



Joint Report of Investigations of Allegations of
Abuse and Reviews of Conditions at the
Office for People With Developmental Disabilities'
Valley Ridge Center for Intensive Treatment

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SUMMARY OF FINDINGS

In March 2011, Courtney Burke, then-Acting Commissioner of the New York State Office for People With Developmental Disabilities (OPWDD), requested that the New York State Inspector General investigate serious allegations of abuse of residents of the Valley Ridge Center for Intensive Treatment, an OPWDD facility in Norwich.¹ Acting in response to the urgency of the allegations, the Inspector General contacted the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC), and the two agencies immediately directed investigative teams to the facility to conduct interviews and record reviews. The Inspector General and CQC also conducted broader reviews of conditions and procedures at the facility to ensure that safeguards were in place to protect the health and safety of the residents.

The Inspector General and CQC found that residents of Valley Ridge were not at imminent risk of harm due to mistreatment by staff. However, the investigation revealed an incident of staff abuse of a resident which was intentionally not reported and remained unknown to OPWDD until discovered by chance a year after the incident. A second incident revealed further deficiencies in reporting of suspected abuse.

These findings suggest that incidents of abuse and neglect may be unreported or underreported at Valley Ridge. These concerns are underscored by the further finding that while Valley Ridge receives and substantiates numerous allegations of abuse and neglect, almost none of these complaints are made by employees against other employees.

The investigation also found that recent changes in Valley Ridge's leadership have disrupted facility operations. This lack of continuity has created an administrative vacuum in which issues, including the need for on-site supervision on all shifts, have gone unaddressed. The importance of an oversight presence at the facility is reflected in the fact that during the period when the Inspector General and CQC were regularly on-site, overall claims of abuse decreased, while allegations of abuse made by staff against staff increased.

The investigation revealed other issues that warrant attention by OPWDD. These include the finding that as of March 2011, nearly 20 percent of Valley Ridge's direct care staff were on administrative leave pending the outcome of internal investigations of alleged abuse or neglect. This fact reflects the facility's commitment to pursue all allegations of abuse; at the same time, it creates a need for substantial mandatory overtime for remaining staff, thereby burdening the system and employees.

The findings of the Inspector General's and CQC's investigations and reviews have been provided to OPWDD. The Inspector General and CQC will also make available the results of their investigations and reviews to Clarence Sundram, Special Advisor to Governor Andrew M. Cuomo on Vulnerable Persons. In this role, Sundram is

¹ On April 11, 2011, Courtney Burke was confirmed as Commissioner of OPWDD.

responsible for evaluating and providing recommendations to the Governor concerning State programs related to developmental disabilities, mental health, alcohol and substance abuse, children, and the elderly. As part of his duties, Sundram is evaluating the protection, safety, and quality of care of vulnerable persons, and the conditions of related state operated and licensed facilities.

INTRODUCTION

Background and Methodology

On March 23, 2011, Courtney Burke, then-Acting Commissioner of OPWDD, reported to the Inspector General concerns of staff abuse of residents at Valley Ridge. The Inspector General, in turn, contacted CQC, the agency which provides independent oversight of the quality of services provided to individuals with disabilities.

During the course of reviewing the issues referred by OPWDD, the Inspector General and CQC were alerted to several incidents of suspected abuse and misconduct at Valley Ridge. One of the incidents involved a resident (Resident 1), who allegedly was subjected to physical abuse by a direct care aide.² In addition to these allegations, CQC already had been contacted by Valley Ridge regarding another significant incident in which another resident (Resident 2), at the direction of facility staff, was subjected to possibly unnecessary daily body checks and photographs of an unexplained injury to his genital area.

These specific allegations of resident abuse, combined with the issues reported by OPWDD's Acting Commissioner, raised concerns that dangerous conditions might exist at Valley Ridge. As a result, the Inspector General and CQC quickly dispatched teams of investigators to the facility. Additionally, OPWDD initiated immediate protections, including providing technical support from its central office as well as temporarily reassigning administrative staff to Valley Ridge from the Broome Developmental Disabilities Services Office (DDSO) and other DDSOs. After determining that Valley Ridge residents were not in immediate danger, the Inspector General and CQC commenced comprehensive and coordinated investigations of the two allegations described above. The Inspector General focused on the Resident 1 allegation while CQC examined the Resident 2 matter.³ Further, in response to then-Acting Commissioner Burke's concerns about potential systemic problems at Valley Ridge, the two offices undertook a broader review of conditions and processes at the facility. The Inspector

² New York State Mental Hygiene Law Article 33 (referred to as "Jonathan's Law") bars the public disclosure of the names or other identifying information of residents and employees in state facilities in relation to allegations and investigations of abuse or mistreatment.

³ In addition to the matter involving Resident 1, the Inspector General also investigated two allegations of physical abuse of residents and one allegation of employee misconduct. After interviewing pertinent witnesses and reviewing relevant records, the Inspector General did not substantiate the allegations of potentially criminal conduct.

General examined several issues, including frequent required overtime for staff, lengthy periods of administrative leave for staff under investigation, and confusion over reporting requirements to law enforcement. CQC focused its care and treatment review on the areas of incident reporting, resident perception of safety, medication administration, and administrative oversight, among others.

As part of this investigation and review, the Inspector General conducted unannounced site visits during all shifts; interviewed more than 80 former and current Valley Ridge staff and residents; and examined thousands of pages of pertinent documentation including allegation of abuse reports, intervention reports, facility electronic entry and exit logs, residents' Behavior Management Plans, and records of internal investigations and staff discipline. Similarly, CQC conducted multiple unannounced and announced site visits; interviewed 22 residents; interviewed staff involved in the care of Resident 2; and comprehensively reviewed the complete clinical treatment records of 12 residents, including their individual medication administration records (MARs). CQC also completed an expansive review of Valley Ridge's medication administration practices, policies and procedures, as well as interviews of nursing and Approved Medication Administration Personnel (AMAP), and analyzed communication logs, incident reports, and incident special review committee meeting minutes.

In addition to issues specifically pertaining to Valley Ridge, during the course of this investigation the Inspector General apprised OPWDD Commissioner Burke and other OPWDD executive staff of concerns identified in a number of other ongoing investigations. These concerns related to system-wide matters, including the health and safety of residents and OPWDD's administrative oversight at other facilities.

Valley Ridge Center for Intensive Treatment

Valley Ridge Center for Intensive Treatment, which opened in 2002 and is administered by the Broome DDSO, is one of two highly secure OPWDD centers for intensive treatment and provides care for up to 60 individuals with developmental disabilities in the most restrictive environment in the OPWDD system. Many residents of Valley Ridge are involuntarily placed there as a court-ordered condition of probation or parole following incarceration; some are voluntarily admitted by family members or guardians. Most have committed crimes, have serious behavioral issues, or are a threat to themselves or others. Residents range in age from 20 to 50 and remain in the facility an average of approximately two years. Currently, all but one resident of the facility are male.

Valley Ridge residents are evenly distributed among five houses, each of which is self-contained with a kitchen, laundry room, common area, living rooms, bedrooms and bathrooms, as well as medication rooms, offices and "time-out" rooms. The facility resembles a small college campus with dormitories, a central courtyard and gym, and a main building with classrooms, dining rooms and administrative offices. Valley Ridge is staffed with approximately 200 employees, including direct care workers and

supervisors; administrative employees; clinical staff; and security officers, among others. Depending on the shift and needs of the residents, three to nine employees are assigned to each house, and supervisors and “floaters” move among the houses. Residents requiring one-to-one support are assigned a staff member at all times.

As a secure facility, Valley Ridge is surrounded by a 14-foot high curved perimeter fence. Security officers patrol the facility and staff the entrances. Access to the facility, the houses and the rooms within is gained by electronic key cards issued to all staff. Employees also carry personal alarms to summon other staff in an emergency.

Consistent with OPWDD’s mission to help people with developmental disabilities live fuller lives, Valley Ridge uses a therapeutic care and treatment approach with the goal of moving residents to less restrictive environments as their conditions allow. Residents attend daily programs in basic living skills, anger therapy, sex offender treatment and relapse prevention, among others. Some residents will graduate to regional and local intensive treatment centers, and possibly move on to group homes in communities.

OPWDD utilizes a Behavioral Support Program in its care and treatment of residents. The program consists of two components: a Functional Analysis and a Behavior Management Plan (BMP). The Functional Analysis evaluates residents’ behaviors to determine which behavioral interventions and rights restrictions are appropriate to protect the health and safety of the residents and others. The BMP acts as a guide for the direct care staff working with the residents to “minimize maladaptive behaviors and maximize functional independence.”

The BMPs are tailored to each resident’s behaviors and contain approved approaches to reinforce good behaviors and deal with challenging behaviors. When challenging behaviors occur, least restrictive approaches, including verbal and non-verbal calming techniques, are tried first. If the behavior escalates, staff may employ physical interventions.⁴ Some residents’ BMPs allow for use of a time-out room, a room in which the resident is placed to calm for periods of less than one hour under visual contact and supervision. Staff must complete an Intervention Report shortly after each event ends, including a narrative of the incident.

For the protection of residents, all allegations of abuse and neglect are required to be reported on an OPWDD Form 147. This form contains a brief description of the allegation and participants, immediate protective actions taken, as well as notifications to OPWDD, CQC, and law enforcement, when appropriate, among others.

⁴ Interventions utilized are techniques included in the Strategies for Crisis Intervention and Prevention curriculum – Revised or SCIP-R.

INSPECTOR GENERAL'S INVESTIGATION AND REVIEW

Investigation of the Alleged Abuse of Valley Ridge Resident 1

The Inspector General conducted an investigation of an incident of alleged abuse involving Valley Ridge Resident 1. In this investigation, the Inspector General obtained sworn testimony in 10 interviews of staff involved in the incident and other employees, and reviewed relevant documentation including access logs, intervention reports, and Resident 1's Behavior Management Plans, among other records.

The Inspector General learned that in early August 2010, a former employee of Valley Ridge told certain OPWDD officials that he possessed audio recordings of several Valley Ridge employees, which he had surreptitiously made during their work day.⁵ The former employee disclosed to OPWDD officials several recordings that appeared to indicate staff had been engaged in physical and psychological abuse of residents.⁶ OPWDD contacted the New York State Police, which investigated the matter as a possible eavesdropping incident and closed its review after it was unable to obtain the recordings from the former employee.

On August 30, 2010, the former employee provided OPWDD access to the audio recordings. On one recording, a Valley Ridge direct care aide (Employee 1) described an intervention involving Resident 1 and two other direct care aides (Employee 2 and Employee 3). The recording proved alarming:

Fuckin' me and fuckin' [Employee 2] threw [Resident 1's] fuckin' ass in [the time-out room]. I bounced his head off the back fucking wall, I got pissed at him 'cause fuckin' it's ten of six, ten after six, the mother fucker comes runnin' down the fuckin' hall in his pajamas, attacks [Employee 3]. So fuckin' [Employee 2] and I fuckin' take him to fuckin' time-out and I go fuck, and I trip over [Employee 2's] feet as we throw him in time-out, I trip over his feet so I'm on my knees in the fuckin' time-out room, I'm like oh, fuck so I stood up and [Resident 1's], you know, got his hand back, he's gonna hit me, so I grab him right by his fuckin' throat, grab him by his hair and I'm slamming his fuckin' head off the side of the wall, "Like why the fuck are you doing this every fuckin' morning [yelling]." Then I fuckin' went to leave and he come at me again so, I went like that and he [slapping noise] his head hit the back fucking wall [slapping noise] just like that, loud, and I went fuck, 'cause it's right there that fuckin'

⁵ On August 14, 2010, the former employee wrote in an e-mail to the Broome DDSO Personnel Director, "[Y]ou don't want to let [Employee 1 and Employee 2] back in contact with consumers, especially [Resident 1]." In a subsequent e-mail dated August 30, 2010, the former employee informed OPWDD Counsel that Valley Ridge supervisors had knowledge that Resident 1 was being treated roughly by treatment aides. That same day, the former employee advised OPWDD Counsel that audio recordings describing this abuse, as well as other abuse and misconduct, would be posted on an Internet site for download by OPWDD.

⁶ The other recordings are not relevant to this investigation.

stitch is.⁷ Mother fucker if that splits open. He stood back up and I, we started to close the door and he got to the door and booted it and we fuckin' closed the door. He said he was going to put me out [on administrative leave pursuant to a complaint] and he never did. That was the night he stood at the door tellin' fuckin' [Employee 2], "Yeah I'm going to rape [Employee 2's] girlfriend. Ha-ha-ha." [Employee 2's] like, "I'll see you tonight fucker." [Laughter.]

After listening to the recording, OPWDD officials filed allegations of abuse or neglect naming Employee 1 as the perpetrator and several other employees as having knowledge of the abuse but failing to report it. All named employees were immediately placed on administrative leave, and an internal investigation began. According to OPWDD, in October 2010 the State Police reviewed the recordings but did not investigate the matter further.

When confronted with the recording in February 2011 by OPWDD, Employee 1 resigned.⁸ OPWDD concluded that the claim of abuse was substantiated. OPWDD terminated Employee 3 in March 2011, after determining that he was neglectful for failing to report the incident. Employee 2, who also was found to have been neglectful for his failure to report the incident, had already been terminated in March 2010 after he received an insufficient grade on a direct care aide Civil Service examination.

The Inspector General, based on the compelling recording, commenced an independent comprehensive investigation. At the outset, the Inspector General reviewed Resident 1's background and treatment history. A male in his mid-20s, Resident 1 was admitted to Valley Ridge from a less secure facility in August 2008. Resident 1 had been moved numerous times since he was first committed to an institution at age 16 when his family became unable to control his severe and unprovoked aggression. His psychiatric diagnoses include Schizoaffective Disorder and Intermittent Explosive Disorder, and he is mildly mentally retarded with a "Full Scale IQ" of 66. Resident 1 is able to communicate verbally. While at Valley Ridge, Resident 1 was assessed and a Behavior Management Plan (BMP) was developed. Resident 1's BMP allowed for restrictive interventions and the use of the time-out room when maladaptive behaviors escalated and less restrictive techniques failed.

In the 11 months following his arrival, according to numerous Intervention Reports and testimony by staff, Resident 1 continued to be highly aggressive and assaultive towards staff, particularly male direct care aides, whom he appeared to have

⁷ On August 2, 2009, while assigned to E-House, Resident 1 sustained a serious head injury during an incident. According to the Intervention Report filed by Employee 2, Resident 1 assaulted Employee 2 by swinging "wildly." When Employee 2 deflected the blows, Resident 1 turned, "tripping himself up and hit his head on the bathroom door jamb," opening a large gash on the top of his head. Resident 1 was transported to the hospital where he received 22 staples to close the wound. The staples were removed on August 10, 2009, eight days later. This injury serves as a means to date the incident referred to in Employee 1's recording.

⁸ Employee 1 was absent from Valley Ridge due to a work-related injury from January to September 2010, and then on administrative leave until his resignation.

“targeted.” During this time, OPWDD records indicate that Resident 1 was involved in 701 interventions, of which 437 were non-restrictive and 264 were restrictive.⁹ This unusually high number of interventions accounted for more than 56 percent of all Valley Ridge interventions during this period.

During an intervention in early August 2009, Resident 1 sustained a scalp injury requiring numerous staples. About a month later, in the early morning of August 29, 2009,¹⁰ Resident 1 was involved in the intervention described by Employee 1 on the recording. Significantly, no report of an intervention which matches this description was ever filed. In addition, no report of abuse or neglect was filed until the recording came to light a year after the event.

As recounted on the recording of Employee 1, Employee 2 and Employee 3 were present during this intervention. However, as discussed below, the testimony of staff and residents purportedly participating in or witnessing this event differs significantly from Employee 1’s recorded description. Indeed, the first documented intervention of Resident 1 that morning is described as a strikingly different and almost routine intervention.

The first intervention report involving Resident 1 on August 29, 2009, was authored by Employee 3. This report describes a 6:28 a.m. intervention; a two-person removal of Resident 1 to the time-out room by Employee 3 and Employee 2 following Resident 1’s attempted assault of Employee 3 in the E-House hallway. The report also notes that a supervisor arrived on the scene within five minutes and a body check was performed of Resident 1 by a registered nurse within seven minutes of the intervention. No mention of Employee 1 is found anywhere in the document nor is there any reporting of the “slamming [of Resident 1’s] head off the side of the wall,” as recounted by Employee 1 on the recording.

The Statement of Resident 1

In March 2011, more than a year-and-a-half after the incident occurred, the Inspector General spoke with Resident 1 and asked his recollection of any incident involving Employee 1. Resident 1 reported that Employee 1 had once pushed him against a wall in the time-out room to “calm him down.” Regarding this event, Resident 1 stated, “I didn’t think it was right.” However, Resident 1 was unable to provide any

⁹ Non-restrictive interventions include one-person and two-person removals; restrictive interventions include a one- or two-person takedown, a two- or three-person supine, or a three-person supine with assist.

¹⁰ Both the Valley Ridge Investigations Unit and the Inspector General, in separate investigations, determined that the incident in question took place on August 29, 2009, because that is the only date following Resident 1’s injury where swipe card records indicate that Employee 1, Employee 3, and Employee 2 were present at E-House at the same time. Valley Ridge utilizes individual swipe cards assigned to employees to record their entry to and exit from the facility, as well as their movement between houses and into residents’ rooms. Employee 1’s August 29, 2009 swipe card door access logs indicate that he arrived at E-House at 1:14 a.m. and departed at 6:49 a.m.

additional description of the event, including the date or other possible participants or witnesses.

The Testimony of Employee 1

Employee 1 began employment at Valley Ridge in July 2007. After almost 15 months as a direct care aide trainee, Employee 1 was promoted to a Developmental Disabilities Secure Care Treatment Aide. In this direct care role, Employee 1 interacted with residents living in E-House and B-House during the night shift (11:00 p.m. to 7:00 a.m.). His duties varied each day and included making meals in the kitchen, passing out medications, monitoring the behavior of residents, and associated recordkeeping. When Employee 1 worked overtime, as he often did, he worked both day and evening shifts.

Employee 1 provided testimony to the Inspector General about Resident 1, interventions in general, and the events in E-House on August 29, 2009. According to Employee 1, on numerous occasions during his employment he attempted to calm Resident 1 through persuasion, but was unsuccessful. Employee 1 described his frustration when dealing with Resident 1, as he was a frequent target of Resident 1's assaults and was sometimes "attacked three or four times a night." As for interventions using the established protocol, Employee 1 replied, "It doesn't work . . . The problem is you're taught [the protocol] on a non-combative person . . . your arms are down at your side, you're not flailing." However, Employee 1 noted that some techniques, including the "supine" positioning of a resident on the floor, are effective. Asked if he ever modified the protocols during an intervention because the methods were not effective, Employee 1 denied any such action.

After reviewing Employee 3's report of the first intervention on the morning of August 29, Employee 1 initially denied any involvement in that intervention and denied he was even present in E-House on this date, as he was typically assigned to another house. Employee 1 also testified he had never been involved in an intervention where the incident and his participation in it were not documented in an Intervention Report (IR). When informed that the electronic swipe card door access logs revealed he was present in E-House on that date, Employee 1 responded, "O.K. [sigh.] I have no idea, because, apparently, if I was involved in this, I would have been on the IR."¹¹

The Inspector General then confronted Employee 1 with the recorded conversation. "The tape is bogus," Employee 1 testified. Although stating he did not want to hear the recording again as he had listened to it during his interview with the Valley Ridge Investigations Unit, Employee 1 reviewed a partial transcript of the recording, agreed it was authentic, and that the voice on the recording was his. Employee 1 denied, however, the incident described in the recording ever took place and instead

¹¹ Of note, Employee 1's assignment for this night shift was in B-House, but he and others were frequently "floated" to other houses when needed. In addition, testimony of numerous employees, including Employee 1, revealed that employees often went to E-House, as well as others, to participate in card games during the night shift.

offered that the recording represented mere exaggeration on his part in an attempt to intimidate a co-worker. “I was talking shit to [the co-worker], seeing what he was going to say,” he explained. “It was a pissing contest – trying to make myself look like a bad ass, more or less.”

Employee 1 then suggested that the incident he described in the recording was not the same incident reflected in the Intervention Report written by Employee 3, but rather a different unreported incident. Of this unreported incident, Employee 1 said, “I recall [the] event, yes.” Employee 1 admitted that something similar to the event on the recording did occur, but, “that [it] did not happen the way it sounds.”

Among the differences between the incident he described on the recording and the actual incident was “the hair thing. [Resident 1] didn’t have any [hair]. So you can’t actually grab, I mean, so when I say throat and hair, ya’ know what I’m saying, it’s not grab it like this [Employee 1 clenched his fist to demonstrate], it’s put my hands up [Employee 1 placed his hand as if on Resident 1’s forehead], he had his hands – and I wasn’t slamming his head like this [Employee 1 motioned in a forceful manner] I put him into the wall and I tried to get up. It wasn’t slamming, you know, per se.” He explained, “It was more of positioning of my hands trying to keep him away from me so that I could get up off my knees. ‘Cause I was on my knees.” Employee 1 also denied grabbing Resident 1 by the throat; rather he asserted he put his forearm across the upper part of his chest. “I’ve never grabbed him by his throat; I’ve never grabbed him by his throat, ever.” Employee 1 went on to describe this unreported intervention as follows:

[T]he two person removal, you walk them into the time-out, you’ve got to give them a shove, and you start to back out. Well, I tripped, of course, over [Employee 2’s] feet. And now I’m . . . knees, actually hands and knees, I went down. And when I looked up, [Resident 1] had his hands back [motioning as if Resident 1 would hit Employee 1], and that’s when I put my hand on his chest and pushed him to the wall. It wasn’t a, ya’ know, come here and come here. It was a, you know, trying to, almost a front deflection almost, to an extent, except I never took my hands off. I held him so I could get up. But, as far as ya’ know that way; it wasn’t the way it sounds.

I put my, I put my, I pushed him against the wall. It was not a slamming procedure. The spot where it says he said he hit his head on the back wall [referring to the recording], [Resident 1] is very uneven, do you know what I’m saying? And he pushed it, that’s what I meant by him hitting his head on the back wall. He fell, when we pushed him back in the time-out, fell and hit his head. He stood back up. No blood, no nothing. O.K. He didn’t get hurt. But, of course, I’m thinking, holy shit. So that is the sentence [referring to the recording].

I held him to the wall and asked him why he did this every day at whatever time and when he fell and hit his head, that’s when I said “Oh

shit” and that’s the slap [referring to the sound he made on the recording] is him falling. Not me slamming his head off the wall.

It was a moment of frustration. Absolutely. And that’s where the comment comes from, “Why do you do this?”

Employee 1 further admitted that he did not recall documenting the event in a report and did not know if Employee 2 had documented it, despite Valley Ridge procedures requiring an Incident Report. Employee 1’s reasoning for his omission was, “Because you get fired for that,” referring to deviations from protocol.¹² Employee 1 testified, “I don’t think there was an IR written. I don’t think so; I’ll give you that.”

Testimony of Employee 2 and Employee 3

Employee 2

Employee 2 worked at Valley Ridge from November 2006 to March 2010. Employee 2, a provisional and temporary employee of the facility, served in a direct care role. During his tenure, he was assigned to various residential houses as needed, including D-House and E-House, where he worked the evening and night shifts, respectively. In March 2010, before the recording came to light, OPWDD terminated Employee 2 after he failed to score a sufficient grade on a Civil Service examination.

Employee 2 provided sworn testimony to the Inspector General regarding the incident with Resident 1. During the period at issue, Employee 2 was assigned to the 11:00 p.m. to 7:00 a.m., or night, shift in E-House. According to time and attendance records and electronic door logs, Employee 2 was present in E-House with Employee 1, Employee 3, and Resident 1 in the early morning hours of August 29, 2009.

Employee 2 testified that although he was familiar with Resident 1, he had no recollection of any particular intervention, as Resident 1’s attacks on employees and the resulting interventions were an everyday occurrence, with one indistinguishable from the next. However, Employee 2 claimed not to recall many interventions of Resident 1 by him and Employee 1. After being provided with a transcript of Employee 1’s recorded statement in which Employee 2 was described as a participant in what can only be described as a memorable intervention, Employee 2 again denied any recollection. Employee 2 said he did not know why Employee 1 had made this statement and why Employee 1 would implicate him in this seemingly abusive intervention. He advised, “If he said he did it, then he did it, I don’t know. I just don’t remember hearing that.”

Although stating that he would remember if Employee 1 had treated Resident 1 in the abusive manner described in the recording, Employee 2 offered several explanations why he might not have even witnessed or heard the incident. One was that he had walked

¹² The Inspector General’s review of all Intervention Reports filed during this period did not uncover a single report in which Employee 2 and Employee 1 participated in an intervention of Resident 1 in E-House at or about 6:00 a.m.

away: “If this was to happen, I had gotten [Resident 1] in time-out and I turned around and walked out.” The other was that he just didn’t recall: “I was there in the hallway, I obviously helped him in the time-out, [but] I don’t recall this event.” Employee 2 offered no response to Employee 1’s recorded statement placing him at or in the time-out room.

Additionally, Employee 2 claimed he did not recall this intervention even though Resident 1 had purportedly also threatened to rape his girlfriend during the incident. According to Employee 1’s recorded statement, Resident 1 “stood at the door tellin’ [Employee 2], ‘Yeah I’m going to rape [Employee 2’s girlfriend].’” Employee 1 went on to claim that Employee 2 responded to Resident 1, “I’ll see you tonight, fucker.” Employee 2 informed the Inspector General that Resident 1 “always” threatened his girlfriend, and, therefore, this fact would not necessarily trigger his recall. Employee 2 was neither able to explain why an Intervention Report was not written for this incident nor why the report that was written by Employee 3 fails to mention Employee 1 at all.

Employee 2 claimed if he had witnessed the event described by Employee 1, or any abuse of a resident, he “would have reported it, like you should.” However, like most Valley Ridge employees interviewed by the Inspector General, Employee 2 had never filed an allegation of abuse or neglect against a fellow staff member for resident abuse in his more than three years at the facility.

Apart from this particular incident, which he claimed not to recall, Employee 2 testified that Employee 1’s demeanor when working with Resident 1 was, at times, less than professional. Employee 2 stated, “He was okay with [Resident 1]” but it was “just things [Employee 1] would say . . . [Employee 1] had a shitty disposition towards [Resident 1].” Employee 2 stated that Employee 1 would curse in Resident 1’s presence and, “when he had him on the floor, he was a little rough, but, you know, it was nothing like extremely violent.” Employee 2’s description of “a little rough” included, “Like too much pressure on the shoulder, like sitting in on the hip area too high and you get into the diaphragm and squeeze the air out of him.”

Employee 3

Employee 3 worked as a direct care aide at Valley Ridge from February 2007 to March 2011, and was assigned to several houses. In Employee 3’s testimony to the Inspector General, he too claimed no recollection of the incident described by Employee 1 and no knowledge of why an Intervention Report was not filed to reflect this incident. Of Employee 1’s recorded statement, Employee 3 testified, “No, definitely, I didn’t see that” and “No, I definitely wasn’t there at all.” Employee 3 added, “I don’t know why [Employee 1] said this, but that didn’t happen in my presence. Period.”

Employee 3 worked in E-House during August 2009, and recalled working the night shift with Employee 2 and, on rare occasion, with Employee 1. But much like Employee 2’s testimony, Employee 3 testified that Resident 1’s attacks on staff and interventions were so frequent that no single incident stood out. When shown the report he filed on August 29, 2009, for a 6:28 a.m. intervention of Resident 1, Employee 3

responded, “It looks the same as any other IR” and he did not “remember this exact incident.” As for his recollection of any earlier intervention that day of Resident 1 by Employee 1 and Employee 2, Employee 3 stated he had none. Employee 3 testified he had never written an Intervention Report containing an inaccurate description of what occurred and had never neglected to write a report to describe an intervention in which he was involved.

Contrary to Employee 2’s testimony that Resident 1 “always” threatened his girlfriend, Employee 3 claimed never to have heard Resident 1 threaten that he was going to rape Employee 2’s girlfriend. Employee 3 further claims that he had not observed Employee 1 interacting with Resident 1 in any manner that could be considered inappropriate.

In conclusion, the Inspector General’s investigation developed evidence indicating that Employee 1 engaged in physical and psychological abuse of Resident 1. Employee 1’s recorded statement, his sworn testimony, and other facts constituted compelling evidence of his abuse of Resident 1. The investigation also found that Employee 2 and Employee 3 were present at the time of the abuse and neglected their responsibility to stop and report the abuse.

Referral to Chenango County District Attorney Joseph McBride

On August 2, 2011, the Inspector General referred its findings to Chenango County District Attorney Joseph McBride. The Inspector General and the District Attorney’s Office conducted joint interviews of several key witnesses. Following consideration of the evidence, and the burden of proving guilt beyond a reasonable doubt, District Attorney McBride declined to prosecute the matter.

The Inspector General notes that impediments to prosecution often exist in allegations involving individuals with developmental disabilities in institutional settings. Many individuals with developmental disabilities who have been abused are unable to effectively testify.¹³ Additionally, direct care staff who have witnessed abuse might be fearful about implicating co-workers or otherwise reluctant to come forward. Given these and other challenges, legislative action should be considered to strengthen prosecutors’ ability to bring criminal action against persons who abuse individuals with developmental disabilities.

¹³ New York State Penal Law § 260.25 Endangering the welfare of an incompetent or physically disabled person requires that a person “knowingly acts in a manner likely to be injurious to the physical, mental or moral welfare of a person who is unable to care for himself or herself because of physical disability, mental disease or defect.” Resident 1, a mildly mentally retarded resident with Schizoaffective Disorder and a “Full Scale IQ” of 66, has been evaluated as unable to consent to medications, sexual activity and restrictive interventions.

Issues Identified in Inspector General's Review of Valley Ridge

As noted, in addition to investigating the alleged abuse of Resident 1, the Inspector General examined a number of issues relating to conditions and processes at Valley Ridge. The findings of this review are described below.

Safety of Residents

The Inspector General conducted over 80 interviews of residents and former and current Valley Ridge employees in an effort to determine if an undercurrent of physical or psychological abuse or neglect exists at the facility but which is unreported or underreported. Each individual was questioned about the safety of the facility's residents, and the overwhelming majority reported the residents were in safe hands at Valley Ridge and they had no observations or knowledge of unreported abuse or neglect.¹⁴ Additionally, direct care staff members stated that they would not be intimidated by co-workers from reporting any abuse about which they had knowledge.

Despite this testimony, the Inspector General determined in its investigation of the incident involving Resident 1 that abuse of a resident occurred which was not reported. This failure by employees demonstrates that, at least in this instance, the required filing of documentation for an intervention that had gone awry was disregarded, presumably to prevent any review of the employees' conduct. The Inspector General therefore questions whether employees are reporting as required. Indeed, as discussed below, evidence shows that staff members rarely file allegations of abuse or neglect against co-workers.

Lack of Staff-Generated Allegations of Abuse and Neglect

Records reveal that from August 1, 2007 to July 31, 2011, 754 allegations of abuse and neglect were reported to the Valley Ridge Investigations Unit. Of the 754 reports, 661 alleged staff abuse of a resident and 93 reports alleged resident abuse of a fellow resident. However, only 16, or 2 percent of the 754 reported incidents, had been filed by employees who were reporting on their co-workers or residents based on their own observations. This low percentage is consistent with the testimony of the employees interviewed by the Inspector General, who largely reported they had not initiated an abuse report against another employee in their entire employment at Valley Ridge. Despite this low reporting percentage, almost all those providing testimony to the Inspector General asserted that they would report abuse if they observed it and were not intimidated by other employees from reporting. Significantly, of the 754 incident reports, 148 cases, or 18.86 percent, were substantiated. Based on the number of substantiated investigations, the Inspector General questions whether staff members have been abdicating their responsibilities as mandated reporters by failing to report abuse.

¹⁴ Two former Valley Ridge employees stated that residents and staff alike were in danger from assaults by other residents.

Further, the Inspector General notes that the presence of outside investigative and monitoring entities at Valley Ridge for an extended period appears to have had a positive impact. During the course of the Inspector General's and CQC's investigations and regular presence at the facility, overall allegations of abuse and neglect dropped. However, allegations made by staff members against co-workers significantly increased. From August 2007 to the end of 2010, a total of five such allegations were filed. In contrast, from January 1 to November 8, 2011, a period which encompasses the Inspector General's and CQC's regular presence at the facility, nine allegations of this kind have been filed.

It should also be noted that during the period when the Inspector General and CQC were regularly on-site, OPWDD implemented reforms on abuse reporting, including training staff and requiring staff to attest when signing time sheets that they reported all abuse incidents.

Staff Cite Difficulty in Handling Challenging Behavior of Residents

The Inspector General's interviews of staff and residents at Valley Ridge revealed that a number of employees had suffered injuries, several quite serious, at the hands of assaultive residents. Staff expressed frustration about a lack of procedures which would allow them to effectively address particularly challenging behaviors by residents, including violent assaults on staff. Underscoring their concern, staff cited a number of serious injuries inflicted by residents.

Additionally, staff stated that they perceived a shift in treatment modalities at Valley Ridge from a corrections mentality to a therapeutic approach. Reflecting on this change, one employee stated, "Basically, the [residents] can do whatever they want around here . . . everybody is so afraid that if they tell the [residents] not to do something they are going to be put out on a 147; it's mayhem right now." A number of staff pointed to the need for thorough evaluations and routine assessments of the residents who exhibit assaultive behavior so that protocols could be established to better address repeated and violent behaviors.

These findings reveal a need for OPWDD to examine the issues underlying these staff concerns. This examination should focus on the need for revised procedures and additional training.

The Reporting Process to Law Enforcement

The Inspector General notes that issues involving reporting abuse and neglect to law enforcement have been identified at various State agencies which operate residential facilities, including OPWDD. Just what is to be reported to law enforcement is an area of diverse interpretations. Mental Hygiene Law requires OPWDD to report matters to law enforcement "if it appears that a crime may have been committed" against a client receiving services. This definition allows for a great deal of discretion and provides few specifics.

During the course of this investigation, in August 2011, Governor Cuomo announced an agreement between OPWDD and the State Police to reform the abuse reporting system. Notably, the agreement provides specific guidance as to what instances should be reported to law enforcement, and includes such actions as intentional hitting, slapping, pinching, kicking, hurling, strangling or shoving of a consumer by a staff member; sexual contact between staffers and consumers; and any situation where a staff member knowingly fails to act or acts in a manner that is injurious to the physical or mental welfare of a consumer, among others. In addition, the agreement focuses on creating consistent procedures for reporting, processing and investigating allegations, designating a staff liaison for local law enforcement, and providing OPWDD training to the State Police in the areas of interviewing witnesses and investigating crimes against people with developmental disabilities. It is expected that the greater clarity in reporting obligations and processes provided by this agreement will improve the thoroughness with which incidents of abuse and neglect are reported going forward. The State Police has also designated a member of its staff to review questions regarding possible referrals.

The Toll of an Overburdened Investigatory System – Excessive Overtime and Administrative Leave

A frequent complaint among almost all interviewed by the Inspector General was the toll of implementing the goal of “zero tolerance” of abuse and neglect at Valley Ridge. In fact, in March 2011, at the onset of the Inspector General’s investigation, approximately 25 employees, or almost 20 percent of the direct care workforce, were absent from the facility on administrative leave pending the outcome of an investigation of alleged abuse or neglect. These administrative leave absences resulted in significant overtime for remaining employees, who were often mandated to work back-to-back shifts to make up for the absence of their co-workers. Indeed, from 2008 through 2010 overtime hours increased nearly four-fold, from approximately 16,000 hours to 62,000 hours. Allegations of abuse and neglect doubled, from 118 in 2008 to 236 in 2011.¹⁵ Many employees pointed out that the strain on the system from the soaring administrative leave and overtime was a “recipe for disaster,” *i.e.*, may have contributed to the increase in allegations of abuse.¹⁶

Several strategies were recommended by staff to address these issues. One was to implement protocols for a rapid triage of complaints to assess and rule out frivolous and obviously incredible claims and focus on those complaints with merit. According to many employees, numerous false complaints are made by residents bent on revenge for a perceived wrong or boasting of the power they wield. For example, a staff member reported that a resident alleged to her that several direct care aides had raped him in the middle of a common area during a busy time in the house. Although this staffer knew for a fact that this claim was “preposterous,” she nonetheless filed an allegation of abuse on behalf of the resident and the subjects were placed on administrative leave. In other instances, employees reported that residents had made false allegations when they were

¹⁵ The reporting period runs yearly from August 1, 2007 to July 31, 2011.

¹⁶ One employee testified to the Inspector General he had worked various shifts for 100 consecutive days, and during the eight months he worked in 2010, he amassed 1,100 overtime hours.

denied food that was outside of their dietary plans or when angered over having to brush their teeth. Yet another example was a staff member who was placed on administrative leave for a number of weeks for arguing and cursing at another staff member in front of a resident. One employee advised that while intolerant of any abuse and recognizing the need for “zero tolerance,” “somewhere along the way we lost our way; common sense is not there anymore.”

Another approach involved the greater use of False Allegation Protocols, which are designed to deal with residents who exhibit a pattern of making the same false allegation in response to a particular set of circumstances. For example, if within a certain period a resident, every time he was denied food outside of his dietary plan, filed a false allegation claiming that an employee physically abused him, subsequent similar allegations under these circumstances would be reviewed in a different light. Rather than immediately placing the subject on administrative leave and commencing a potentially lengthy investigation, subjects are removed from resident contact while an abbreviated investigation is undertaken. If similar to earlier false reports and no other evidence is found to bolster the claim, the claim is deemed unsubstantiated and all restrictions are lifted.

Work Adjustment, the temporary re-assignment of an employee to a non-direct care role pending an investigation, was also offered by employees as a means to potentially curtail overtime among direct care aides. For example, employees involved in allegations have been re-assigned in the past to shopping, cleaning and administrative duties in lieu of direct care roles. This reassignment allows the employee to remain working, thereby reducing overtime needs.

Of note, Valley Ridge plans to implement a pilot program to video-record activities in the common areas of the facility and the time-out rooms of the houses.¹⁷ The purpose of the recording is to deter abuse and assist in investigations. As such, it may result in a reduction of false allegations and the length of investigations.

Centralized Disciplinary Process for Abuse and Neglect Investigations

In May 2011, in an effort to ensure greater consistency in the application of discipline to its employees and hold those employees found to have engaged in abuse and neglect accountable, OPWDD issued new procedures for centralized discipline. The redesigned procedures require the Central Office’s Employee Relations Office (ERO) be included at the onset to streamline the disciplinary process and shorten the duration of claim to resolution. So as to ensure sanctions are applied equally, Central Office ERO will now determine the appropriate disciplinary penalty rather than the respective DDSO.

The process triages cases based on the severity of the alleged incident or misconduct. Those cases deemed most critical or highly significant are to be expedited and worked in conjunction with a Central Office representative. For serious abuse and

¹⁷ The Centers for Medicare & Medicaid Services (CMS) is requiring that Valley Ridge obtain the consent of the residents or their guardians for this monitoring.

neglect cases, OPWDD will pursue the employee's termination. These include such acts as physical, sexual or serious psychological abuse; neglect that results in serious injury, death or puts individuals at serious risk of harm; criminal acts; repeated neglect, abandonment of post and failure to intervene to prevent harm.

CQC'S INVESTIGATION AND CARE AND TREATMENT REVIEW

Investigation of Alleged Abuse of Valley Ridge Resident 2

On March 17, 2011, CQC commenced an investigation of Valley Ridge practices and procedures in response to a complaint lodged by a clinical staff member of Valley Ridge that Resident 2, following an unexplained injury to his groin area, received daily body checks, including photographs of his groin, and such actions were not medically required and a violation of Resident 2's rights. To investigate this claim, CQC interviewed Resident 2 and staff involved in his care and treatment, and reviewed Resident 2's clinical record, progress notes and other medical documentation.

Resident 2, a 21-year old male, was admitted to Valley Ridge in February 2010 from a less restrictive residency in Broome DDSO due to escalating behaviors. Resident 2 is diagnosed with mild mental retardation, bipolar disorder, oppositional defiant disorder and impulse control disorder. His target behaviors include touching others in a sexual manner, making comments of a sexual nature, assault, property destruction, elopement, and suicidal gestures.

CQC interviews of Resident 2 and involved staff, as well as record reviews revealed the following:

On March 7, 2011, after a heavy snowfall, Resident 2 assisted staff in shoveling facility walkways and decks. Later that evening, Resident 2 informed staff that his genital area was bruised and sore. He was examined by a nurse who noted no medical injury to his scrotum.¹⁸ The following day, Resident 2 attended a half-day of programming before returning to his residence complaining of pain. According to nursing notes, Resident 2 was again examined and found to have bruising extending to the base of his penis. At this time, Resident 2 denied any knowledge of how the injury occurred.

Valley Ridge policy mandates, upon staff observation or discovery of an incident, that the Head-of-Shift is to be immediately informed and an OPWDD Form 147 is to be initiated. The Head-of-Shift is then responsible for ensuring examination and treatment (if needed) are conducted, documented actions on the 147 form are complete and the resident's parent/guardian is notified of the incident within 24 hours. The later two actions, however, did not occur in a timely fashion and the OPWDD Form 147 was not filed until several days later.

¹⁸ The nurse noted no bulging, deformity or guarding in the scrotum.

On March 9, 2011, according to nursing notes, Resident 2's scrotum remained discolored and he continued to deny injury or trauma to the area. Resident 2 was then examined by the facility physician, John Cruz, M.D., and told Cruz that "[his scrotum] turned black after shoveling." Cruz's notes document that Resident 2 had a large bruise at the base of his penis and that direct care staff reported the injury occurred while Resident 2 was shoveling. Cruz ordered periodic monitoring and blood work and scheduled Resident 2 for a March 11, 2011 appointment to check on the injury. At this time, nursing staff began to photograph the injury. The medical staff opined that Resident 2's injury could have been caused by the handle of the shovel pushing into Resident 2's lower abdomen causing blood to pool in the scrotal sack resulting in bruising. Also on March 9, the Valley Ridge Incident and Minor Occurrence Log documented that a 147 had been initiated due to the fact that Resident 2's injury was of unknown origin and the Head-of-Shift had been notified.

Later in the evening of March 9, a Valley Ridge investigator who was using a facility digital camera for an unrelated purpose discovered photographic images of Resident 2's groin area on the camera. Unaware that the images were related to medical staff's evaluation of Resident 2's injury, the investigator notified the Valley Ridge Investigations Unit and Quality Assurance of the images.¹⁹ According to the Investigations Unit, which had yet to receive notification of an incident report (147), a subsequent search located Resident 2's incident report in a pile of paperwork in the Head-of-Shift's office.

On the morning of March 10, Resident 2 was seen by nursing staff after he was found crying uncontrollably. Nursing notes indicate Resident 2's bruising remained, no swelling was observed, he complained his thigh and back hurt, and Cruz had been notified. Shortly thereafter that same day, Resident 2 reported pain in his lower abdomen and groin area. Treatment Team Leaders (TTL) attempted to alert a Valley Ridge official via telephone of the need to transport Resident 2 to the hospital to rule out any immediate medical concerns due to his presentation. By the time the official returned the team leader's phone call, Cruz was on his way to the facility, therefore, the official directed that Cruz see Resident 2 immediately upon his arrival.²⁰ Cruz's examination found no medical concerns; the soreness Resident 2 was experiencing was a result of the bruising.

During their daily meeting, TTLs noted that Resident 2 had sustained multiple injuries of unknown origin in the past two months and therefore decided to conduct daily body checks of Resident 2 and photograph his injury. According to the TTLs, the daily photographs of the injury could assist in determining the source for the trauma to the area.²¹ On March 11, 2011, a TTL e-mailed all nursing staff of this decision. The e-mail read, "Until further notice, nursing will be responsible to take daily photos of Resident

¹⁹ The camera is assigned to Valley Ridge Quality Assurance.

²⁰ The official directed that Resident 2 would remain at the facility and await the arrival of Cruz rather than be transported to a hospital for treatment as the hospital wait would likely be longer.

²¹ As per the OPWDD Basic Investigations Manual, color photographs are recommended for bruises every 8 hours for a period of 2-3 days.

2's genitals. This requirement is necessary to aid in an investigation and is not for medical purposes. This is not an option, it must be completed daily."

The physician's note made by Cruz on this same date showed his disagreement with the decision to photograph Resident 2's injuries each day. Cruz wrote that Resident 2's scrotal discomfort had resolved, and that the daily photographing of his groin area was medically purposeless and intrusive and demeaning. Cruz recommended photographs be taken every three days and instructed staff to do so as long as Resident 2 was agreeable. However, a nurse treating Resident 2 was directed by another TTL that she was to continue to take the photos as the photos were being used for an investigation, not medical purposes.

According to nursing staff and Cruz, over the next few days, nursing staff complained to Cruz that they were uncomfortable photographing Resident 2's groin area. On March 15, 2011, the State Central Register (SCR) was contacted about the matter, and the caller was referred to Adult Protective Services (APS) to file a rights violation. Cruz contacted Resident 2's social worker who reported he was unaware of the photographing. In turn, the social worker contacted the Broome DDSO Director of Investigations, who was aware of the photographing. The Director of Investigations advised the social worker that if he believed Resident 2's rights were being violated, then he should file an incident report.

Cruz's notes for the following day indicate that Resident 2 had no discomfort, and although Resident 2 reported he had blood in his urine, a urinalysis was negative. Again, Cruz noted he was opposed to the schedule of daily pictures. On this same date, Resident 2 reported to a nurse that he did not want her "looking at him everyday." Cruz then filed an incident report targeting the official and the TTLs who had made the decision to photograph Resident 2 on a daily basis.

On March 17, 2011, the social worker contacted Resident 2's mother and informed her of the daily photographs. She requested they be stopped as she had not been contacted regarding any of these actions. That same day, the Nurse Administrator notified the TTL that Resident 2's mother wanted all photos and body checks to stop immediately.

An allegation of sexual and psychological abuse was then completed by a Valley Ridge social worker based on Resident 2's statement that he did not want to be photographed and the claim that nursing staff had been threatened with insubordination and termination if they did not follow the order to take non-medical daily photographs of Resident 2's groin area.

The investigation of what was reviewed as psychological abuse was conducted by OPWDD's Central Office Internal Affairs. The investigation found that the taking of photographs was a direct order from the Valley Ridge official, and relayed to nursing staff through the two TTLs and others. The allegation of psychological abuse was not substantiated as the subjects were acting in Resident 2's best interest from a protection

standpoint, and the official had the authority to direct that photographs be taken for investigative and potentially evidentiary reasons. OPWDD recommended that the actions of Cruz and the social worker in this matter be investigated.

CQC'S Care and Treatment Review of Valley Ridge

In addition to investigating the allegation regarding Resident 2, CQC conducted an assessment of the care and treatment of residents at Valley Ridge. The review focused on incident reporting, resident perception of safety, resident medication, administrative oversight, and other issues. CQC made multiple unannounced and announced visits to the facility, interviewed residents and staff, and reviewed incident reports, policies and procedures, and other documents.

Assessment of Resident Safety

To ensure the safety of residents, CQC staff interviewed 22 residents of the five Valley Ridge houses. CQC interviewed the residents regarding their safety as well as their comfort level in reporting allegations of abuse or neglect. Overall, the residents reported they felt safe at Valley Ridge. Those who had concerns about their safety in the facility stated that their unease was due to the actions of other residents, not staff.

Regarding reporting abuse and neglect, the residents stated they were familiar with the process for filing an allegation and most had done so in the past. Some residents described instances in which they witnessed and reported abuse and/or neglect, and the subject staff members were placed on administrative leave. Several residents also reported that in some instances employees had been unfairly placed on administrative leave as a result of false allegations.

Site Visit Observations

CQC conducted an unannounced site visit to the facility in April 2011 and observed the interactions between staff and residents, the general environment of the residents' houses and medication administration, and ensured appropriate supervision was being provided by staff members. During the visit, CQC found the houses to be clean, free of odors and staffed appropriately.²² Due to inclement weather, the residents were not participating in outside "programming" or recreation but were in the residence houses. Some were engaged in individual activities including molding clay, using an exercise machine and watching a televised baseball game, and were eager to explain their activities and engage in appropriate conversation. Others wandered around the dining room or sat idly in chairs. CQC found that assignment sheets were appropriately completed and staff assigned to a resident with a heightened level of supervision was supervising the resident. The administration of medication was also found to be compliant with procedures.

²² During CQC's April 2011 visit, the outside temperature was unseasonably hot and humid. Conditions within the several houses visited too were very warm. Valley Ridge reported the air conditioning had not yet been turned on for the year.

CQC also observed an admirable performance by staff members in defusing a tense situation: As a resident's agitation continued to escalate, he began to engage in severe self-injurious behavior. After an hour of attempting to de-escalate the situation, and as the self-injurious behavior worsened, staff used the personal duress alarm and a safety officer and nurse responded. CQC found that the staff members were patient and calm in their approach with the resident, and no physical intervention occurred. The resident's behavior support plan was followed and staff acted properly at all times in defusing the situation.

Incident Reports

CQC reviewed 183 incident reports for the period April through June 2010 for D-House and E-House to ensure that reports were classified and investigated appropriately.²³ Minutes of meetings of Valley Ridge's Special Review Committee (SRC), which reviews all cases twice monthly and provides guidance for further investigation, were also cross-referenced with the incident reports to ensure that the incident reports were investigated and that the findings, recommendations, and corrective actions were appropriate. CQC's review found that the incident reports were classified and investigated appropriately, and that the SRC minutes were thorough and adequate in response to the investigations.

As a result of its review, CQC identified concerns relating to the Awareness, Training and Feedback (ATF) Program, which assists employees in performing their job more effectively with supervisory assistance, and the Consolidated Traveling Record (CTR), a binder carried by residents in which staff record the resident's progress throughout the day. CQC noted that 11 staff members who were the subject of abuse/neglect investigations during the period reviewed had been recommended to participate in the ATF Program. While in the program, employees are made aware of the policies and procedures they have not been following and which might be the cause of the problems in their job performance. Supervisors assist employees in the program through training and modeling proper techniques and behavior. Employees can participate in the program from 30 days to a year, during which time supervisors provide feedback to participants. In its review of SRC minutes, CQC found that several direct care staff have been repeatedly recommended for the program and that a number of staff members have been involved in the program on more than one occasion. As a result, it appears that Valley Ridge may not be monitoring the program to ensure its effectiveness or that certain employees may have problems on the job which the program is not effectively addressing.

CQC also identified concerns with the CTR, the binder carried by residents which serves as a data collection monitoring tool for both positive and negative behaviors. Staff members' written progress notes on the residents' behavior are maintained in CTR

²³ The reports reviewed included reports that were generated as a result of minor occurrences and reportable incidents, which are filed within the facility, as well as serious reportable incidents and allegations of abuse, which must be documented on an OPWDD Form 147 and reported to OPWDD Central Office through the local DDSO.

binders. Some residents' behavior plans incorporate earning money or tokens for attending groups or for refraining from target behaviors. When residents display negative behaviors, these behaviors are tallied, and the data is used to revise behavior goals and rights restrictions. CQC found that the CTR can become a source of escalation for many residents. A review of incident reports shows that when a resident displays a negative behavior and a staff member writes a note in the CTR, an escalation of the resident's behavior may occur, ultimately resulting in physical intervention. CQC also notes that Valley Ridge lacks a policy or protocol on use of the CTR.

Medication Administration and Documentation

In response to concerns about medication practices reported to CQC by the Valley Ridge Deputy Director, a CQC nurse conducted an unannounced visit to Valley Ridge in April 2011. During the visit, CQC became aware of a "communication log book" used by nursing staff. Examination of the log book revealed several entries indicating that borrowing or swapping of resident medications had occurred when a resident's medication was missing from blister packs or had run out. It was further noted that nursing staff did not sign their log book entries. Due to these concerns, CQC conducted a comprehensive medication review.

In conducting this review, a CQC Registered Nurse assisted by a Psychiatric Nurse Practitioner examined clinic stock medications and the medication rooms in several houses, and obtained copies of medication related policies and procedures, medication error investigations, medication administration records (MARs), minor medication error reports, medication recertification tracking tools and medication administration course recertification records. In addition, nursing and Approved Medication Administration Personnel (AMAP) staff at Valley Ridge were interviewed.

CQC learned that the evening nurse is responsible for ensuring residents have sufficient medications for the week, and a doctor is contacted for needed refills. The night shift nurse is responsible for ordering medications, conducting monthly on-site audits at each house, monitoring drug counts, doctor's orders and MARs to ensure proper accounting. To obtain certification as an AMAP and administer medications, staff members must successfully complete an OPWDD medication administration course and receive on-the-job training. AMAPs must be recertified annually. CQC reviewed documentation and confirmed that all staff currently working at the facility were properly certified or in the process of becoming so.²⁴

During two unannounced visits in April 2011, CQC found the medication rooms to be properly secured and clean, with no expired medications and all controlled medications kept in a double-locked box. The staff member responsible for administration of medications for each shift possessed the keys to the rooms and the locked cabinets within. Medication cabinets contained cubby holes labeled with each resident's name and were stocked with blister packs of their ordered medications. CQC

²⁴ Several staff whose certification had expired were on administrative leave.

found accurate narcotic counts, and most residents had well-stocked medications with extra medication in overflow cabinets.²⁵

CQC found that Valley Ridge's policy with respect to reporting medication errors was out of date. After CQC brought this deficiency to the attention of the facility, it adopted Broome DDSO's policy. CQC reviewed Valley Ridge's Medication Error Investigation Reports and did not find serious deficiencies.

Lack of Administrative Oversight at Valley Ridge

CQC found that Valley Ridge has undergone changes in its leadership, and, in September 2010, the facility director, Fred Barnes, was demoted and transferred to a position at Broome DDSO due to his lack of on-site presence at Valley Ridge. Carl Letson, Executive Director of Broome DDSO, and Anne Marie Peterson, Deputy Director, had the administrative responsibility for Valley Ridge as well as Broome DDSO. Their main offices were located at Broome DDSO.

To compensate for the lack of continuous executive management providing oversight, Valley Ridge has taken a number of actions, including implementation of unannounced rounds by administrative staff during various shifts. In addition, Valley Ridge and Broome DDSO administrative staff conducted random unannounced rounds during critical times. CQC conducted an unannounced site visit in April 2011 during the evening shift and observed that these stopgap actions were occurring.

CQC further found that the gap in leadership at Valley Ridge was exacerbated by a lack of administrative oversight by Broome DDSO. The existing leadership at the facility lacked a sufficient backup plan for oversight at the facility in their absence. CQC found that this situation resulted in failures in communication and deficient supervisory monitoring. Mark Lankes was named as the Executive Director of Broome DDSO on September 29, 2011. CQC understands that a new facility director will be appointed in January 2012.

CQC recommends that OPWDD ensure adequate administrative oversight at Valley Ridge at all times. An oversight plan should be developed if for some reason there is a lack of administrative presence, including vacancies in key administrative positions.

²⁵ CQC found that the supply of Clozaril appeared at times to be low; however, it was learned that Valley Ridge maintains only a seven-day supply of Clozaril due to lab work requirements.

CONCLUSION

Findings and Recommendations of the Inspector General

The Abuse of Valley Ridge Resident 1

The Inspector General's investigation found compelling evidence that Employee 1, a former Valley Ridge direct care aide, engaged in physical and psychological abuse of Resident 1 in August 2009. In a recorded conversation and in his sworn interview with the Inspector General, Employee 1 admitted to abusive conduct during this incident.

The Inspector General found that Employee 1 and other Valley Ridge direct care staff failed to document and report the incident involving Resident 1. Information about the incident only came to light a year later when a former employee referred to it in a meeting with OPWDD concerning unrelated matters. When it learned of the incident, Valley Ridge management commenced an investigation which substantiated the allegation. All staff involved in the incident resigned or were terminated.

The Inspector General referred these findings to the Chenango County District Attorney's Office, and after the matter was reviewed by that office, the Chenango County District Attorney's Office declined to prosecute. The Inspector General recognizes that difficulties often exist in prosecuting allegations of abuse involving individuals with developmental disabilities in institutional settings. These difficulties include the fact that many individuals with developmental disabilities who have been abused are unable to effectively testify, and that employees who have witnessed abuse might be reluctant to implicate co-workers. In addition, at present New York State Penal Law Article 260 sets forth offenses relating to endangering the welfare of incompetent or physically disabled individuals: Penal Law section 260.25 is a misdemeanor, and sections 260.32 and 260.34 are felonies, which require, among other elements, proof of physical injury or serious physical injury. Absent proof of physical injury, in addition to the other evidentiary challenges, law enforcement may be disinclined to invest resources in investigations and prosecutions resulting, at best, in misdemeanor convictions.

In light of these difficulties, legislative action should be considered to strengthen prosecutors' ability to bring criminal action against persons who abuse individuals with developmental disabilities. Such action should, at minimum, consider: 1) elevating the existing offense of endangering the welfare of an incompetent or physically disabled person, as provided in Penal Law section 260.25, to a felony; 2) establishing a new misdemeanor offense of endangering the welfare of an incompetent or physically disabled person, predicated on a lower standard of mental culpability such as that a person acts recklessly or with criminal negligence with respect to their conduct; and 3) elevating the existing crimes of endangering the welfare of a vulnerable elderly person, or an incompetent or physically disabled person in the first and second degrees, as provided in Penal Law sections 260.32 and 260.34, to D and C felonies, respectively.

Review of General Conditions and Processes at Valley Ridge

The Inspector General found that although Valley Ridge regularly substantiates cases of abuse and neglect, direct care staff at the facility almost never file allegations of abuse and neglect against other staff members. Instead, 99 percent of all allegations arise from residents with developmental disabilities, investigations, or other sources. The Inspector General recommends that OPWDD examine this issue and retrain direct care staff in their obligations as mandatory reporters.

The Inspector General notes that during the period when the Inspector General and CQC were regularly on-site at Valley Ridge, OPWDD implemented reforms on abuse reporting, including training staff and mandating staff to attest when signing time sheets that they reported all abuse incidents.

The Inspector General found that lengthy administrative leave periods resulted in excessive mandatory overtime for direct care staff. The Inspector General notes that during the course of this investigation, OPWDD instituted a centralized disciplinary process for abuse and neglect investigations that, in part, triages cases based on the severity of the alleged incident or misconduct and expedites case work. Thus, these efforts are designed to impact the duration of investigations, overtime and administrative leave, among other things.

The Inspector General found that numerous Valley Ridge staff members expressed concerns about what they perceived as limitations in the means used to address especially difficult, including assaultive, behavior by residents. These findings reveal a need for OPWDD to examine the issues underlying these staff concerns, with specific focus on the need for revised procedures and additional staff training.

The Inspector General found that OPWDD and other State agencies have variously interpreted the applicable statutes with respect to reporting allegations of abuse and neglect to law enforcement. The Inspector General notes that during the course of this investigation, Governor Cuomo announced an agreement between OPWDD and the State Police to reform the abuse reporting system, which provided guidance on what should be reported and consistent procedures for reporting and investigating allegations, among other actions.

Findings and Recommendations of CQC

Allegation of Abuse of Resident 2

CQC found that Valley Ridge failed to promptly file a 147 incident report when the injury was reported by Resident 2 to direct care staff. This failure to report violated Mental Hygiene Law (MHL), 14 NYCRR §624, Valley Ridge's policy and procedures (8.3 – Consumer Protection), and OPWDD's Basic Investigations Manual. On March 7, 2011, the Valley Ridge nursing log noted that Resident 2's testicles were dark and bruised, he was complaining of pain, and had denied knowledge of how this injury

occurred. According to 14 NYCRR §624, a 147 incident report should have been filed; however, no report was filed until March 9, 2011. Furthermore, had the 147 been completed in a timely fashion, reporting procedures would have required the immediate notification of the Head of Shift, chain of command, and Resident 2's mother, as provided by Jonathan's Law.²⁶

CQC found that Valley Ridge failed to follow its own internal protocols for basic investigations relative to photographing injuries. The OPWDD Office of Investigations and Internal Affairs Basic Investigations Manual, which describes the need for and use of photographic evidence in investigations, provides that photographs should be taken when the injuries to the individual are the most obvious and serial photographs of bruises are recommended for 2 to 3 days, every eight hours. The decision of the Valley Ridge official and the accompanying TTLs to photograph Resident 2's bruising for six days until they were stopped abruptly under the direction of Resident 2's mother was not in accordance with the protocols for a basic investigation. However, it is noted that the intent of the official's actions was in support of the investigation.

CQC found that Valley Ridge did not seek immediate and supportive medical attention for Resident 2 following discovery of his injury. Due to the lack of supervisory oversight at the facility, Resident 2 was not provided with immediate medical attention, other than Ibuprofen for pain for the injury to his groin. On at least four occasions following his injury, Resident 2 complained of pain and at times was found to be crying. Staff claimed that management officials were not always at the facility or able to be immediately contacted, causing delays in administrative decisions regarding medical treatment. Staff also reported that management staff and Cruz were not always in agreement regarding medical treatment, which caused further delay.

The apparently strained relationship between Valley Ridge management and Cruz affected the actions and decisions which occurred in relation to the Resident 2 matter. In his notes in Resident 2's clinical record, Cruz indicated his dissatisfaction with the handling of the investigation into Resident 2's injury. Had concerns about the handling of the investigation been expressed up the chain of command, possibly even through contact with Broome DDSO, the matter could have been resolved more efficiently.

CQC found that nursing staff failed to properly document Resident 2's injuries on body check forms. In an attempt to determine the point of origin of Resident 2's injuries, Valley Ridge's Quality Assurance (QA) staff requested that body check forms and photographs be completed to document changes in Resident 2's injuries. CQC reviewed the body check forms and found that Valley Ridge nursing staff did not complete the forms thoroughly and in accordance with the request of QA staff. The purpose of these forms is to document the size, location and color of bruises; however, nursing staff only documented that there were no new injuries found. By documenting in this fashion, no

²⁶ "Jonathan's Law" (MHL Article 33) gives parents and guardians of individuals with developmental disabilities who live in government facilities access to records concerning abuse allegations and mandates telephone notification to parents or guardians within 24 hours of an incident followed by a written report within 10 days.

updated information was provided regarding the existing bruising on Resident 2; therefore, the body checks were not useful in providing the requested information in an attempt to determine the point of origin of Resident 2's injury.

CQC found a lack of communication among Valley Ridge staff that negatively impacted Resident 2's care. In interviews with Valley Ridge staff, CQC found a distinct gap in communication between Cruz, nursing staff and QA. Nursing staff described their dissatisfaction with the mandated photographs of Resident 2's injuries, yet they never documented their concerns and only reported them to Cruz and Nurse Administrator Lisa Jones. They also received mixed directives from both QA and Cruz regarding the frequency of the photographic documentation. Jones reported to CQC that although she was aware that nursing staff were upset with having to take photographs on a daily basis, she never attempted to evaluate Resident 2 herself or address the concerns of her staff with QA or management. Open communication between all of the facility providers, including management, is necessary to ensure a therapeutic environment.

CQC found that the OPWDD investigation was not comprehensive. OPWDD's Internal Affairs investigation of the claim of psychological abuse against a Valley Ridge official and the TTLs was deficient based on the fact that targeted staff was cleared to return to their duties within seven days. Staff interviewed by CQC reported their concern over the rapid investigation and noted that when direct care staff members become targets of allegations of abuse, their administrative leave continues for weeks and sometimes months. CQC found that investigators failed to interview key personnel, including Resident 2, Cruz and medical personnel, who may have been able to provide additional information regarding the allegation, and only interviewed the targets, complainant and a Valley Ridge investigator.

Recommendations Resulting from Investigation of Resident 2 Matter

CQC recommended that all Valley Ridge personnel receive mandatory re-training in 14 NYCRR §624 and Valley Ridge policy and procedures related to Incident Reporting and Consumer Protection.

CQC recommended that Valley Ridge develop procedures to ensure communication between clinical, medical, investigative and managerial staff regarding medical practices when warranted.

Additionally, CQC recommended that Valley Ridge undertake a review to ensure that medical staff follows appropriate documentation requirements regarding body checks and implement a monitoring process of the same.

Lastly, CQC recommended that OPWDD ensure that all investigations include interviews with key witnesses as well as the involved individual when clinically appropriate, and all OPWDD investigations be completed within a reasonable period, as the targets of investigations at Valley Ridge appear to be placed on administrative leave for lengthy periods.

Findings Regarding Review of Medication Practices

CQC found that nurses should be trained to ensure they sign all entries in the communication log book. In April 2011, Valley Ridge reported it had trained nurses as appropriate and that a Nurse Administrator will monitor the log book on a weekly basis to ensure compliance.

CQC found that borrowing medications from a resident to supplement a missing medication for another is problematic. In May 2011, Valley Ridge advised it will promulgate new policy to prevent the unnecessary borrowing of medications. The policy will address instances when a resident's medication runs out or is unusable because it has been dropped or otherwise contaminated. Under the policy, the AMAP will notify the nurse who will call the pharmacy for replacement of the medication. The policy also will implement a new Record of Destruction of Medications, which will be reviewed and initialed weekly by the house nurse and monthly by the Nurse Administrator. Training for staff in use of the document and the overall policy will be provided. The Emergency House Stock Medication Box will be revamped to include several medications known to frequently run out due to resident refusals of medication and/or medication contamination. In-service training was provided to the Nurse Administrator for online ordering and efficient delivery of immediately required medications. Subsequently, the Nurse Administrator trained facility nurses in these issues.

CQC also found a failure to consistently document residents' refusal of medication. The facility will review and revise as needed procedures for medication refusals, and will train staff in any new procedures implemented.

* * *

The findings of the Inspector General's and CQC's investigations and reviews have been provided to OPWDD. The Inspector General and CQC will also make available the results of their investigations and reviews to Clarence Sundram, Special Advisor to Governor Cuomo on Vulnerable Persons.

Further, during the course of this investigation the Inspector General apprised OPWDD executive management of additional concerns relating to the health and safety of residents and OPWDD's administrative oversight at other facilities. OPWDD's response to this report, which is attached, reflects an ongoing effort to reform the agency and addresses the issues specific to Valley Ridge as well as these broader concerns.

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December 29, 2011

Honorable Ellen Biben
New York State Inspector General
Empire State Plaza
Agency Building 2, 16th Floor
Albany, New York 12223

Honorable Roger Bearden
Chair, New York State Commission on Quality of Care
and Advocacy for Persons with Disabilities
401 State Street
Schenectady, New York 12305

Dear Inspector General Biben and Chairman Bearden:

The Office for People With Developmental Disabilities (OPWDD) is in receipt of your December 22, 2011, draft Report based on an investigation conducted by the New York State Office of the Inspector General and the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD).

Reports of troubling conditions at the Valley Ridge Center for Intensive Treatment (Valley Ridge) led me to contact the Inspector General in March 2011 to request that your offices perform this investigation. Please accept my thanks for the many hours your investigators and staff spent interviewing witnesses, reviewing documents and preparing these recommendations.

Your report confirms OPWDD's assessment of the serious issues existing at Valley Ridge when I became Commissioner of OPWDD and underscores the need for the immediate protections put in place at the time and the systemic reforms we have implemented since. OPWDD's review concluded that the culture at Valley Ridge by March 2011 had grown increasingly negative with respect to how staff interacted with individuals with developmental disabilities; incidents were not being appropriately reported and investigated and a general distrust existing among staff, management, and individuals with developmental disabilities. These findings are confirmed by the Report you have shared with us today.

Honorable Ellen Biben
Honorable Roger Bearden
December 29, 2011
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In response to OPWDD's concerns with conditions at Valley Ridge I sent in a team of OPWDD's high-level administrators to assess the situation and put in place immediate protections. We requested that the Inspector General investigate and provide assistance in assessing the environment at Valley Ridge; to highlight deficiencies and to make recommendations. The combination of our enhanced oversight and presence of both the Inspector General and CQCAPD had a calming effect on what was perceived to be a potentially explosive situation.

Unfortunately, I found that many of the problems at Valley Ridge were not unique within the OPWDD system of services. Overall, I found inconsistent and inadequate oversight and a lack of accountability throughout the OPWDD system. As a result, the system's focus on the health, safety and dignity of individuals with developmental disabilities had eroded and the system had lost sight of its true mission. Most importantly, instances of abuse and neglect were often unreported and consequences related to substantiated allegations of abuse often did not reflect the severity of actions.

In the wake of my review of the OPWDD system, several steps were taken to immediately ensure that protections were in place for all individuals receiving services from OPWDD. During the next several months, a comprehensive review was undertaken of OPWDD policies and practices to ensure the safety and well-being of individuals in our care.

Prior to discussing the specific issues noted in your report, I would like to take this opportunity to review with you reforms that have been implemented or are in the process of being implemented system-wide¹ since I first asked your offices to investigate the matter at Valley Ridge:

Health and Safety Reforms

Protocol for Reporting Possible Crimes

- Require immediate notification to law enforcement of all incidents of physical and sexual abuse that may be a crime.
 - Reporting of all allegations of physical abuse increased from 16.8% in 2009 to 96.5% for October 2011
 - Reporting of all allegations of sexual abuse increased from 74.7% in 2009 to 100% for October 2011

Partnership with State Police on Abuse Reporting

- Developed protocol and MOU with the State Police and designated liaison for local law enforcement so that OPWDD and its provider agencies will consistently report abuse to the

¹ Additional detail on these reforms, and information about additional reforms in the OPWDD system, may be found in OPWDD's Six-Month Progress Report "Building a Better System for People With Disabilities" at www.opwdd.ny.gov. A copy is attached with this response.

police where a crime may have been committed. The new protocol was distributed to all providers and associations on August 18, 2011.

- Contacted other law enforcement entities to enlist their support to reach out to local law enforcement agencies across the state, inform them of the new protocol for reporting possible crimes, and aid in the adoption of localized protocols. As of October 2011, these agencies include the NYS District Attorneys Association, NYS Association of Chiefs of Police, New York City Police Department, NYS Inspector General, Office of the Medicaid Inspector General, Attorney General's Medicaid Fraud Control Unit, and the Albany County District Attorney.

Centralizing Incident Management Reporting

- Created the Incident Management Unit to oversee, analyze, and follow-up on reports of incidents of abuse and neglect in both the state and nonprofit provider systems.
- Mandated the use of OPWDD's Incident Report and Management Application (IRMA) by nonprofit agencies. All agencies were trained in its use.
- From March 2011 to September 2011 the average amount of time it took a reported incident to be entered into the IRMA system decreased from over 10 days to 3 days: a dramatic increase in the immediacy of key information related to incidents by 70 percent.
- In October 2011, OPWDD issued an administrative memorandum, which will be followed up with a proposed regulation that mandates the use of IRMA for the reporting of all allegations of abuse to occur within 24 hours (or next business day).
- IRMA data is used to generate trending and management reports to identify areas where there is an opportunity to improve the quality of services provided to individuals. Working with the Statewide Committee on Incident Review (SCIR) and other experts in this area, OPWDD is further developing and refining standardized trend reports to allow completion of root cause analysis of incidents. OPWDD is also providing guidance to providers specific to requirements for trend reports that will be completed on an annual basis by all service providers.
- Establishing a data sharing agreement with CQCAPD to ensure accurate and timely data between OPWDD and CQCAPD.

Strengthened Investigations

- Restructured the agency's investigative process in April 2011 to make investigations independent from operations and to ensure consistency statewide.
- To create consistency and improve quality of investigative reports, the investigations format for a centralized unit was reviewed in June 2011 by a national expert and implemented in June 2011.
- State investigators are required to undergo training from a nationally recognized consultant. To date, 51 investigators have been newly trained and certified. In addition, training is being

offered to initial responders to the incident to ensure consistency in terms of securing physical and documentary evidence.

- A director of investigations with over 20 years of experience as a police investigator was hired in August 2011.
- Established additional investigator positions, which are now in the interview and hiring stage.
- Issued a proposed regulation, effective November 1, which requires all providers to have investigations conducted independently from the operations entity being investigated.
- State investigators will conduct investigations of events that occur in voluntary provider agencies when the situation dictates the need for involvement of specially trained investigators.

Creating and Strengthening Safety Initiatives

- Issued an updated transportation safety memorandum reinforcing policies and procedures, and adding directive about accountability for all individuals.
- Implemented an ongoing series of health and safety alerts initiative as a means of raising awareness and promoting collective mindfulness to be proactive in identifying where health and safety may be compromised. Alerts will include regulatory and/or policy reminders, guidance, and best practices for appropriate action. These email alerts will be released at the beginning of every month, with one or two additional alerts issued over the course of each month to share critical information that is brought to OPWDD's attention from incidents, as well as from potential accidents that were avoided. This initiative began in November 2011.
- Developed a poster campaign around choking to increase awareness and prevention. The poster will be distributed to all of OPWDD state and nonprofit provider homes. In addition, curriculum guidance to reinforce individual program plans will be given to all providers.
- Developed a formal tracking process that monitors the amount of overtime that OPWDD's state employees work. OPWDD is tracking three specific outcomes: 1) Staff working greater than 32 hours (four shifts) of overtime in any two-week pay period; 2) Staff working greater than 16 consecutive hours (two shifts) on any occasion; and 3) Staff working greater than 7 consecutive days within any two-week pay period.
- Signed a Memorandum of Agreement (MOU) with the State Office of Fire Prevention and Control (OFPC) in March, 2011 that will have OFPC conducting all fire and Life Safety code inspections at all of OPWDD's state-operated sites and those of its nonprofit provider agencies. Specially trained fire safety experts of OFPC will begin their field work in January 2012.
- OFPC will review evacuation plans and report deficiencies to OPWDD; conduct random evacuation drills; conduct fire and safety training programs; conduct pre-opening and annual Life Safety code surveys of certified residential facilities and certain other sites; and

will act as a liaison for OPWDD with local fire departments with respect to fire and life safety matters.

- A uniform fire drill and evacuation report, as well as a fire event reporting format have been developed for use across the system; these tools will enhance access to information and trends and help direct support to the appropriate locations. Both reports will be online applications for the first time.
- OPWDD will report all fires that occur in or on OPWDD properties, and OFPC will work to determine the cause and origin.
- Finalized a new fire safety training curriculum, which was developed by the OFPC in collaboration with OPWDD and voluntary provider agencies. This curriculum includes a train-the-trainer component and is now available online to all providers.
- Issued an administrative memorandum on October 7, 2011 standardizing fire safety practices at all state and nonprofit homes, which will take effect in January 2012.
- In January 2012, OPWDD will reconvene a group of state and national experts in fire safety and construction to review the progress made to date in the gap analysis study of existing homes and review next steps regarding prioritization. At the same time, OPWDD has identified funds to implement priority upgrades.
- Developing “how to” training videos for the OPWDD workforce on how to develop a site specific fire evacuation plan and how to report a fire event that occurs in an OPWDD certified residence.
- In January 2012, OPWDD, in collaboration with OFPC, will conduct a fire safety webinar that will consist of a panel discussion by experts who will present information on steps that have been taken to improve awareness, prevention, preparedness, and response to fire emergencies. This webinar will be broadly available to all providers and questions will be solicited from the field to identify areas of interest. Once completed, the webinar will be posted online for use by interested audiences.

Holding Employees Consistently Accountable

OPWDD has restructured the agency’s disciplinary review process to increase consistency.

Strengthening the Disciplinary Process

- Restructured and streamlined the agency’s disciplinary review process, creating a statewide disciplinary panel. The process will result in increased consistency and improved management of the agency’s Employee Performance Management Program.
- In substantiated cases of physical and sexual abuse, with disciplinary penalties of termination, the employee is now immediately suspended without pay, rather than remaining on administrative leave. Data reflect the intent of this policy change—for the seven months prior to March 2011, on average, 69 OPWDD employees were on suspension

without pay on a monthly basis. From March-September 2011, the average rate rose to 130 employees suspended without pay, reflecting the increased use of unpaid leave as the means to separate the target employee from all contact with individuals served.

- Established a statewide protocol for enhanced supervision to provide awareness, training, and feedback for employees with performance issues or history of substantiated abuse.

Consistent Application of Penalties Ratified in CSEA Contract

- With the CSEA contract ratification, New York State will negotiate a table of penalties for abuse and neglect cases to be used by the arbitrator issuing a decision.
- The CSEA contract also provides for the development and implementation of a new training program for arbitrators that will compose the abuse panel. The training better aligns with current disciplinary expectations.

Building Better Relationships through Culture Change and Transparency

OPWDD continues to build positive relationships through culture change promoting open communication among individuals with developmental disabilities, staff, and DDSO leadership.

- DDSO directors and deputies have conducted over 1686 unannounced site visits to OPWDD's community homes and campus programs since March 2011. These visits promote open communication among individuals with developmental disabilities and staff with DDSO leadership. They also provide an opportunity to assess services provided the physical condition of homes, and staff accountability and familiarity with how to report abuse. To date, over 75 percent of homes have been visited at least one time.
- A team has been formed to comprehensively address culture change and to develop methods to measure progress in a way that is accountable to the public. A 40-member focus group, comprised of individuals with developmental disabilities, family members, nonprofit providers, and OPWDD staff, including leadership and direct support professionals, met in November 2011 to discuss the culture change mission and goals to strengthen the system through positive relationships and open communication. Action plans were developed and the group will reconvene in January 2012.

Training on Positive Relationships

- All 23,000 OPWDD employees—including Commissioner Burke—attended a mandatory training in June to reinforce principles of individual respect, dignity, and professional ethics around supporting people with developmental disabilities. This training has also been made available to the nonprofit provider agencies regulated by OPWDD. Regulations effective November 1, 2011 will require annual training of all state and nonprofit provider staff in promoting positive relationships and in abuse reporting requirements.

Positive Relationships Offer More Opportunity to Everyone (PROMOTE) Training

- Developed and piloted the first phase of the PROMOTE curriculum, which is designed to emphasize the importance of positive relationships and proactive measures to prevent challenging behaviors. It is expected that PROMOTE training will be made available to all direct care professionals across the system beginning in the spring and summer of 2012.

Behavior Management Regulations

- OPWDD has filed new regulations to establish new requirements concerning behavior management in the OPWDD system. The regulations contain comprehensive requirements for the management of maladaptive and inappropriate behavior. These new requirements (in the New York Register December 28, 2011) will help agencies provide high quality services, and will protect the health, safety, and rights of individuals who engage in maladaptive or inappropriate behaviors. The anticipated implementation date is June 2012.

I Spoke Out Campaign

- OPWDD launched the *I Spoke Out* campaign in July 2011 to remind employees of OPWDD's policy on abuse and neglect, and the obligation of all employees to speak out when they witness or suspect abuse or neglect.

Ensuring Every Employee's Voice is Heard

- OPWDD conducted its first anonymous employee trust and safety survey in June 2011 to research organizational culture change, and to get baseline data regarding whether rank and file employees feel they have the supports and resources they need to foster abuse prevention and reporting. The survey focused on the knowledge of staff to understand abuse and reporting, and why the agency has a history of under-reporting. The survey will be conducted every six months. Some baseline survey results include:
 - Across state and across role—employees reported high level of knowledge about abuse, neglect, and how to report
 - Based on role—between 4% and 19% of employees admitted that there were circumstances where they would not report alleged abuse or neglect
 - Based on role—between 39% and 79% of employees believed their co-workers would not report in all instances
- *Developing a Stronger Communications Platform*
 - OPWDD has prioritized communication throughout the agency, and commissioner's weekly messages with important updates sent to all stakeholders and the workforce.
 - As of August 2011, close to 7,000 members of OPWDD's workforce did not have an email account. Since then, almost 6,000 accounts have been created, with the rest on track by early 2012.

- OPWDD re-launched an agency-wide newsletter for OPWDD employees, individuals and stakeholders called *People First* (www.opwdd.ny.gov/newsletters/october_2011/index.jsp) in July 2011, which shares information about administrative reforms and initiatives. OPWDD communications director has been working with designated communication liaisons in each DDSO and has developed a localized version of the newsletter for each DDSO's employees, which contains consistent statewide information as well as pertinent local efforts. 5,000 copies of the newsletter go into the field each month, with thousands of others visiting online.
- OPWDD is using its Facebook page to distribute press releases, share stories about individuals in our care and the employees who have dedicated themselves to this work. Since the site went live in July, it has received more than 200,000 unique visits. OPWDD has also launched a YouTube channel, which is used to distribute training opportunities and timely information about relevant topics and initiatives.
- The agency is in the initial phases of a total website redesign, with the focus of the new site being accessibility and interactivity.
- A revamped OPWDD careers page was launched on August 25, 2011, which is focused on the values of the direct support professionals the agency wants to attract, ways OPWDD can be helpful in navigating the complex and confusing application/testing/hiring process, and ensuring that all job openings (Central Office and at DDSOs) are publicly posted in this one location. A broader, more comprehensive job listing database will be developed in accordance with the website redesign. A marketing campaign, as well as more sound programs ties with colleges and higher education opportunity programs will provide access to desirable applicants.
- A dedicated email address has been established, people.first@opwdd.ny.gov, which enables people who may have allegations of abuse or concerns they would like to raise.
- OPWDD has a dedicated comment line where people can call to report, anonymously, if needed, any incidents of abuse or neglect (1-866-946-9733). There is also a TTY number (1-866-933-4889) for those who need it.

Workforce Reforms

OPWDD has tightened hiring standards for all state direct care applicants and outlined clear job expectations and functions for prospective employees. The agency is also supporting employees with consistent standards and competencies as well as training to reinforce principles of individual respect, dignity, and professional ethics.

Raised the Bar for New Hires

- New hires must have at least a high school diploma or its equivalent and undergo psychological and fitness testing, mandatory drug testing, criminal background check, and be screened through the Statewide Central Registry of Child Abuse and Maltreatment. OPWDD

has reinforced the requirement that applicants be screened against the Medicaid Excluded Provider Registry (federal and state).

- Created the title of direct support assistant for state staff, replacing the title of developmental aide, to clearly outline job expectations and functions for prospective applicants.
- Employees must now serve their full probationary period, regardless of previous experience.
- No one is re-hired who has been terminated from state employment, or who has resigned in lieu of termination because they were found to have abused or neglected an individual in our care.

Attracting Talented Candidates for Direct Support Positions

- Developed a recruitment campaign designed to highlight the work done by our direct support professionals. The campaign focuses on positive relationships and respect, commitment, and ethical behaviors.

Competencies for All Direct Support Professional Staff and Supervisors

- Created the New York State Developmental Disabilities Talent Development Consortium (made up of parents, unions, nonprofit provider agency representatives, direct care staff, national experts, and OPWDD staff), which is developing a consistent set of core competencies for all direct care staff by creating a training and development plan to support direct support professionals in mastering competencies, as well as forecasting talent development trends in the field of developmental disabilities.
- The Talent Development Consortium is also establishing core competencies for front line supervisors. In addition, the consortium will review best practices in the following areas: recruitment and selection/interview process used to hire front line supervisors, mentoring approaches designed to support front line supervisors, and existing training strategies.
- Special competency areas, such as supporting individuals with autism, are being identified and a curriculum developed to support unique needs.

While the reforms described in the Six Month Progress Report will help to address many of the conditions I found lacking at Valley Ridge, and through the OPWDD system, I would also like to take this opportunity to specifically address several issues raised in the Report:

The Inspector General Investigation:

Safety of Residents and Failure by Staff to Report Abuse

The Inspector General noted that, in the instance of Resident 1, the required filing of documentation for an intervention that had gone awry was disregarded and questions whether employees are reporting as required. The Inspector General also noted low percentages of reporting by employees

who are reporting on their co-workers and questioned whether employees were reporting in accordance with OPWDD policy.

OPWDD was concerned with the lack of appropriate incident reporting in this matter and system-wide and has taken several steps to increase awareness of reporting requirements at Valley Ridge and throughout the system. All Valley Ridge staff were trained on incident reporting and individual rights in July 2010. All direct care staff were also trained on reporting responsibilities and stress management in September 2010. Additional training in confidentiality and reporting responsibilities was provided to Valley Ridge supervisory staff in October 2010. Individuals living at Valley Ridge were trained on rights and incident reporting in July 2010 and again in June 2011.

In addition, all 23,000 OPWDD employees were trained in promoting positive relationships, which includes reporting requirements surrounding abuse and neglect as of August 2011, including all staff at Valley Ridge. OPWDD now requires annual retraining each year for all OPWDD employees in this curriculum. OPWDD will evaluate the need for additional training going forward as part of its ongoing review of data from incident reporting.

Lastly, OPWDD is undertaking a culture change initiative designed to enhance employees' sense of personal responsibility for safety and dignity of individual we serve. OPWDD is engaging stakeholders, including individuals with developmental disabilities, parents, providers and employees in developing this initiative.

Staff Cite Difficulty in Handling Challenging Behavior of Residents

The Inspector General found that a number of employees had suffered injuries based on assaultive behavior by some residents and that some staff cited the need for Valley Ridge to routinely evaluate and assess residents who exhibit assaultive behavior to better address repeated and violent behaviors. The Inspector General recommended that OPWDD examine the need for revised procedures and additional training.

OPWDD has recently filed new regulations concerning behavior management. These regulations, which take effect in June 2012, are designed to provide a framework for staff response to inappropriate and maladaptive behaviors. In addition, OPWDD will be piloting its new training curriculum called Positive Relationships Offer More Opportunities To Everyone (*PROMOTE*). The pilot will begin in 2012 and is the OPWDD-approved staff training curriculum designed to address challenging behaviors of individuals with Intellectual Disabilities/Developmental Disabilities (ID/DD). This new curriculum will replace the current staff training program known as Strategies for Crisis Intervention and Prevention-Revised (SCIP-R). The need to have well trained staff members that are capable of developing relationships and creating environments that are conducive to helping the individuals we serve to lead richer lives is critical to achieve the agency mission and vision. *PROMOTE* is intended to shift the philosophy of staff from behavior control and crisis intervention to that of fostering positive and functional relationships, environments,

communication, and respect to reduce the likelihood of challenging behaviors on the part of individuals being served. PROMOTE will teach staff the necessary skills to assure health and safety of the individuals and staff alike.

Staff will be taught tools to help them increase an individual's self-confidence, connections to others, and opportunities for recreation and relaxation. In addition, staff will be provided with the tools to effectively intervene with people who are presenting with challenging behaviors but who are not placing themselves or others at immediate risk of harm through their actions. Finally, staff will be provided with training in the physical techniques needed to help ensure an individual's safety and the safety of others in the environment when the individual's challenging behavior is presenting an immediate health and safety risk to self or others.

The Reporting Process to Law Enforcement

The Inspector General noted the issues that have long arisen involving the reporting of abuse and neglect to law enforcement and those incidents which require reporting. As noted in the Report, OPWDD developed protocol and MOU with the State Police and designated liaison for local law enforcement so that OPWDD and its provider agencies will consistently report abuse to the police where a crime may have been committed. The new protocol was distributed to all providers and associations on August 18, 2011. OPWDD has also contacted other law enforcement entities to enlist their support to reach out to local law enforcement agencies across the state, inform them of the new protocol for reporting possible crimes, and aid in the adoption of localized protocols.

The Toll of an Overburdened Investigatory System—Excessive Overtime and Administrative Leave

The Inspector General noted that lengthy administrative leave periods resulted in excessive overtime for staff not on administrative leave. The Inspector General also noted employees' concern with OPWDD's "zero tolerance" policy for abuse and neglect and the result of this policy on remaining staff.

Protecting individuals in our care from abuse and neglect and ensuring their well-being is OPWDD's highest priority. In any situation in which OPWDD feels that individuals may be at risk of potential abuse or neglect based on the action or inaction of an employee, such employee is placed on administrative leave until OPWDD has investigated and determined that no individuals in our care are at risk. At the same time, as noted in the Report, an excessive amount of staff on administrative leave may generate increased overtime by those workers not on administrative leave, in some cases resulting in excessive overtime hours for some employees.

Recognizing this problem, OPWDD has analyzed administrative leave data to determine those Developmental Disabilities Services Offices (DDSO)'s with the highest percentages of staff on administrative leave, and those staff members who had been on administrative period for the greatest lengths of time. Results of this analysis were shared with DDSO's, and OPWDD is working

to resolve open investigation such that staff involved in incidents which were unsubstantiated could return to work. OPWDD expects that, as its investigations unit comes to full staff capacity, investigations will be completed much faster and this number will decrease even more. In addition, the establishment of protocols for individuals with developmental disabilities who have a history of frequent false reporting of abuse have long been a practice in the OPWDD system. OPWDD will work with DDSOs to ensure that there are consistent protocols in place for individuals who frequently make false reports of abuse while ensuring that any necessary protections are put in place for individuals and such incidents are appropriately reported and investigated. This will include the use of training and modifications to treatment plans for individuals with developmental disabilities who make frequent false reports.

Lastly, while overtime remains a concern at Valley Ridge and must be addressed it has not materially grown since 2010-11.

Findings and Recommendations of the Inspector General

The Abuse of Resident 1

The Inspector General found compelling evidence that Employee 1 engaged in physical and psychological abuse of Resident 1 in August 2009 and that other Valley Ridge staff had failed to document and report the incident.

As noted in the Report, when OPWDD became aware of this incident, an investigation was immediately launched as law enforcement was notified. As further noted, staff involved in this incident, including Employee 1, have resigned or been terminated.

As described above, all Valley Ridge staff were trained on incident reporting and individual rights in July 2010. All direct care staff were also trained on reporting responsibilities and stress management in September 2010. Additional training in confidentiality and reporting responsibilities was provided to Valley Ridge supervisory staff in October 2010. Individuals living at Valley Ridge were trained on rights and incident reporting in July 2010 and again in June 2011. All 23,000 OPWDD employees were trained in promoting positive relationships, which includes reporting requirements surrounding abuse and neglect as of August 2011, including all staff at Valley Ridge. OPWDD now requires annual retraining each year for all OPWDD employees in this curriculum. OPWDD will evaluate the need for additional training going forward as part of its ongoing review of data from incident reporting.

The Inspector General recommended potential legislative action to arm prosecutors with the tools they need to prosecute abuse and neglect cases. OPWDD agrees with efforts to strengthen protections for individuals in our system and to ensure accountability for offenders.

Review of General Conditions and Processes at Valley Ridge

The Inspector General recommended that OPWDD retrain employees in the Reporting Requirements of Part 624. See OPWDD response on training related to the previous finding. The Inspector General found that only 2 percent of the 754 incident reports filed at Valley Ridge from August 2007 to July 2011 were generated based upon coworkers reporting. OPWDD has embarked on a culture change initiative with all OPWDD staff to reinforce that the safety, dignity and respect of individuals we serve is the highest priority of OPWDD employees and has retrained employees in incident reporting as noted in this response. In addition, OPWDD will review reporting by employees on incidents of abuse and neglect to review the impact that training and culture change initiatives have had on employee reporting, with a particular focus on those reports that have been substantiated.

Findings and Recommendations of CQCAPD

At the outset, OPWDD would like to address two issues identified by CQCAPD in the Draft Report with respect to Incident Reports. First, CQCAPD found that several direct care staff had been repeatedly recommended to participate in an Awareness, Training and Feedback (ATF) program. CQCAPD expressed concern that Valley Ridge may not be monitoring the program to ensure effectiveness and that the program is appropriately addressing certain employee issues. OPWDD will evaluate data at Valley Ridge and system-wide concerning the ATF program to determine when employees should be required to participate and to modify training/mentoring programs accordingly to ensure their effectiveness.

CQCAPD also identified concerns with the Consolidated Traveling Record (CTR), containing written progress notes on residents' behavior. CQCAPD noted that the CTR contains information on residents' behavior plans, including and the use of positive and negative consequences for certain behavior because an escalation of behavior may occur when a note is written in the CTR as residents may anticipate a negative consequence. CQCAPD also expressed concern that Valley Ridge lacks a policy or protocol on the use of the CTR. OPWDD will reevaluate the use of the CTR in the OPWDD system and, should use of the CTR continue, OPWDD will develop standardized policies and protocols on its use.

OPWDD would also like to address CQCAPD's observations with respect to the lack of administrative oversight at Valley Ridge. OPWDD took steps in April to send in an outside technical assistance team to assess the situation and to make recommendations on how to improve Valley Ridge operations. One of the recommendations of the team was to immediately enhance the administrative presence at Valley Ridge because it was operating without a lead administrator. In May 2011, Carl Letson was removed as Director of the Broome DDSO. OPWDD designated John Gleason to act as Director on an interim basis. Currently Mark Lankes, whose appointment is pending, is the Acting Director of Broome DDSO. In addition, until a lead administrator could be recruited and put in place at Valley Ridge there has been a rotating administrator presence from

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Broome DDSO at Valley Ridge. While unfortunately this effort has taken several months, OPWDD has just found an appropriate replacement and the new administrator will be starting in early January.

OPWDD will continue to assess and evaluate the effectiveness of the administration at Valley Ridge and will make appropriate adjustments as necessary to ensure the most effective oversight of the program.

Recommendations Resulting from Investigation of Resident 2 Matter

CQCAPD recommended that all Valley Ridge personnel receive mandatory retraining in the Incident Reporting and Consumer Protection provisions contained in 14 NYCRR Part 624. As noted, all Valley Ridge staff were trained on incident reporting and individual rights in July 2010. All direct care staff were also trained on reporting responsibilities and stress management in September 2010. Additional training in confidentiality and reporting responsibilities was provided to Valley Ridge supervisory staff in October 2010. Individuals living at Valley Ridge were trained on rights and incident reporting in July 2010 and again in June 2011. All 23,000 OPWDD employees were trained in promoting positive relationships, which includes reporting requirements surrounding abuse and neglect as of August 2011, including all staff at Valley Ridge. OPWDD now requires annual retraining each year for all OPWDD employees in this curriculum. OPWDD will evaluate the need for additional training going forward as part of its ongoing review of data from incident reporting.

CQCAPD recommended that Valley Ridge develop procedures to ensure appropriate communication between clinical, medical, investigative and managerial staff regarding medical practices. OPWDD has appointed a high level administrator, who will be starting January 3, 2012, to oversee the daily operation of Valley Ridge. He will coordinate weekly meetings with managerial, clinical, medical and investigative staff to ensure that appropriate communication and cooperation is established and maintained among these functional groups.

CQCAPD recommended that Valley Ridge undertake a review to ensure that medical staff follows appropriate documentation requirements regarding body checks and implement a monitoring process of the same. Nursing staff were trained on detecting potential abuse, body checks and photographic evidence following restrictive physical interventions in October 2010. Monitoring to assure compliance is completed by the Nursing Administrator assigned to Valley Ridge. The Special Review Committee at Valley Ridge will also review documentation concerning body checks for all incident reports for allegations of physical abuse.

CQCAPD recommended that OPWDD should ensure that all investigations include interviews with key witnesses as well as the involved individual when clinically appropriate, and all OPWDD investigations be completed within a reasonable period, as the targets of investigations at Valley Ridge appear to be placed on administrative leave for lengthy periods. As noted, OPWDD has

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centralized investigations to ensure that investigations are appropriately, consistently and thoroughly conducted and expects that, as its investigations unit comes to full staff capacity, investigations will be completed much faster and this number will decrease even more.

Medication Practices

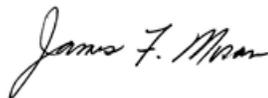
CQCAPD found that nurses should be trained to ensure they sign all entries in the communication log book. As noted in the Report, this has been accomplished as of April 2011, and the Nurse Administrator has monitored the log book on a weekly basis since to ensure compliance. CQCAPD found that borrowing medications from a resident to supplement a missing medication for another is problematic area. As noted in the Report, in May 2011, Valley Ridge advised it will promulgate new policy to address this deficiency, including areas such as notification of nurses to replace unusable or missing medication, a Record of Destruction and a revamp of the Emergency House Stock Medication Box. Accordingly, Valley Ridge has already provided in service training to the Nurse Administrator for the online ordering of medication, and that Nurse Administrator has provided training to other Nurses in the program. The missing medication policy has been promulgated as of May 2011 and staff have been trained as of June 30, 2011.

In addition, CQCAPD found a failure to consistently document individuals with development disabilities' refusal of medication. At the time, Valley Ridge reported that it would review and revise, as appropriate, procedures for medication refusals and would train staff in new procedures implemented. These procedures were revised as of May 2011 and staff were trained as of June 30, 2011.

Conclusion

In conclusion, OPWDD appreciates your offices' investigation into this matter and your recommendations, and I trust that our collaborative effort will continue to ensure that the State's most vulnerable individuals will be treated with the dignity and respect they deserve as part of our mission of helping people with developmental disabilities live richer lives.

Sincerely,



James F. Moran
Acting Executive Deputy Commissioner