen little evidence that DDA verifies whether safeguards were considered and documented before a person's rights were restricted.

Outcomes:

Federal findings and a new assessment section - In FY23, the DD Ombuds alerted CMS to unauthorized restrictions in HCBS settings, particularly within CPP. CMS visited Washington DSHS in September 2023 to review health and welfare concerns and issued a findings letter in March 2024. CMS agreed that some program-completion goals were unfair and unrealistic, including requirements for "no sexual thoughts, no cussing and no aggression." In FY25, DDA added a section to its annual assessment addressing eight questions required by the HCBS Settings Rule to prevent unfair and unrealistic goals that restrict basic rights. However, DDA has provided little oversight and virtually no standards for how Case Resource Managers should meet this requirement.

Persistent implementation gaps - New policies took effect in FY24 to train providers and case managers on these requirements. Nevertheless, throughout FY25 and FY26, we routinely encountered providers and case managers who were unaware of the rules. In FY25, DDA headquarters indicated that it would emphasize contract compliance and enforcement. In FY26, we continued to provide DDA's HCBS policy teams with examples of PCSPs that lacked required safeguards. To date, DDA has declined to acknowledge that any of these PCSPs are noncompliant.

Concerns with draft HCBS provider rules - DDA is substantially revising the rules governing HCBS providers under the Washington Administrative Code. Although DDA was required to share the draft

with the DD Ombuds, it initially declined to do so. DDA later provided the draft and indicated that the DD Ombuds would remain involved, but no further involvement has occurred. Our review found that the draft made it harder for people to understand their rights while making it easier for providers to restrict them. We submitted comments on more than 50 pages of proposed rules. Rather than revising provisions on rights, restrictions, and Positive Behavior Supports, DDA announced that it would postpone changes to those sections. DD Ombuds will continue to monitor.

7. Advocate for improvements to DDA's Positive Behavior Support Plan processes.

Problem: The DD Ombuds continues to raise concerns about DDA's oversight and development of functional behavior assessments and Positive Behavior Support Plan (PBSP). The DD Ombuds has also alerted DDA to problematic PBSPs that include threats, punishment, and restrictions of rights.

Outcome: DDA has reorganized some clinical teams and new training has been implemented for PBSP plan writers. However, the DD Ombuds remains concerned about the quality of PBSPs that still include punishment and restrictions of rights and continues to raise these concerns with leadership. The DD Ombuds has learned that reviewing individual plans is outside the scope of most leadership positions. Leadership is often surprised when they read the harmful language some plans use to describe the people they are intended to support.

DDA must provide effective Positive Behavior Support training to reduce practices that place people eligible services at greater risk of abuse and neglect. Training should teach Case Resource Managers (CRMs) and contracted providers to distinguish punitive practices from reinforcement-based strategies and recognize punishment as a form of abuse.

8. Protect the DD Ombuds' access to information for complaint investigations and monitoring.

Problem: Delayed and restricted access to information
The DD Ombuds relies on timely, accurate information from DSHS to investigate complaints and fulfill its monitoring responsibilities. DDA responses to information requests, are often delayed, often requiring repeated reminders or correction of inaccurate record submissions. These delays consume limited resources, impede investigations, and interfere with the office's statutory duties. DDA also restricts the DD Ombuds' ability to present directly to case managers at some staff and regional meetings.

Outcomes:

Procedural improvements, but persistent delays - DDA agreed to revise its procedures for responding to DD Ombuds requests. In February 2024, the DD Ombuds proposed updates to DDA's management bulletin establishing response procedures and timelines; DDA implemented the revised bulletin in early 2025. Despite this progress, obtaining necessary information from DDA and other DSHS administrations remains difficult. The DD Ombuds continues to explore ways to preserve its independence from the service system and fulfill its statutory duties. FY26 data showed that DDA took an average of 25 business days to provide requested records.

Direct employee education - DDA recently agreed to work with the DD Ombuds to develop a training video for new employees. Direct communication with DDA employees is a positive step toward improving awareness of the office's role and addressing persistent abuse and neglect of people receiving DDA services.

9. Monitor Critical Case Protocol implementation and advocate for improvements

Problem: DDA clients were having their residential services terminated and being taken to general hospitals or other less supportive environments while new placements were sought. DDA created a new policy, the Critical Case Protocol (CCCP), as a way to prevent hospitalizations and have people stay with their current supported living provider. However, instead of problem-solving so the person can maintain their placement, some providers appear to be using the process as a discharge plan

Outcome: DD Ombuds provided recommendations to DDA on how to create person-centered meetings for people with developmental disabilities to give input on their services, what would help them be successful, and how they can best be served. DD Ombuds continues to monitor this process and bring concerns to DDA when providers use the process to terminate services.

DD Ombuds comments on Washington Administrative Code (WACs)

Developmental Disabilities Administration Service Rules

Throughout FY25 and FY26, DDA has been drafting changes to the 388-101D WACs, which govern requirements for residential service providers. DDA filed a CR-101 but failed to notify the public that rule development had begun. After the DD Ombuds alerted DDA to this failure, DDA withdrew the CR-101 and said in FY26 it planned to work extensively with the DD Ombuds and service providers to draft the rules. This has not occurred. Recently DDA indicated they would not be changing the WAC's that govern Positive Behavior Support Plans or Home and Community Based Services – two of the areas of rules where we see the most abuse and neglect of people in DDA services. We will continue monitoring the rule-development process and asking DDA to involve our office so we can identify problematic rules that may contribute to abuse and neglect of people with developmental disabilities.

DD Ombuds comments on Home and Community Based Services Waiver Amendments

DDA did not submit any HCBS waiver applications or amendments this year. We are monitoring and expecting significant changes to be submitted in FY27.

Legislative recommendations and outcomes (SFY 2026)

One of the DD Ombuds duties is to make recommendations to the Washington State legislature. Each year the DD Ombuds reviews proposed legislation and weighs in on the issues important to people with developmental disabilities.

HB 1390- Repealing the community protection program.
The DD Ombuds testified in support of the bill. This legislation is the result of work the DD Ombuds have put in educating the community about the Community Protection Program. The DD Ombuds have reports about concerns with the Community Protection Program (https://ddombuds.org/wp-content/uploads/2022/07/No-Way-Out-Short-Version-6-13-22.pdf
The bill passed. The bill Removes references to the Community Protection Program from statute effective January 1, 2027. Requires the Developmental Disabilities Administration to develop and implement a plan to transition all individuals participating in the Community Protection Program into other services or programs by December 31, 2026.

SB 5863/ HB2252 - Concerning the preservation and inspection of state historical records
The DD Ombuds testified in support of the bill. The bill passed. Extends the period when no documents or artifacts identified as part of the Lakeland Village preservation plan may be destroyed, until fiscal year 2030. This could allow for records at Lakeland Village to be reviewed and saved to help tell the stories of people who lived in Lakeland Village.

SB 2350 - Increasing transparency regarding residential habilitation center compliance with certain federal requirements.
The DD Ombuds testified in support of the bill. The bill passed. Requires the Department of Social and Health Services, whenever it is notified that a residential habilitation center (RHC) is out of compliance with Centers for Medicare and Medicaid Services requirements, to provide notice of the noncompliance and certain other related notices at the affected RHC and to designated persons.

HB 2415 - Concerning unexpected fatalities of residents of department of social and health services facilities.
The DD Ombuds testified in support of the bill. The bill did not pass. Requires the Department of Social and Health Services (DSHS) to convene an unexpected fatality review team (including the DD Ombuds) to conduct a review upon the unexpected death of any resident of a DSHS facility.

HB 2200 - An act relating to increasing access to data related to the safety and stability of residential settings for individuals with developmental disabilities.
The DD Ombuds tracked and provided information to legislators and the community. The bill did not pass. It requires the Joint Legislative Audit and Review Committee to conduct a review and report to the Legislature regarding safety and stability outcomes across the Department of Social and Health Services (DSHS) developmental disabilities residential services continuum. Directs the DSHS to produce an annual report on emergency service utilization and placement stability for contracted residential settings as compared to state-operated residential settings for clients with developmental disabilities.

HB 2429 - Supporting children and youth behavioral health.
The DD Ombuds testified in support of the bill. The bill passed. Extends the Children and Youth Behavioral Health Work Group two years, until December 30, 2031. Requires the Governor to maintain an executive coordination officer for the children and youth system of care for the purpose of monitoring the implementation of a strategic plan for children and youth behavioral health.

Requires the Governor to establish a leadership council to address children and youth health and wellness issues and coordinate efforts to implement the strategic plan.

HB 2230 - Streamlining monitoring and oversight activities related to community residential service business providers.
The DD Ombuds testified other on the bill. The bill passed. The bill would Limit the Department of Social and Health Services (DSHS) to no more than one annual routine review of community residential service business providers in specified areas and requires the DSHS to combine review activities from multiple areas where possible. Require the DSHS to adopt rules or policies that require document and record sharing between and within DSHS divisions when performing monitoring and oversight of residential community service business providers. The DD Ombuds wants to ensure that people receiving services are receiving them from Residential Providers who are meeting state requirements.

SB 5654/HB 1795 Addressing restraint or isolation of students in public schools and educational programs.
The DD Ombuds signed in support of the bill. The bill did not pass. The bill would have: created limits to restraint and isolation of students, including by prohibiting chemical and mechanical restraint; modified requirements for incident notification, incident review, incident reporting, behavioral intervention planning, and policies and procedures; added staff and governing body training requirements; established state compliance monitoring and support, including, subject to appropriation, trainings and coaching services; and required multiple reports from agencies to the Legislature.

HB 1200/ SB 5211- Authorizing payment for parental caregivers of minor children with developmental disabilities
The DD Ombuds signed in support of the bill. The bill did not pass. The bill would require the Department of Social and Health Services to submit a request to amend applicable home and community-based services waivers to allow parents to receive payment for providing extraordinary personal care services.

HB 2319- Renaming certain state residential facilities for persons with developmental disabilities.
The DD Ombuds tracked and provided information to legislators and the community. The bill did not pass. The bill would rename Fircrest School the Fircrest Residential Habilitation Center, Rainier School is renamed Rainier Residential Habilitation Center, and the Yakima Valley School is renamed the Yakima Valley Residential Habilitation Center.

HB 2688- Providing adjustments to the early support for infants and toddlers program.
The DD Ombuds tracked and signed onto a letter to legislators and helped educate the community. The bill did not pass. The bill changes the multiplier for the Early Support for Infants and Toddlers program funding formula from aligning with the special education excess cost multiplier for prekindergarten students to a set multiplier of 1.00. This cut services to youth and families.

HB 2314- Concerning dental care services at residential habilitation centers - The DD Ombuds tracked the bill and helped self-advocates and community members understand the bill and know how to give input. The bill did not pass. The bill would require the Department of Social and Health Services to establish a pilot allowing certain clients with developmental disabilities who live in community settings to access dental services at residential habilitation centers.

SB 5823- An act relating to patient advocates. The DD Ombuds tracked the bill and helped self-advocates and community members understand the bill and know how to give input. The bill did not pass. The bill would require that licensed hospitals, on or before January 1, 2027, must have at least one person physically present every day in the acute care setting to assist patients navigating the health care system on the patient's behalf or provide patients with access to a patient advocate through a patient advocacy service.

SB 5681- Concerning the age at which clients of the home and community living administration may receive employment and community inclusion services. The DD Ombuds met with advocates for the bill along with self-advocates to help people understand what the bill would do and how to give input. The bill did not pass. The bill allows clients of the Home and Community Living Administration of the Department of Social and Health Services to begin receiving employment and community inclusion services beginning at the age of 20.

SB 5156-Concerning elevator standards in smaller apartment buildings- The DD Ombuds met with advocates for the bill along with self-advocates to help people understand what the bill would do and how to give input. The bill passed. The bill changes elevator standards in apartment buildings.

Budget Bills – DD Ombuds testified on the state budget, advocating for more funding for DD services in community settings. DD Ombuds focused on Caseload growth, against caseload reduction for DDA Case Resource Managers, funding for community capacity to transition clients out of residential habilitation centers to community settings, Community Supports for children and their families who are caring for the youth with significant behavioral challenges, and Residential Crisis Stabilization Programs.

DD Ombuds Reports on Systemic Issues

The DD Ombuds publishes reports on systemic issues to highlight the need for improvements and make recommendations.

Investigating the Lake Burien Transitional Care Facility (2026)

DD Ombuds published *Investigating the Lake Burien Youth Transitional Care Facility* in January 2026. The report conveyed DD Ombuds' serious concerns with the Lake Burien Youth Transitional Care Facility (Lake Burien) due to its organizational mismanagement, lack of regulatory oversight,

widespread abuse and neglect allegations, and the facility's use of isolation and restraint. For these reasons, DD Ombuds published the report to alert advocates to the abusive and neglectful environment found at Lake Burien. To provide humane and therapeutic services, DD Ombuds advocated for Lake Burien to implement regulatory oversight, maintain accurate and transparent incident reporting and abuse investigation findings, and end its dependency on physical de-escalation tactics. To improve services for youth in Washington, DD Ombuds advocates for Washington to re-prioritize investment in community-based care.

The DD Ombuds' report spurred change at Lake Burien that included replacing the Executive Officer and clinical staff, the facility beginning to re-evaluate and modify its policies and protocols, and receiving Department of Health (DOH) licensure and Joint Commission (JCO) accreditation. However, it remains to be seen if Lake Burien's initial changes translate to long-term positive improvements for the facility. DD Ombuds still receives regular complaints from families about the facility's discharge and transition planning processes, including youth discharged without community supports in place. DD Ombuds continues to receive allegations of serious abuse and neglect. Also, there still has not been any meaningful reinvestment in Home and Community Based Services (HCBS) for Washington's youth.

Rainier Report

The legislature added a duty in the 2025 session for the DD Ombuds. By November 1, 2028, and in compliance with RCW 43.01.036, the office of the Developmental Disability Ombuds shall submit a report to the appropriate committees of the legislature that includes summaries of resident, parent, and guardian feedback regarding transition of residents out of the Rainier school following the effective date of this section, July 2025

Less than 70 people live at Rainier Residential Habilitation Center in Buckley, WA. Most people have moved out into the community. Soon, Rainier can no longer accept new long-term residents. As people move, the DD Ombuds will gather information from the residents and their family and guardians about their transition into the community. The report is due in November of 2028.

Stuck in the Hospital

The issue of children and adults with developmental disabilities stuck in hospitals and unable to discharge is still prevalent in 2026.

DD Ombuds published the "Stuck in the Hospital" report in December 2018. The report responded to the high volume of complaints DD Ombuds received about adults with developmental disabilities stuck in a hospital without any medical need. Most of these individuals were Developmental Disabilities Administration (DDA) clients who had been receiving residential services prior to hospitalization. Some individuals went to the hospital for a medical condition, but when they were ready for discharge, they had no place to go because their residential services provider had terminated their services. Other individuals were dropped off at the hospital by a provider who could no longer manage their care. These individuals with developmental disabilities spent weeks or months or years in a hospital because DDA could not locate available residential placement with staff to provide care. As a result, these individuals had to live in hospitals while waiting for residential

placement. In SFY 2023, DD Ombuds published the report, "I Want to Go Home – Reevaluating DDA' Children's Services to Prevent Hospitalization and Out of State Placement".

Children and adults with developmental disabilities continue to be boarded in community hospitals without a medical need. They are not receiving the habilitative services they need, sometimes they are restrained and cannot go outside for the duration of their stay. Hospital staff often have not received the training they need to work with individuals with developmental disabilities. Hospitals do not have the capacity to board individuals who have no medical need to be hospitalized.

Community Protection Program

DD Ombuds focused this report, "No Way Out - An Introduction to the Community Protection Program", on the Developmental Disabilities Administration's (DDA) Community Protection Program (CPP). DD Ombuds hears many complaints regarding CPP. This report provides background on CPP and identifies concerns resulting from monitoring and complaint investigation. Since this report the DD Ombuds has been advocating for the elimination of the program and for people to move to other DDA services. DDA proposed agency request legislation which passed in 2026. The Legislature's decision to end the program and the Governor's approval of the bill marked important progress. However, staff must still complete problematic training that portrays participants as manipulative, dangerous, and not credible. At the request of CPP participants, the DD Ombuds continues to attend meetings where they must advocate for basic dignity and respect—or justify ordinary rights, such as having an email address or cell phone and visiting friends. The program will end, most likely in 2028. The DD Ombuds will continue to make recommendations for improved transitions.

Office of Developmental Disabilities Expansion Plan

DD Ombuds proposed in November 2019, an expansion plan based on DD Ombuds experience providing services, analysis of the LTC Ombudsman Program model and stakeholder input. The DD Ombuds has learned that it will receive increased funding in SFY 2027 to expand services. DD Ombuds continues to do this important work and will be able to serve more people across the state with additional resources. SFY 2027 we will be able to hire a Deputy Director and new DD Ombuds in each of the three regions.

Key areas of focus for expansion

- Reach people with developmental disabilities in rural areas and isolated settings.
- Reach people with developmental disabilities from diverse communities.
- Increase visits to people with developmental disabilities living in certified and licensed residences.
- Increase number of complaints resolved/closed from people living in the community.
- Increase capacity to respond to incidents which affect groups of people with developmental disabilities, such as a facility closure or provider decertification.
- Increase capacity to provide self-advocacy trainings and support.
- Increase capacity to work with policy makers on improvements to the service system.

Annual Report Conclusion

The DD Ombuds staff are dedicated to listening to the concerns and complaints of individuals with developmental disabilities and their families through multiple ways of community engagement. The DD Ombuds works with individuals to resolve their complaints and when necessary, takes action at the systemic level to improve systems of supports. The DD Ombuds learns of the barriers people and their families face to get the services they need. As evidenced by the information in this report, much progress has been made in SFY 2026 and the need for the DD Ombuds work continues.

Questions or comments about this report?

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