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October 17, 2014

Kerry A. Delaney
Acting Commissioner
New York State Office for People With Developmental Disabilities
44 Holland Avenue
Albany, NY 12229

RE: NYS IG 0166-031-2011

Dear Acting Commissioner Delaney:

My office received numerous complaints pertaining to the Office for People With Developmental Disabilities (OPWDD) from [redacted] Our review determined that a number of the allegations were unfounded, required no further action, or were not within our jurisdiction. As discussed below, we are now referring several of the matters brought to our attention by [redacted] to OPWDD with recommendations for review and action as appropriate.

Allegation 1

[redacted] alleged that in February 2009 he informed then-[redacted] Director [redacted] that male employees of OPWDD and a private day program agency had repeatedly transported female residents of OPWDD's [redacted] without a female employee present, in violation of New York State Mental Hygiene Law. [redacted] claimed that the [redacted] "management team" took no action despite being aware of the situation, and that other IRAs "may have the same transportation issues." According to [redacted] responded that the matter would be addressed, and, [redacted] stated, "For the most part, this [violation of the law] has stopped," with the exception of [redacted] a private day program.

Both New York State Mental Hygiene Law and OPWDD regulation govern the transport of females in the care of OPWDD. Mental Hygiene Law §33.17 ("Transportation of Female Patients") states, "Any female patient who is being transported to or from a facility shall be accompanied by another female, unless accompanied by her father, brother, husband, or son." The relevant OPWDD regulation (14 NYCRR 17.7, "Transfer of Patients") states, "In consultation with the patient, the treatment team shall determine who may accompany a woman patient who is being transported to or from a facility. In permitting a woman or the patient's father, husband, brother, or son to accompany her, the team must ascertain that there are no contraindications to granting such permission."

Former OPWDD Associate Commissioner [redacted] advised us that in response to [redacted] complaint, OPWDD reviewed the matter at the time and found that male employees of the [redacted] were, in fact, transporting female residents without a female staff member present. According to [redacted] DDSO Director [redacted] corrected the problem. However, in response to our inquiry, OPWDD was unable to locate any documentation reflecting what action was taken by [redacted] or other official at the time.

I recommend that OPWDD commence a review to assess statewide compliance with the statutory and regulatory requirements pertaining to the transport of females. The results of this review, as well as any corrective action taken or planned, should be reported to me. In addition, OPWDD should re-issue relevant policy to all staff and obtain confirmation of its receipt. Training on the policy should also be provided to appropriate employees.

Allegation 2

[redacted] alleged that OPWDD did not maintain the required level of supervisory staff at IRAs necessary to monitor the activities of employees during nights, weekends, and holidays.

OPWDD regulation pertaining to supervisory staffing requirements at OPWDD's institutional and community residences (14 NYCRR 633.6) requires that each facility establish written policies and procedures for 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. The regulation, however, does not prescribe a number or ratio of supervisors who must be available to employees or present at IRAs. OPWDD advised that although it has not implemented written policy directly addressing staffing requirements at community residences pertaining to employee supervision, staffing patterns are included in each site's Protective Oversight Plan and vary according to the needs of the population.

I recommend that OPWDD review its policies pertaining to staffing requirements at IRAs to ensure that supervisory oversight is sufficient during off-shifts. The results of

this review should be provided to my office. By separate letter I am also referring this complaint to the New York State Justice Center for the Protection of People with Special Needs.

Allegation 3

[redacted] alleged that the [redacted] provides inadequate training to staff on van safety during accidents and fire evacuations. [redacted] referenced an email he previously forwarded to OPWDD 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 two employees are insufficient to safely evacuate residents.

We reviewed OPWDD regulation (14 NYCRR 633.8) and policy addressing these issues. The regulation requires the training of OPWDD employees and clients with regard to facility "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 states that it is the responsibility of the House Leader/Day Program Director to provide training within the first 10 days of an employee's hiring and prior to transporting individuals. The policy also addresses procedures for wheelchair vans. In addition, in February 2011, OPWDD issued a Safeguarding Alert bulletin, entitled, "Important Information about Van Safety," concerning the transport of individuals who use wheelchairs.

In addition to van safety, we examined OPWDD policy pertaining to residential facility safety evacuation. We note that OPWDD has established protocols for safety evacuation plans in accordance with the National Fire Prevention Association. These plans are designed for each residential unit based on the building structure and the ability of the residents to evacuate. OPWDD advised that its Division of Quality Improvement is responsible for rating each residence and reviewing fire evacuation plans and fire drill reports. OPWDD procedures require that each residential unit conduct one fire drill, per shift, every quarter. In the event that an evacuation time requirement is not met during a drill, the residence must repeat the drill within 24 hours. If the time requirement for evacuation is still not met, modifications are immediately to be made.

I recommend that, in addition to the training in van safety during accidents and fire evacuations that is provided at the time of an employee's initial hiring and prior to transporting individuals, OPWDD provide annual training thereafter. OPWDD also should take steps to ensure that fire safety drills are occurring as necessary. Further, OPWDD should re-disseminate agency policy on these issues to staff and obtain acknowledgement of the policy's receipt.

Allegation 4

[redacted] alleged that OPWDD employees assigned to community residences within the [redacted] were using personal vehicles to conduct state business other than resident transport, for which they sought reimbursement, despite the availability of state vehicles, specifically vans used to transport residents.

OPWDD Travel Guidelines require that employees use mass transit when available; however, acknowledging that public transit is not practical for most community home staff, the guidelines state, "Employees should carpool or use pool cars whenever possible." When neither mass transit nor a pool vehicle is available, the employee is expected to use the less expensive option of a rental car or personal car. Similarly, [redacted] policy for the use of state vehicles and mileage reimbursement (PPM § 1210-22) requires that staff, "[w]hen traveling on official State business, use State vehicles when possible." According to OPWDD's Business Office/Travel Unit, resident vans are considered pool vehicles and should be used for general state purposes when other pool vehicles are unavailable.

We did not investigate this allegation and are referring it to OPWDD, which should ensure that it has implemented statewide vehicle usage policy promulgated in November 2013. In addition, OPWDD should adopt the vehicle use recommendations included in the Uniform Guidelines we provided to your agency in February 2013.

Allegation 5

[redacted] claimed that, after reviewing records he received from OPWDD in 2005 or 2006 through the Freedom of Information Law, he believed that OPWDD's [redacted] IRA might not have been tested for radon gas. [redacted] further stated that although he later obtained documentation that a radon gas test was performed at that location, he did not know if testing was conducted at other IRAs.

We inquired whether OPWDD conducts radon gas testing at its regulated residences, including IRAs. OPWDD reported that it utilizes a "Site Review Checklist" to evaluate general site and building conditions at its residences. Among other matters assessed, OPWDD requires that information regarding environmental hazards like radon be obtained from local building departments. However, OPWDD currently has no policy regarding radon testing. I note that the New York State Office of Children and Family Services requires radon testing for child group daycare facilities.

I recommend that OPWDD review the issue of radon testing and other environmental hazards at its community residences and promulgate policy as necessary.

Allegation 6

[redacted] alleged that OPWDD lacked procedures to ensure toiletries and food were properly inventoried at IRAs. According to [redacted] while two staff members are required to review purchases, no procedure exists to account for consumable goods once they are purchased by an IRA. Notably, [redacted] alleged no specific instance of misappropriation of consumable goods at any IRA.

Our review confirmed that existing OPWDD procedure requires two staff members to verify all purchases for IRAs. However, there is no accounting for the inventory and use of consumable items after they are received at an IRA. I recommend that OPWDD consider conducting random audits of expenditures on consumable goods at IRAs to determine if excessive purchasing or overuse is occurring. Procedures for inventory accounting should be considered.

Allegation 7

[redacted] alleged that [redacted] IRA House Leader [redacted] administered an as-needed medication, or "PRN," to an unnamed resident outside of the resident's prescribed orders during the period April 4-10, 2011. [redacted] further alleged that the Capital District DDSO [redacted] was involved in "covering-up" the matter.

After reviewing the allegation at our request, OPWDD advised that it found no record of any medication-related incident pertaining to a resident of the [redacted] IRA during the period cited by [redacted] When questioned by my office, [redacted] stated that he had no recollection of any such event. [redacted] further stated that protocol requires that he be contacted for approval when a staff member seeks to administer as-needed medications beyond prescribed orders, and this had not occurred.

I recommend that OPWDD review [redacted] administration of PRNs and confirm that she is following the proper PRN recording protocol.

Allegation 8

[redacted] claimed that he was "suspicious" that former OPWDD IRA house leader [redacted] engaged in time and attendance abuse. As we did not investigation this allegation, I recommend OPWDD should review [redacted] time and attendance and take action as appropriate

It is requested that within 45 days of the date of this letter you advise us of any actions or decisions taken in response to the above recommendations. As appropriate, please include copies of any new or revised policies. If you require further information about this investigation, please contact Deputy Inspector General Audrey Maiello Cunningham at 518-474-1010.

Sincerely,

Catherine Leahy Scott
Inspector General