STATE OF NEW YORK
OFFICE OF THE INSPECTOR GENERAL
EMPIRE STATE PLAZA
AGENCY BLDG. 2, 16TH FLOOR
ALBANY, NEW YORK 12223
(518) 474-1010

61 BROADWAY, SUITE 2100
NEW YORK, NEW YORK 10006
(212) 635-3150

65 COURT STREET, 5TH FLOOR
BUFFALO, NEW YORK 14202
(716) 847-7118

Catherine Leahy Scott
INSPECTOR GENERAL

October 17, 2014

Jeff Wise
Executive Director
New York State Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310

RE: NYS IG 0166-031-2011

Dear Executive Director Wise:

My office received numerous complaints pertaining to the Office for People With Developmental Disabilities (OPWDD) from [redacted] alleged that OPWDD did not maintain the appropriate minimum number of supervisory staff at Individualized Residential Alternatives (IRAs) during nights, weekends and holidays, and that OPWDD's Capital District Developmental Disabilities Services Office (DDSO) inadequately trained staff on van safety during accidents and fire training evacuations. We reviewed these allegations with officials of the former New York State Commission on Quality of Care and Advocacy for Persons with Disabilities. As these allegations relate to potentially ongoing issues that impact the health and safety of individuals with special needs, we are now referring these matters for your review as appropriate.

Regarding [redacted] claim of inadequate supervisory staffing relative to OPWDD employees, we reviewed OPWDD regulations addressing supervisory staffing requirements at OPWDD's institutional and community residences (14 NYCRR 633.6). OPWDD regulations require that each facility establish written policies and procedures relative to the supervision of employees that, at minimum, identify all line and on-site supervisors and their responsibilities, and provide a mechanism whereby employees are made aware of the identity and availability of their supervisors, among other things. The regulation, however, does not address the number or ratio of supervisors that must be available to employees or present at IRAs. OPWDD advised that although it maintains no

written policy directly addressing staffing requirements at its community residences relative to employee supervision, staffing patterns are part of each individual site Protective Oversight Plan and vary according to the needs of the population.

OPWDD also advised that staffing requirements relative to clients' needs at its Intermediate Care Facilities (ICFs) are governed by Centers for Medicaid and Medicare Services (CMS) regulations (see, 42 CFR 430(d) and CMS Interpretive Guidelines W186-188). These regulations require facilities to provide "sufficient" direct care staff to manage and supervise clients in accordance with individual program plans.

In light of these concerns, I recommend that the Justice Center evaluate the efficacy of the regulation and accompanying practices to determine if supervisory oversight is sufficient during off-shifts within OPWDD community residences and if OPWDD should promulgate policy directly addressing supervisory staffing requirements at its community residences.

Regarding [redacted] claim of inadequate staff training pertaining to van safety during accidents and fire training evacuations, [redacted] referenced an email he sent on October 22, 2009, to then-OPWDD Commissioner [redacted] in which he wrote, "In some DDSO group settings, two staff are required to transport up to five clients who are confined to wheelchairs and tethered to the floors of a van." [redacted] opined that he did not believe it was safe or practical for just two staff to safely evacuate residents.

We reviewed OPWDD regulations (14 NYCRR 633.8) and policy addressing this issue. The regulations require the training of OPWDD employees and clients with regard to "the facility's safety and security procedures," among other things. Relevant OPWDD policy, entitled "Safety in Transportation (Car, Wagon & Van)" (Section 320.23), outlines the responsibilities of employees and procedures to be followed when operating a vehicle with individuals receiving OPWDD services. The policy reads that it is the responsibility of the House Leader/Day Program Director to provide training within the first 10 days of hire and prior to transporting individuals. Further, the policy contains a section which addresses procedures for wheelchair vans. In addition, in February 2011, OPWDD issued a Safeguarding Alert bulletin, entitled, "Important Information about Van Safety," which addresses transporting individuals who use wheelchairs.

As for [redacted] specific allegation concerning the ability of two staff members to safely evacuate five residents who are wheelchair-bound and properly secure them in a van, OPWDD has established protocols for safety evacuation plans in accordance with the National Fire Prevention Association. OPWDD advised that its Division of Quality Improvement is responsible for reviewing fire evacuation plans and fire drill reports for all residences. In accordance with OPWDD policies and procedures, each residence is required to conduct one fire drill, per shift, every quarter. Protocols have been established for instances when an evacuation time requirement is not met during a drill; the residence has 24 hours to repeat the drill. If the time requirement for evacuation is still not met, modifications are immediately to be made.

When asked to respond to [redacted] specific complaint, OPWDD advised that it could not evaluate the allegation as stated without additional facts about the type of residence in question. OPWDD noted that there could be instances where two staff members can safely evacuate up to five wheelchair-bound residents as required under protocol established in accordance with National Fire Prevention Association guidelines.

I recommend that the Justice Center review OPWDD's training on, and implementation of, client evacuation and transportation policies and practices to determine if further action is warranted.

I would appreciate if you would notify me within 45 days of any action you have taken. If you require further information about this investigation, please contact Deputy Inspector General Audrey Maiello Cunningham at 518-474-1010.

Sincerely,

[redacted]

Catherine Leahy Scott
Inspector General