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May 14, 2013

**A REVIEW OF THE BERNARD FINESON DEVELOPMENTAL CENTER
MULTIPLE DISABILITIES UNIT:
FAILURE TO MEET BASIC CARE, TREATMENT, AND SAFETY NEEDS
FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES**

The Commission on Quality of Care and Advocacy for Persons with Disabilities (the Commission) conducted a review of the Bernard Fineson Developmental Center's (BFDC) Multiple Disabilities Unit (MDU) at the request of Assemblyman Andrew Hevesi's office, which forwarded the Commission a written complaint received from an MDU staff member that alleged ongoing abuse of residents on the MDU dating back to 2010. The Commission spoke at length with the complainant seeking substantive detail on the alleged abuse.

Generally, the complainant stated that many of the allegations had already been shared with the facility but internal investigations did not lead to the discipline of perpetrators of abuse and neglect, and did not ensure adequate protections for individuals served.

The Commission reviewed the incident management processes, the safety of individuals living at the facility, and the overall quality of services provided at the MDU, specifically focusing on the care provided to the seven individuals identified in the written complaint, as well as facility responses to incidents in which the individuals had been involved. Commission staff additionally conducted general observations and documentation reviews in day program/sheltered workshop classrooms and on the MDU over three multi-day site visits in March, April and September 2012, two of which were unannounced. NYS Department of Health (DOH) representative, Howard Shea, accompanied the Commission on its initial visit and conducted separate review activities.

The Commission reviewed facility investigations into allegations of abuse and neglect for the seven individuals named in the complaint and found that the determinations of these investigations were reasonable based on the evidence presented. However, internal investigations did not explore or seek to correct systemic factors which contributed to incidents, including evidence of inactivity, poor staff training, and inadequate supervision of individuals.

Further, incident management practices as a whole were inconsistent with the intent of governing regulations: to enhance an individual's quality of care by protecting them from harm

and by identifying and correcting problems in order to minimize the potential for recurrence.¹ Several Commission findings detailing deficient safety and service quality were not identified or addressed by BFDC's quality assurance mechanisms or by Department of Health certification reviews. These deficiencies, which limited behavioral improvement, health and social outcomes for the individuals being served, included:

- A failure to provide aggressive or consistent active treatment services;
- A failure to evaluate and revise active treatment goals and objectives in a timely manner;
- Active treatment goal and behavior observation data was inconsistent with reported and observed activities;
- The failure to identify, explore, or resolve underlying causes of individuals' aggression toward peers and staff, often resulting in injuries to individuals;
- Insufficient and inadequate community inclusion activities;
- Inappropriate interactions by staff members toward individuals served; and
- Poor administrative supervision of staff.

Both the NYS Office for People With Developmental Disabilities (OPWDD) and the DOH reviewed and responded to the Commission's draft report. OPWDD agreed with the findings and recommendations, and implemented corrective actions. Both agency responses are attached to this final report.

Program Description

BFDC is located at 80-45 Winchester Boulevard, Queens, New York. Day and residential services are provided in large buildings and some cottages on the facility grounds. The facility grounds are gated, which isolate it from the local community. The MDU is on the second floor of building 71 and has four locked wings, A through D. Each wing houses up to 18 individuals, which were at or near capacity during the Commission's site visits. The MDU primarily serves individuals with co-occurring psychiatric disorders and mild to moderate intellectual disability. Eight day program classrooms/sheltered workshops are located on the first floor of the building, and most of the individuals on the MDU attend one of these day programs/sheltered workshops.

BFDC Deputy Director, Pat Gunn, informed the Commission during its first site visit in March 2012, that, of the 183 total BFDC residents, more than one third (63) were assessed as ready and eligible for community placement and had been placed on a waiting list.

Methods

The Commission conducted three two-day site visits in March, April, and September 2012, and reviewed individuals' clinical records, program and unit records, interviewed staff and individuals, and observed day program/sheltered workshop classrooms and all four residential

¹ 14 NYCRR §624.2: Background and Intent. (a) The purposes for reporting, investigating, reviewing, correcting and/or monitoring certain events or situations are to enhance the quality of care provided to persons with developmental disabilities who are in facilities, to protect them (to the extent possible) from harm, and to ensure that such persons are free from mental and physical abuse. (b) The primary function of the reporting of certain events or situations is to enable a governing body (see Glossary), executives, administrators and supervisors to become aware of problems, to take corrective measures, and to minimize the potential for recurrence of the same or similar events or situations.

MDU wings. During its three site visits, the Commission observed staff and individuals in day program/workshop classrooms for a total of 10 hours and on the MDU residential wings for a total of 11 hours.

Commission Findings

1. Aggressive and consistent implementation of active treatment services is not occurring at the facility.

Federal regulations (42 CFR §483.440(a)) require that each client residing in an Intermediate Care Facility (ICF) “receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services...that is directed toward (i) the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and (ii) the prevention or deceleration of regression or loss of current optimal functional status.”

The Commission did not observe continuous and aggressive implementation of training and services geared toward increasing individuals’ self-determination and independence, as required of ICFs by federal regulations. During each of the Commission’s three site visits in March, April, and September 2012, with few exceptions, recreational activities, such as taking walks around the facility campus, coloring, board games, and watching television/movies were the main activities observed in the day program/workshop classrooms and MDU during the day and evening shifts, while staff members were mostly observed sitting idly by and/or socializing amongst themselves. Consequently, individuals interviewed expressed feeling bored and have not made progress toward attaining active treatment goals (see Commission finding number two).

Day program/workshop staff reported that recreational activities witnessed by the Commission during one- to three-hour observation periods described above took place because there was no teacher present or because active treatment goals had already been completed for the day. However, the observations by the Commission seem to be more of the norm. In four out of five classrooms observed in September 2012, individuals and staff went for lengthy walks around the facility at unscheduled times in lieu of scheduled activities, such as working on active treatment goals. In classroom 118-C, individuals spent only 20 minutes in the classroom after arriving to class one hour late, skipping scheduled active treatment programming in order to take a 90-minute walk around the facility.

Further, residents and MDU staff interviewed by the Commission did not give any indication that work on active treatment goals took place at all during the evening shift; instead, they identified occasional outings, dinner, on-grounds recreational activities, and showers as the usual evening routine, which declarations were confirmed by Commission observations on the MDU and by reports found in MDU communication logs. Staff members observed sitting idly by during the Commission’s three-hour observation of the B-wing in March 2012 were questioned about the schedule of activities for the evening and stated that they were “taking it easy” because they were working overtime. During the Commission’s observation of the MDU in September 2012, staff members were ill-prepared for a group activity, having to make photocopies of Bingo boards and only having the unit’s stock of shampoo and toothpaste to offer the individuals as prizes.

Staff on the evening shift further reported that they do not have access to goal information, as the “goal books”² are kept in the day program classrooms. As a result, day program staff are responsible for and have signed off on individuals’ activities of daily living (ADL), such as learning to apply body lotion or hair gel, which would be more suited for the residential unit where these goals can be integrated into a daily routine and where privacy can be assured. Though most goal tracking sheets were completed for active treatment goals, there was also evidence that records did not accurately reflect classroom/workshop activities, as described in finding number three.

2. Active treatment goals and objectives were not properly evaluated and revised, despite a lack of progress toward attainment.

The Commission’s review of the seven individuals’ records revealed that active treatment goals and objectives that were in effect for several years were not effectively evaluated or revised when goal progress was minimal or negative, as required by federal regulations.³ As a result, individuals’ treatment needs were not met, preventing progress toward independence, self-determination, and movement to a level of care permitting greater community integration and enhanced opportunities for independence.

These deficiencies were found in many of the records reviewed, and are detailed in the following examples:

- Individual A’s Comprehensive Functional Assessment (CFA), dated April 2011, identified a need “to reduce physical aggression,” and the only associated objective was to “exhibit 0 episodes of physical aggression (pushing) per month for 3 consecutive months.” This goal and objective was established when Individual A was admitted to the facility in April 2010, and had not been revised since that time. The stated objective appears unrealistic, as the average frequency of exhibited behavior from admission to April 2011, was 33 episodes per month. However, this frequency is likely an underestimate.⁴ Similarly, a quarterly review of Individual A’s CFA showed that the frequency of this behavior increased 1400% (from 2 to 30 episodes) between July and September 2011. Overall, the frequency of three of the remaining five behaviors (inappropriate sensory stimulation, head banging/face slapping, need for physical contact) for which Individual A had a formal active treatment goal and behavior plan increased during that time period by 45% (51 to 74 episodes), 23% (47 to 58 episodes), and 11% (76 to 84 episodes), respectively. All of Individual A’s behavioral goal plans

² Goal books: three-ring binders containing descriptions of individuals’ active treatment goals and objectives, including implementation guidelines for staff, data recording requirements and forms.

³42 CFR §483.440(f): Standard: Program monitoring and change. (1) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client (i) has successfully completed an objective or objectives identified in the individual program plan; (ii) is regressing or losing skills already gained; (iii) is failing to progress toward identified objectives after reasonable efforts have been made; or (iv) is being considered for training towards new objectives.

⁴ The facility’s behavior data sheets require staff to mark with a check whether a target behavior was observed during the shift, but do not measure how many times the behavior was observed during that shift. For example, an individual may display physical aggression 10 times during a given shift, but the staff would only check whether or not the behavior was observed (present or absent). While a more accurate description of the collected data would be that the behavior occurred during an average of 33 shifts per month from April 2010-April 2011, it would not represent a meaningful measure of the overall occurrence of the behavior.

lacked skill-based training objectives to proactively teach Individual A how to manage antecedents to the behavior at Individual A's developmental level. Staff were relied upon to use various interventions (verbal prompts, physical escorts, etc.) to address the behavior only after physical acting out was observed. As a result, Individual A became involved in repeated instances of serious aggression toward peers during the review period, many of which resulted in minor injuries to Individual A and peers.

- Individual B's CFA identified a need to "reduce/eliminate verbal abuse," and the objective to meet that goal was also to "exhibit 0 episodes of verbal abuse for 3 consecutive months of the year." This objective was unrealistic for Individual B to achieve, as 45-46 episodes of verbal abuse per month were exhibited from December 2011 to February 2012. Additionally, this and the four other behavioral goals and objectives did not include skill-based training, and as a result, Individual B has not developed meaningful skills to independently address Individual B's own behavioral needs, as evidenced by the fact that all five of Individual B's targeted inappropriate behaviors increased during 2011 by monthly averages of 58% (fabricating stories - 9.5 to 15 episodes), 54% (assault - 7.8 to 12 episodes), 367% (leaving assigned area - 3 to 14 episodes), 29% (verbal abuse - 14 to 18 episodes), and 23% (self-injurious behavior - 5.7 to 7 episodes). Individual B also exhibited multiple episodes of aggressive behaviors toward peers and staff during the review timeframe, (many of which resulted in minor injuries for Individual B and peers). Seven ad hoc meetings were held from May 2011, to December 2011, to review the frequent use of STAT medication to manage Individual B's difficult behavior. After five of the seven meetings, Individual B's standing medications were changed (dosage increased or medication added), as well as at other times between meetings, but there was no documented consideration of revising Individual B's behavior plan to better address Individual B's behavioral needs. As a result, Individual B's social development has suffered: according to Individual B's CFA, dated 9/22/11, "...it is no wonder that [Individual B] has no real friends on the unit, as everyone is very careful to avoid contact with [Individual B]."
- Individual C received 25 STAT medications for behavior between September 2011, and April 2012, and 11 ad hoc meetings resulted in frequent standing medication changes (dosage increased or medication added). Individual C also displayed drooling, drowsiness, impaired speech, and unsteady gait (leading to falls) throughout this time period reported as being due to medication side effects, which led to some of these medication changes. However, there was no documented consideration given to modify Individual C's behavior plan in order to avoid these frequent medication changes and the use of STAT medication interventions.

The seven identified individuals each had similar objectives as described in the examples above, which lacked skill-based training objectives, timely revision, and contributed to limited behavioral improvement. Though every individual interviewed expressed the desire to move to a group home, poor behavioral control was listed in their records as the primary rationale for why they were not currently appropriate for care in a more integrated community setting. Individuals would have been better served if behavioral objectives included proactive training and practice of replacement behaviors in progressive and achievable increments, rather than focusing goals and objectives solely on what behaviors individuals would *not* exhibit and what level of staff action would be required in response.

In lieu of skill-based training to assist individuals to self-regulate, individual goal plan methodologies for target behaviors required staff to identify warning signs to negative behaviors early enough to encourage the use of replacement behaviors. Unfortunately, Commission observations and record reviews revealed that behavioral incidents on the unit were already in progress by the time staff noticed and intervened. Also, behavior data sheets did not allow staff to describe antecedent circumstances which may have contributed to the negative behavior, and as a result, clinical and unit records frequently stated that a target behavior occurred “for no reason.” Had such records included detailed information about antecedents, behaviors, and consequences of the behavior, it may have assisted clinical staff to revise behavior goals/objectives and behavior intervention plans based on concrete data, providing a basis for more effective preventative measures and responses to the warning signs of target behaviors.

3. Collected active treatment goal and behavior observation data was missing, incomplete, or inconsistent with reported and observed classroom activities, negatively affecting individuals’ treatment and behavioral outcomes.

The Commission observed and reviewed records for five out of eight day program/workshop classes during the September 2012, visit, and found that most of these data sheets were either missing, blank, or completed in advance of actual classroom programming, rather than recording observed abilities and behaviors at the completion of the activity or at the end of the day. This practice led to inaccurate predictions of individuals’ engagement in active treatment goals and target behaviors and prevented accurate monitoring and revision of active treatment goals and behavior plans.

The following are examples of missing, incomplete, or inaccurate data collection:

- A review of individuals’ “goal books” and behavior observation sheets revealed that in two out of the five observed classrooms, data was completed one to three days in advance of the actual date of service.
- In two out of five observed classrooms, goal data did not accurately reflect Commission observations. For example, records indicated that in classroom 122-B, on the date of the Commission’s observation (September 12, 2012), Individual D had completed the active treatment objective apply moisturizing hair gel. However, Individual D’s hair was in braids and frizzy, and it did not appear that the goal was actually completed on that day.
- In four out of five observed classrooms, none of the individuals’ goals were initialed by a staff person indicating who had assisted the individual to complete the goal.
- Goal data sheets were not available in classroom 120-B for staff to complete as active treatment goals were accomplished.
- As of September 2012, several months of goal data were missing or incomplete for all individuals in classroom 120-B. Goal data was only provided for five out of 13 assigned individuals (eight individuals’ goal data was missing altogether), and the data sheets provided had not been completed since mid-July 2012. The teacher first reported that this was because he takes notes on individuals’ progress and records the data later, and then admitted he does not have time to work on active treatment goals because his assigned individuals go on recreational trips and also do work on facility grounds to earn money.
- Individual E from classroom 118-C and Individual F from classroom 122-B each had incomplete data for one goal since mid-July 2012.
- In classroom 116-C, behavioral data completed prior to the end of the date of observation

did not reflect observed behaviors for some individuals. For example, Individual G was observed yelling at Individual H. A review of Individual G's behavior data revealed a behavioral goal to reduce verbal abuse, but the data for the day was completed in advance and indicated "no problem." The Commission was also informed that Individual I had left the program room due to behavioral problems, but Individual I's behavior data had been completed in advance and indicated "no problem" for the date of observation.

- Behavior data was blank for all individuals in classroom 122-B from September 1-5, 2012.
- Individual B's quarterly CFA review of December 15, 2011, revealed that no data was collected or evaluated on any of the five behavioral goals during October 2011.

Importantly, this deficient record keeping was not identified in BFDC internal clinical or quality assurance reviews. The failure to adequately monitor program provision inhibits effective revision of active treatment services by allowing inaccurate reporting of services provided to individuals, further impeding individual progress toward independence, self-determination, and a less-restrictive living environment.

4. Internal investigations and incident reviews failed to identify, explore, or resolve underlying causes of aggression against staff and peers, which resulted in injuries to individuals.

Based on a review of clinical and program records from September 2011, to February 2012, for the seven individuals identified by the complainant, the Commission found that facility investigations into incidents of individuals' aggression against staff and peers did not adequately explore underlying causes and circumstances. Rather, motivation for individuals' aggressive outbursts, which often precipitated allegations and/or injuries, was commonly ascribed to jealousy or psychiatric disabilities without assessing the effectiveness of clinical interventions or the supervision and programming provided on the units. Reports of these incidents frequently documented that the individual's behavior occurred "for no reason." Further, there were no programmatic mechanisms in place for staff to report either antecedent events that could have predicted the outburst, or the outcome of early intervention efforts to facilitate the development of data-driven, preventive interventions.

The Commission's review of minor incident reports⁵ for September 2011, to February 2012, revealed an average of 13 incidents per month on the C Wing, during which individuals attacked each other and/or staff, and one or more individuals sustained a minor injury. This average underestimated the overall level of physical aggression on this unit, as the facility did not have a tracking or review mechanism for instances of physical aggression that did not result in an injury. Also, this average did not include additional incidents that met criteria for classification as a serious reportable incident or an allegation of abuse.

The Incident Review Committee (IRC) reviewed minor incidents resulting in minor injuries to individuals, but IRC minutes only listed the individual involved, the number of incidents in which they were involved, the types of injuries sustained, and whether each incident

⁵ Minor incident reports are internal reports of various events (including physical aggression) not alleging abuse or neglect, which do not meet criteria for external reporting to OPWDD, DOH, or the Commission. They involve minor injuries (requiring first aid or less) to an individual or the use of a pharmacological intervention for behavior. Minor incident reports are reviewed by the facility's Incident Review Committee.

was properly classified. The IRC did not document any examination of these incidents for patterns, trends or possible contributing factors connected to staffing, the treatment environment, quality or sufficiency of supervision, or propriety of behavior programming, and did not make any recommendations that attempted to decrease the overall frequency of these incidents and injuries.

5. Community inclusion activities are infrequent and not individualized.

The Office for People with Developmental Disabilities (OPWDD) defines community inclusion as “activities from both the home and day services location that ensure that an individual uses facilities that are typically used by community members; and interacts with people who are not paid staff and who do not have a developmental disability.” Further, OPWDD states that community inclusion does not consist merely of “taking people to community places in large groups...”

BFDC is gated and is thereby isolated from the rest of the community, which requires that MDU staff transport residents off facility grounds for community inclusion activities. The Commission found that “community ride[s]” and walks around the facility campus have been improperly described as community inclusion activities in individuals’ records and in the communication log. These activities do not take place in the community and do not provide opportunities for significant interaction with community facilities or community members.

Similarly, Commission observations in March, April, and September 2012, revealed that when a community inclusion activity was offered, staff determined what outing would be taking place and identified which individuals would be allowed to attend without consideration of individual interest and choice. Direct care workers also reported that individuals’ opportunities for outings depend on the willingness of staff members organizing the outing to include all individuals, as staff may be reluctant to allow particular individuals to attend an outing if they have had behavior problems in the community in the past. Decisions which directly affect an individual’s ability to benefit from community inclusion activities should be made by the individual’s clinical team, rather than by direct care staff.

Interviewed staff and individuals reported that the primary inclusion activity offered during day and evening shifts is to go to a local 99-cent store or occasionally a restaurant. The interviews were consistent with the Commission’s review of monthly recreation summaries which indicated that individuals have the opportunity to participate in outings two to four times per month, which is lower than the staff members’ verbal reports that individuals participate in inclusion outings up to three times per week.

Based on the Commission’s evening shift observations and a review of the communication logs, individuals typically attend these outings in large groups (six to nine individuals). The trips to the 99-cent store and an occasional restaurant do not provide sufficient opportunity for significant interaction with a variety of community facilities and community members that would prepare individuals for successful community placement. Interviewed staff suggested that a greater variety of community inclusion activities would help improve current services, and religious services, haircuts, and recreational activities that currently take place on facility grounds are missed opportunities for individualized community inclusion.

6. Staff did not consistently treat individuals with dignity and respect during the Commission's site visits.

During the Commission's March and April 2012, site visits, the Commission observed several instances of inappropriate verbal and physical interactions by staff toward consumers in the day program/sheltered workshop and on the residential units. The observations below were shared with the DDSO administrators at the time of the Commission's visits.

During the Commission's March 2012 visit, classroom 106-C was staffed with six direct care staff, and the only activity offered to individuals was a children's movie. Individual J, a resident of the Corona Unit who was not included in the Commission's review of MDU records, was instructed to watch the movie, but was ruminating on an appointment scheduled for later that day. A staff member became noticeably frustrated and responded several times by putting her hands on Individual J's shoulders and arms and forcibly seating Individual J in a nearby chair. The staff's voice became progressively louder as Individual J did not comply, and the staff member began physically escorting Individual J to a seat on the opposite side of the room loudly stating, "[Individual J], this is your chair! Sit down!" Neither she nor the five other staff members in the room attempted to engage Individual J in any activities or active treatment programming to distract Individual J from ruminating on the upcoming appointment.

The same staff member in classroom 106-C was also heard complaining to other staff in the classroom that it was a shame that Individual J was removed from one-to-one supervision because Individual J takes up all of the staff's time, which causes other individuals not to get any attention. The staff member then began to thumb through an advertisement and passed it around to her co-workers as the other individuals in the room remained unoccupied in any staff-directed programming.

Staff were also observed in classroom 106-C inappropriately interacting with Individual K during the March 2012 visit. Individual K had been quietly sitting at a table unoccupied for the two hour observation period, when staff called over to Individual K and stated, "What's your name?" The staff member repeated this a few times and then Individual K quietly stated Individual K's name. The staff member then started to imitate the way Individual K said their name and nearby staff began to laugh at her mocking impression.

The Commission also observed classroom 120-B in March 2012, where there were 15 individuals and four staff present. A staff member appeared frustrated with Individual L and was heard loudly stating in front of Individual L and the other individuals in the classroom, "Nobody wants him [Individual L] in their class." On several occasions, the same staff person also stated that she felt there were too many individuals in this classroom, and stated that this was because, "no one wants them. They get dumped here."

Finally, on the C Wing during the April 2012 visit, the Commission observed Individual D suddenly scream at someone across the room. A nearby staff member reacted by tapping Individual D on the arm with the back of her hand. This staff member looked over at the Commission investigator and then started to play fight with Individual D, as if the initial tap was part of a joke.

While such staff behavior is never acceptable, it further disturbed the Commission that

each of these individuals and their nearby peers were generally high functioning and capable of understanding the disdainful nature of staff's comments and actions.

7. Administrators have not provided direct care workers with appropriate supervision in day program/workshop classrooms or on the MDU.

During the Commission's observations of day program/workshop classrooms, program administrators periodically made rounds in the classrooms but did not address inappropriate staff behaviors. For example, during the Commission's visit of April 2012, two program administrators conducted rounds in classroom 106-C during the same time that the Commission observed six direct care workers sitting idly by and/or falling asleep while the individuals watched a children's video, but neither administrator addressed this staff misconduct.

When the Commission learned that one teacher could not provide goal data for more than half of the individuals for whom he was responsible, and that the goal data provided had not been updated since mid-July 2012, the program supervisor stated that she was aware of ongoing problems with the teacher's documentation, but could not demonstrate that she had adequately addressed this performance problem.

The Commission also found evidence that the communication logs were not regularly reviewed by supervisory staff, which delayed appropriate action in response to safety issues identified by direct care workers. For example, several times beginning on October 18, 2011, staff noted in the communication log broken tile in a B-Wing shower room as an environmental hazard needing attention. However, the problem went unaddressed for more than one month, and Individual M used the broken tile from this shower room for self-injurious behavior on both November 14 and 15, 2011, requiring first aid. Similarly, a broken door with exposed nails was repeatedly noted in the log as an unaddressed environmental hazard from September 11-18, 2012.

Recommendations

In addition to other corrective actions deemed appropriate by OPWDD to address the Commission's findings, the Commission recommends the following:

1. Revision of active treatment goals for behavior to focus on skill-based training for individuals on the use of replacement behaviors, with achievable benchmarks and more critical analysis of achievement, and the initiation of an ongoing quality assurance process for review of these goals/objectives and for timely revisions consistent with needs and goal/objective achievement identified during quarterly treatment team reviews.
2. Staff training on implementation methodologies for the revised, skill-based active treatment goals/objectives.
3. Revision of behavior tracking data sheets to include frequency of behavior per shift, objective and detailed descriptions of antecedents to behavior (and exploration of circumstances prior to behavior) and individuals' responses to approved interventions.
4. Use of this comprehensive behavior tracking mechanism for the review and revision of preventative and reactive behavioral intervention strategies.
5. Community inclusion activities should be planned with individuals based on their personal interests. The facility should also consider replacing routine campus based

activities, such as religious services and haircuts, with equivalent services in the community, whenever possible.

6. Sensitivity training should be provided for direct care workers to address disrespectful verbal interactions. Clinical documentation (CFAs, behavior plans, progress notes) which reflects a negative attitude toward individuals and contributes to a culture of disrespect should be revised to support strength based approaches and end the use of demeaning language.
7. Administrative supervision of services must be improved to ensure that appropriate individualized active treatment is continuously offered in all treatment settings and in the community. The facility governing body must be held accountable for ensuring that shift leaders and team leaders exercise effective leadership over service provision.
8. The facility should initiate supervisory and quality assurance processes to regularly review documentation of services for accuracy and completeness and to observe service provision, with a goal to immediately rectify any identified problems with classroom/unit activities.
9. In order to ensure the completion of these activities and others deemed necessary to address outstanding issues, OPWDD Central Office should provide close monitoring and oversight of the day program/sheltered workshop and the MDU.
10. OPWDD must address the large list of individuals currently identified as ready for community placement. The Commission requests a current BFDC waiting list detailing the length of time each person has been waiting for community placement, a description of BFDC's overall plan to rectify the backlog of pending discharges, what assistance has or will be rendered by OPWDD central office and expectations for when community placement will be obtained.



May 10, 2013

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Dear Ms. Trumpfheller,

Thank you for your correspondence of January 4, 2013, which highlights findings from the Commission's review of the Bernard Fineson Developmental Center's Multiple Disabilities Unit (MDU). We understand your findings represent multiple on-site visits taking place over a period of several months and we appreciate the diligence with which this review was undertaken. Since your findings described a broad and significant range of concerns we have understandably taken some time in assuring that a thorough, thoughtful, and sustainable array of follow up actions were arrived at, implemented, and will be maintained going forward.

In response to concerns related to the quality of care and treatment of persons residing at the Bernard Fineson MDU, in early December of 2012, OPWDD's Technical Assistance Team was sent to the facility to assess its strengths and weaknesses, and to formulate recommendations toward correction. Their conclusions in many areas mirror findings enumerated in the Commission's report. Since that time, we have undertaken significant steps to implement corrective measures in many of these areas. Attention to staff training; the provision of active treatment services; and clinical staff involvement in planning, program development, delivery, and oversight are all areas that we are focusing concerted efforts on at this time.

The aforementioned Technical Assistance Team has made four subsequent week long visits to the Fineson campus to assist in planning and implementing corrective actions with a primary focus on active treatment. We have enlisted staff development and training resources from throughout OPWDD's New York City's based operations to assist in large

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We help people with developmental disabilities live richer lives

scale staff retraining initiatives which were completed early April of this year. To further assist two deputy directors from upstate regions with extensive campus experience were deployed to the facility for a three month period. They assisted with oversight of these multiple corrective activities while also assisting in the development of systems to assure that corrections will be sustained. These additional staff were assigned full time from mid-January through March 31, 2013, and remain involved on an as needed basis as of the present time. They will continue to assist in the upcoming weeks with additional active treatment training and observations across settings and shifts.

Finally, Ms. Jan Williamson, who possesses a wealth of campus-based experience at the Brooklyn Developmental Center, was appointed Director of SOO Region 6 in December 2012, which includes both the Bernard Fineson facility and our state operations on Long Island.

Through these efforts, we are confident that necessary supports are in place to provide and sustain significant quality improvement at the Bernard Fineson facility, to include its MDU program. Recent verification visits by the Department of Health have also resulted in findings of significant improvement at this facility which serves to affirm these beliefs.

In more specific response to the annotated recommendations in the Commission's report, I offer the following:

- 1. Revision of active treatment goals for behavior to focus on skill-based training for individuals on the use of replacement behaviors, with achievable benchmarks and more critical analysis of achievement, and the initiation of an ongoing quality assurance process for review of these goals/objectives and for timely revisions consistent with needs and goal/objective achievement identified during quarterly treatment team reviews.**

A specific review of the active treatment goals of each person residing at the MDU has been undertaken and will be accomplished by June 15, 2013. Where goals are found to lack training leading to the use of replacement behaviors, the goals will be modified or rewritten. Measureable outcomes and reasonably achievable benchmarks will be ensured, and the quarterly review process will be fully utilized to assure that goals and progress are thoroughly assessed and that revisions occur in a timely manner wherever and whenever necessary. A random quality (record) review process has also been developed and implemented to ensure that quality oversight of active treatment services outside of the treatment team is provided for. The Deputy Director and DDPS IV will be attending at least one case conference review per month to ensure the process reflects the needs of the individuals and the teams are in compliance with this commitment.

2. Staff training on implementation methodologies for the revised, skill-based active treatment goals/objectives.

As noted in the foregoing text, extensive and comprehensive retraining has been completed at this facility over the past three months. This training extended to active treatment supports. Specific staff training on implementation of all revised, skill-based active treatment goals and objectives is ongoing.

In addition, a review of all annual mandated training within the Campus Programs was completed. Annual mandated training includes Rights and Incident Reporting, SCIP-R, CPR, First-Aid, Right-to-Know, Fire Safety, Blood Borne Pathogens, TB, Promoting Positive Relationships, and Workplace Violence. Annual mandated training has been updated for all MDU employees, with a 100% completion date achieved in early April, 2013. Over this 3 month period, close to 200 staff were trained in these topics essential to health and safety. Additionally, systems have been implemented to ensure that as staff on extended leaves return to duty their retraining is immediately addressed, and that retraining for all staff in required areas is provided for on a predictably scheduled basis in the future.

3. Revision of behavior tracking data sheets to include frequency of behavior per shift, objective and detailed descriptions of antecedents to behavior (and exploration of circumstances prior to behavior) and individuals' responses to approved interventions.

Behavior tracking data formats are in process of being revised to ensure that all relevant elements (frequency of behavior per shift, antecedents to behavior, and individuals' responses to implementation of approved interventions) are included. The revised format is being developed by the Chief Psychologist in conjunction with the psychologists on the campus.

4. Use of this comprehensive behavior tracking mechanism for the review and revision of preventative and reactive behavioral intervention strategies.

As with any quality behavior plan, the comprehensive behavior data described in #3, above, will form the basis for review and revision of both the preventive and reactive elements of the plan. Such data will be reviewed, with corresponding documentation, on at least a monthly basis by the assigned psychologist. Plan revisions will be timely where necessary.

- 5. Community inclusion activities should be planned with individuals based on their personal interests. The facility should also consider replacing routine campus based activities, such as religious services and haircuts, with equivalent services in the community, whenever possible.**

Community inclusion schedules have been developed and are revised prior to the beginning of each coming month via the direct input of the persons residing on the living unit. This has been accomplished through meetings with residents and staff to discuss interests, preferred activities, and plans for the coming month. These schedules are publicly posted in the living area, with implementation monitored by unit and building supervisor(s). The facility has also begun the process of replacing campus-based activities with their community-based opportunities. This is reflected on the inclusion activity schedules.

The MDU has also begun to roll out the "Shift Happens" philosophy developed by Delaware ARC. Since its initiation in February, the quality of inclusionary activities has increased as individuals and staff were canvassed as to their specific interests. Activities now include weekly visits to a local animal shelter, crochet with a church group and DSA lead activities in their areas of interest (salsa dance lessons, dj, etc).

- 6. Sensitivity training should be provided for direct care workers to address disrespectful verbal interactions. Clinical documentation (CFAs, behavior plans, progress notes) which reflects a negative attitude toward individuals and contributes to a culture of disrespect should be revised to support strength based approaches and end the use of demeaning language.**

All MDU staff (direct support and clinical) have received retraining in OPWDD expectations regarding staff/consumer interactions. The OPWDD Promoting Positive Relationships training module has been prominently featured in this effort. In addition, supervisors have received retraining in their role in ensuring that positive, respectful interactions are expected and that staff struggling to measure up to this expectation receive additional training, enhanced supervision and finally are referred for progressive disciplinary actions where warranted. Clinical documents and service plans are undergoing review to ensure language that could be considered negative, disrespectful, or disparaging is removed. Clinical and supervisory staff have been assigned to provide mentoring and spend time with staff and individuals to model appropriate, respectful and positive interactions. With regard to specific events documented by CQC as a result of your observation, incident reports were filed where warranted and appropriate follow up actions were taken.

- 7. Administrative supervision of services must be improved to ensure that appropriate individualized active treatment is continuously offered in all treatment settings and in the community. The facility governing body must be held accountable for ensuring that shift leaders and team leaders exercise effective leadership over service provision.**

Expectations of administrators, supervisors, and team leaders has been explicitly clarified and is supervised/monitored on an ongoing basis to ensure that their leadership role in the provision of ongoing, therapeutic active treatment services and the maintenance of an environment conducive to this goal is consistently fulfilled. The governing body meets weekly to discuss our role as leaders, emergent trends and strategies to address and so on. This group is lead by the Director and DDO, and includes the DDPS IV, all TTL's on the campus, clinical department heads, and all support department heads. This has proven to be a valuable initiative in that the group better understands their respective role with regard to the whole of the organization and that we set the tone for all levels of leadership.

- 8. The facility should initiate supervisory and quality assurance processes to regularly review documentation of services for accuracy and completeness and to observe service provision, with a goal to immediately rectify any identified problems with classroom/unit activities.**

As noted in #6, above, supervisory retraining of our expectations has been accomplished. This training included the expectation that service provision is routinely observed and "teachable moments" seized to ensure quality improvement. Additional oversight of service provision by clinical and team leader level staff is now also routinely in place.

- 9. In order to ensure the completion of these activities and others deemed necessary to address outstanding issues, OPWDD Central Office should provide close monitoring and oversight of the day program/sheltered workshop and the MDU.**

As noted in the foregoing text, some additional resources (Technical Assistance Team, redeployed Deputy Directors) have already been assigned on either a full or part-time basis to provide guidance, leadership, and oversight. These resources will remain involved on a limited basis for the next two to three months to assure that progress is sustained.

10. OPWDD must address the large list of individuals currently identified as ready for community placement. The Commission requests a current BFDC waiting list detailing the length of time each person has been waiting for community placement, a description of BFDC's overall plan to rectify the backlog of pending discharges, what assistance has or will be rendered by OPWDD central office and expectations for when community placement will be obtained.

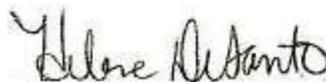
OPWDD is completely committed to assisting all of those persons who are ready for community placement to achieve this objective at the earliest opportunity. The attached document is a listing of all persons currently residing on the Bernard Fineson campus. It includes the specific community placement plan and associated timeframe for each person who is either currently ready for placement, or anticipated to be ready within the next 12 months. It also lists those persons who are not yet prepared for community living and, consequently, have no placement plan at this time. Finally, it lists eleven successful placements from the campus to the community which have occurred since 3/25/13. (See Attachment #1).

Relative to community placement, the following information should also be noted:

- a) The overall campus census at the Bernard Fineson facility has decreased by 23 persons via community placements occurring since December 1, 2012, including four persons from the Multiple Disabilities Unit.
- b) An additional nine community placements are planned to occur between now and August 1, 2013; eight additional by December 1, 2013; and seven more by January 1, 2014. This demonstrates OPWDD's commitment to community placement, either by development, backfill opportunity, or individualized living opportunities for all persons who are ready.

I trust this correspondence contains sufficient information to fully respond to those areas of concern raised by the Commission's review of the Bernard Fineson Multiple Disabilities Unit. If there is any additional information that is necessary or needed for clarification, please do not hesitate to contact me.

Sincerely,



Helene DeSanto
Deputy Commissioner
Division of Service Delivery

Attachment

cc: Kerry Delaney, Executive Deputy Commissioner
Megan O'Connor-Hebert, Deputy Commissioner
Lee Weissmuller, DOH
John Gleason, Associate Deputy Commissioner
Jan Williamson, Director Region 6

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

January 10, 2013

Emily Trumpfheller, Facility Review Specialist I
Division of Adult Quality Assurance and Investigations
NYS Commission on Quality of Care and Advocacy
For Persons with Disabilities
401 State Street
Schenectady, NY 12305-2397

RE: Draft Report - Collective 46068

Dear Ms. Trumpfheller:

I am writing in reference to the Draft Report noted above. Thank you for providing it to the Department. I would like to add some minor clarification. The Draft Report does mention that a surveyor from this office (Mr. Howard Shea) conducted a concurrent complaint survey and joint site visit with the Commission. However, the Draft Report fails to note that as a result of the complaint survey, Federal findings were issued to the facility under the Condition of Participation of Client Protections, and that the facility generated an acceptable plan of correction to address these findings.

In reference to the statement "Several Commission findings detailing deficient safety and service quality were not identified or addressed by BFDC's quality assurance mechanisms or by Department of Health certification reviews" and the Commission's findings related to 42CFR483 (Federal ICF regulations), it should be noted that the NYS Department of Health is obligated to follow the Federally prescribed protocols and timelines for conducting certification and/or complaint surveys under 42CFR483.

Not following these protocols and timelines allows the Commission latitude in "fact finding" that is not available to the NYS Department of Health when conducting certification or complaint surveys.

These process differences and their implications were explained to Commission staff by myself and Mr. Shea in a conference call prior to the joint site visit and again by Mr. Shea during the site visit.

Thank you for the opportunity to respond to this draft report. Feel free to contact me as needed.

Sincerely,



Lee Weissmuller, Director
Bureau of ICF/IID Quality and Surveillance

C: Mr. Shea, DOH
Ms. Pappalardi, DOH
Ms. DeSanto, OPWDD
Ms. O'Connor-Hebert, OPWDD
Ms. Mazella, OPWDD

10/10/13 10:10 AM