NEW YORK STATE OF OPPORTUNITY.
Justice Center for the Protection of People with Special Needs

**ANDREW M. CUOMO**
Governor

**DENISE M. MIRANDA**
Executive Director

December 18, 2019

Theodore Kastner, M.D.
Commissioner
Office for People with Developmental Disabilities
44 Holland Avenue
Albany, New York 12229

Dear Dr. Kastner:

The Justice Center for the Protection of People with Special Needs (Justice Center) is charged with protecting people receiving services in facilities under its jurisdiction from abuse, neglect and other conduct that may jeopardize their health, safety and welfare pursuant to Article 20 of the New York Executive Law. To that end, the Justice Center conducts systemic reviews in order to identify risks to the health, safety and welfare of people receiving such services.

On August 6, 2019, the Justice Center issued a draft of our review of wheelchair securement processes entitled *Review of Wheelchair Securement in State Operated Individualized Residential Alternatives*.[1] The Justice Center received a thorough response from the Office for People With Developmental Disabilities (OPWDD) dated December 17, 2019, outlining actions your office is taking in follow up to the review findings as well as plans for additional corrective measures to be implemented in the future. The final review findings, including your response, is attached.

This review was conducted by the Justice Center and would not have been possible without the cooperation and professionalism that staff from Capital District DDSOO, Taconic DDSOO, and Western New York DDSOO provided during the course of the review. We appreciate and join you in your continuing commitment to the care of vulnerable people in New York State.

Sincerely,

Denise M. Miranda, Esq.
Executive Director

[1]This Review was performed pursuant to the Justice Center's authority as set forth in the Protection of People with Special Needs Act, Chapter 501 of the Laws of 2012.

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NEW YORK STATE OF OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

# Prevention and Quality Improvement:

## Review of Wheelchair Securement in State Operated Individualized Residential Alternatives (IRAs)

DECEMBER 2019

161 Delaware Avenue, Delmar, New York 12054
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# The Justice Center's Promise to New Yorkers with Special Needs and Disabilities

## OUR VISION

People with special needs shall be protected from abuse, neglect and mistreatment. This will be accomplished by assuring that the state maintains the nation's highest standards of health, safety and dignity; and by supporting the dedicated men and women who provide services.

## OUR MISSION

The Justice Center is committed to supporting and protecting the health, safety, and dignity of all people with special needs and disabilities through advocacy of their civil rights, prevention of mistreatment, and investigation of all allegations of abuse and neglect so that appropriate actions are taken.

## OUR VALUES AND GUIDING PRINCIPLES

**Integrity:** The Justice Center believes that all people with special needs deserve to be treated with respect and that people's rights should be protected.

**Quality:** The Justice Center is committed to providing superior services and to ensuring that people with special needs receive quality care.

**Accountability:** The Justice Center understands that accountability to the people we serve and the public is paramount**.**

**Education:** The Justice Center believes that outreach, training, and the promotion of best practices are critical to affect systems change.

**Collaboration:** Safe-guarding people with special needs is a shared responsibility, and the Justice Center is successful because it works with agencies, providers, people who provide direct services, and people with special needs to prevent abuse and neglect.

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[redacted]

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## Executive Summary

This systemic review, conducted by the Justice Center for the Protection of People with Special Needs (Justice Center), was initiated in response to cases of substantiated neglect involving the improper securement of people receiving services who used wheelchairs during transportation. In June 2018, the Justice Center closed 12 cases from eight different individualized residential alternatives (IRAs) operated by the Capital District Developmental Disabilities State Operations Office (DDSOO) that involved staff not properly securing people receiving services who used wheelchairs in agency vehicles. Similar incidents have been reported across the state and, although this review focused on the Capital District, Taconic and Western New York DDSOOs, Letters of Determination were also issued to the Central New York, Finger Lakes, Hudson Valley and Bernard Fineson DDSOOs.

The purpose of this review is to examine the policies, staff training, individual protections, and equipment required for the safe transportation of people receiving services, including those who use wheelchairs; and provide recommendations to prevent the improper securement, and potential injury, of people who use wheelchairs in agency operated vehicles. The Justice Center identified factors that may contribute to the improper securement of people receiving services through conducting site visits, interviewing staff and reviewing documentation.

### Program Descriptions

DDSOOs administer and oversee state operations for the Office for People with Developmental Disabilities (OPWDD), including the direct delivery of services and supports to people with developmental disabilities by state staff in settings such as IRAs that provide 24 hour staff support and supervision. The DDSOOs selected for this review all had substantiated cases of abuse and neglect involving improper securement between June and July 2018. Site visits were conducted at four IRAs for each of the DDSOOs.

<u>The Capital District DDSOO IRAs:</u>

The Webster Avenue IRA, located in Glens Falls, New York, is a single story, wheelchair accessible home providing services to four people with developmental disabilities, one of whom required the use of a wheelchair during transportation. The Justice Center conducted its site visit on December 13, 2018.

The Albany Street IRA, located in Schenectady, New York, provides services to six people with developmental disabilities. This IRA is a two story home that is not wheelchair accessible although staff working at this home are also considered a staffing resource to work at identified “sister houses” that are wheelchair accessible and provide services to people in care who require the use of a wheelchair for transportation. The Justice Center conducted its site visit on December 18, 2018.

The Schuylerville IRA, located in Schuylerville, New York, is a single story, wheelchair accessible home providing residential services to 10 people with developmental disabilities and respite services to one person with developmental disabilities. Multiple people in this home required the use of a wheelchair for transportation. The Justice Center conducted its site visit on December 20, 2018.

The Boght Road IRA, located in Watervliet, New York, is a single story, wheelchair accessible home providing services to 11 people with developmental disabilities, including several people who required the use of a wheelchair for transportation. The Justice Center conducted its site visit on December 21, 2018.

The Taconic DDSOO IRAs:

The Olivett Lane IRA, located in Athens, New York, is a single story, wheelchair accessible home providing services to six people with developmental disabilities, including several people who required the use of a wheelchair for transportation. The Justice Center conducted its site visit on January 29, 2019.

The Marlin Road IRA, located in Brewster, New York, is a wheelchair accessible home with a non-accessible finished basement, providing services to four women with developmental disabilities, two of whom required the use of a wheelchair for transportation. The Justice Center conducted its site visit on January 29, 2019.

The Marakill IRA, located in New Paltz, New York, is a two story home with a wheelchair accessible first floor providing services to five people with developmental disabilities, one of whom required the use of a wheelchair for transportation. The Justice Center conducted its site visit on January 30, 2019.

The Wiltwyck IRA, located in Kingston, New York, is a two story home with a wheelchair accessible first floor providing services to nine people with developmental disabilities, including one person who required the use of a wheelchair for transportation. The Justice Center conducted its site visit on January 30, 2019.

The Western New York DDSOO IRAs:

The Jamestown Street IRA, located in Randolph, New York, is a single story, wheelchair accessible home providing services to seven people with developmental disabilities, including at least two people who required the use of a wheelchair for transportation. The Justice Center conducted its site visit on March 20, 2019.

The Bernadette Terrace IRA, located in West Seneca, New York, is a single story, wheelchair accessible home providing services to four people with developmental disabilities, one of whom required the use of a wheelchair for transportation. The Justice Center conducted its site visit on March 21, 2019.

The Heather Hill Road IRA, located in West Seneca, New York, is a single story, wheelchair accessible home providing services to six people with developmental

disabilities, including one person who required the use of a wheelchair for transportation. The Justice Center conducted its site visit on March 21, 2019.

The Beattie Avenue IRA, located in Lockport, New York, is a single story, wheelchair accessible home providing services to four people with developmental disabilities, two of whom required the use of a wheelchair for transportation. The Justice Center conducted its site visit on March 21, 2019.

## Scope and Methodology

The Justice Center conducted a tour of each of the IRAs, interviewed staff and people receiving services, reviewed documentation, viewed wheelchair accessible vans and observed people receiving services as they were secured in wheelchair accessible vehicles.

*Documentation Reviewed:*

- DDSOO policies related to transportation of people receiving services
- Vehicle inspection and maintenance records
- Individual Plans of Protection (IPOPs)
- Site specific, written plans of protection
- Staff training records related to:
    - Wheelchair securement training
    - Vehicle safety training
    - Training on IPOPs
    - Promoting Relationships and Implementing Safe Environments (PRAISE) training
- Staff rosters and staff schedules

Individual findings letters sent to each DDSOO are available [redacted] and include policies and other documents referenced in this review. [redacted]

## Recommendations

The Justice Center's specific recommendations are detailed below. While this review focused on three DDSOOs, the Justice Center recommends OPWDD assess all state-operated IRAs and other programs that provide transportation to people receiving services with attention to these findings and apply the recommendations across all programs, as appropriate.

## Key Recommendations

1. Adopt uniform staff training requirements for wheelchair securement, including training documentation forms that identify the type of wheelchair securement equipment used and also identify training objectives, content, modality of training, duration of training, and retention requirements for training documentation.
2. Create a template for IPOPs for use in state operated residences that identifies supports and safeguards, including the use of postural supports, required for the safe transportation of people receiving services who use wheelchairs.
3. Provide staff training on the IPOPs that is frequent, interactive, and documents training objectives, content, modality of training, and duration of training.
4. Provide routine inspections of vehicles, lifts, and wheelchair securement equipment, and maintain equipment according to manufacturer guidelines in order to ensure equipment remains in good working order.
5. Develop a comprehensive policy for all DDSOOs regarding the safe transportation of people receiving services, including those who use wheelchairs, that identifies training requirements and addresses training for people receiving services.

## Wheelchair Securement Training

1. **Adopt uniform staff training requirements for wheelchair securement, including training documentation forms that identify the type of wheelchair securement equipment used for staff training and also identify training objectives, content, modality of training, duration of training, and retention requirements for training documentation.**

   Training curriculum, documentation of staff training and storage of staff training documentation on wheelchair securement varied at each of the three DDSOOs included in this review. Training on wheelchair securement was not provided to all staff listed on staff schedules at the time of Justice Center site visits and training documentation from the Capital District and Western New York DDSOOs did not reflect training on all the elements of wheelchair securement identified in training materials. Each DDSOO employed some form of a "train the trainer" model with select staff trained to provide training to other staff on wheelchair securement yet none of the DDSOOs had documentation of the training curriculum used for the staff trainers, documentation of retraining or refresher training for the staff trainers, and none provided observations of staff trainers to monitor the effectiveness of the trainers' ability to relay critical information on wheelchair securement. None of the training documentation provided identified the type of wheelchair securement system used during the staff training.

   ***Capital District DDSOO***

   The *Capitol* [*sic*] *District DDSOO Wheelchair Securement Competency* checklist was used to document staff training and competency on wheelchair securement for the Capital District DDSOO. Comprised of 18 detailed, step by step, directions the checklist also contained columns for trainers to indicate whether or not staff

demonstrated competency in each of the 18 steps. However, the checklist did not include the type of wheelchair securement system used during the training and completed checklists were missing for 11 of the 53 staff listed on staff schedules as of the date of the Justice Center site visits. Checklists from the Albany Street IRA had multiple procedural steps marked as "N/A", including all steps related to using a wheelchair lift, ensuring floor tracks used to anchor securement equipment were free from debris and removing and storing lap trays as seen in the photo below:

| Procedure | Yes | No | N/A |
|---|---|---|---|
| 1. Wheelchair van is parked on level surface, with adequate room for lift clearance. Parking brake must be engaged and van should be running prior to operating lift. | | | ✓ |
| 2. All ambulatory individuals are to board the wheelchair van first either using the rear or front passenger entrance. Under no circumstances is an ambulatory individual to stand on the van lift unless there has been a formal evaluation and documentation in the IPOP | | | ✓ |
| 3. Places wheelchair and individual on lift with individual facing outward, wheelchair brakes are locked while on lift, staff remains on ground and operates lift. (Staff are NOT to ride on lift with individual). | | | ✓ |
| 4. Individual is brought into the van by employee standing in van to receive the wheelchair, or, if only one staff is available, is brought partially into van by unlocking brakes from the outside and rolling individual off the lift. Brakes are then locked once the individual is as far in as possible. | | | ✓ |
| 5. Upon entry, van floor should be clear of all securement equipment (anchors and belts are in storage pouches). Track system needs to be free of any debris and cleaned as needed for optimal operation. | | | ✓ |
| 6. Lap trays should be removed and stored prior to installing wheelchair securement system. | | | ✓ |
| 7. Brakes are unlocked and individual is positioned/centered in designated area between the appropriate floor tracks. | ✓ | | |

*Wheelchair Securement Competency Checklist from the Albany Street IRA*

This raised questions regarding the validity of the training provided as well as questions regarding the competency of the staff and their ability to safely secure a person receiving services who used a wheelchair. While this IRA did not have a wheelchair accessible van or any people receiving services at that residence who used a wheelchair, staff stated they felt training in wheelchair securement was important in case they were assigned to cover shifts in another residence.

Training on wheelchair securement was delivered by staff who were trained to be trainers. However, documentation of "train the trainer" training did not include a training curriculum and for two of the four trainers was simply a completed *Capitol [sic] District DDSOO Wheelchair Securement Competency* checklist that reflected them as the student rather than the instructor. Trainers were unable to identify when or if they would receive refresher training.

***Taconic DDSOO***

The Taconic DDSOO also used a *Wheelchair Securement Competency* checklist to document staff training on wheelchair securement. This checklist included 15 procedural steps regarding wheelchair securement along with columns for trainers

to indicate whether or not staff demonstrated competency in each of the 15 steps but did not identify the type of wheelchair securement system used during the training. Staff were also expected to sign an attestation on the form indicating they had watched a video from Q'Straint related to the wheelchair securement.[1] Completed checklists were missing for 12 of the 41 staff listed on staff schedules as of the date of the Justice Center site visits. Staff who were interviewed during site visits could not identify how often retraining on wheelchair securement was required and some training documentation reflected that training had not occurred in over a year.

Although not outlined in the Taconic DDSOO *Travel Safety* policy, communication with staff in Talent and Development and in Quality Improvement indicated that staff slated to work in homes that supported people receiving services who used wheelchairs during transportation received aspects of wheelchair securement training from clinicians while other staff received training from staff trained to be trainers. Documentation of staff training to become a trainer appeared to be the same *Wheelchair Securement Competency* checklist used with staff who were not trained to become trainers and the forms identified the staff trainers as receiving the training rather than providing it.

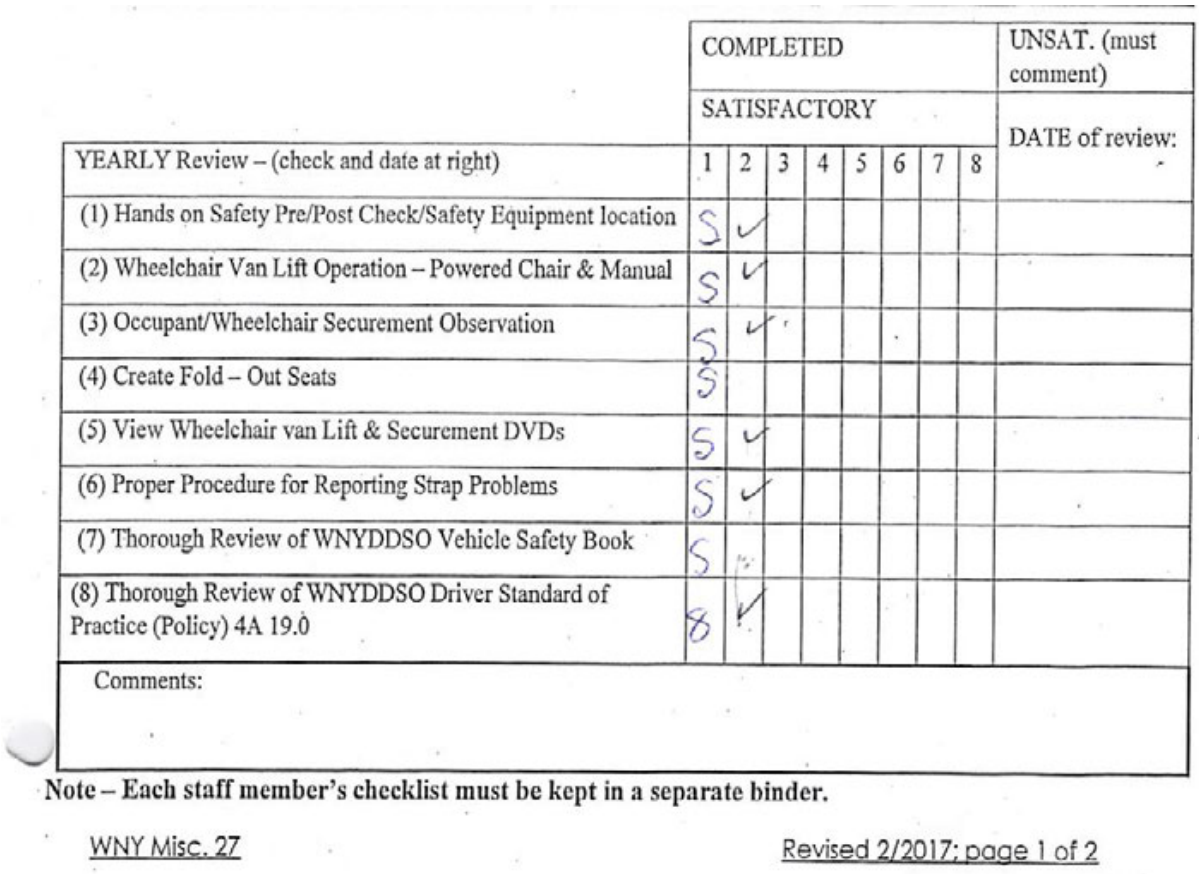
Documentation dated August 10, 2018, submitted with the Corrective Action Plan (CAP) following the cases of substantiated neglect related to wheelchair securement stated that training records, including wheelchair securement competency forms, would be maintained on site. However, none of the Taconic DDSOO homes had documentation of this training on site, and staff were not able to identify who could provide the documentation or where it could be located. Some certificates of completion for staff training were located in the Statewide Learning Management System (SLMS) and *Wheelchair Securement Competency* checklists were located on a regionally shared computer drive. However, the majority of staff training documentation related to wheelchair securement was unavailable to Justice Center staff while on site.

***Western New York DDSOO***

The Western New York DDSOO *WNY MISC 27 Annual Operator Review Checklist* used an eight-step checklist with columns that could be used to document eight years' worth of staff training on wheelchair securement although the checklist did not identify the type of wheelchair securement system used during the training. The least detailed of the checklists from the three DDSOOs, this checklist included two items related specifically to wheelchair securement, "Wheel Chair [*sic*] Van Lift Operation-Powered & Manually" and "Occupant/Wheelchair Securement Observation". However, there are multiple steps involved in both of those processes such as, for "Occupant/Wheelchair Securement", ensuring wheelchair brakes are locked, installing front floor anchors, installing rear floor anchors, unlocking brakes and engaging self-ratcheting mechanisms, locking wheelchair brakes again, removing lap trays, installing seatbelt/shoulder harness

[1] Q'Straint is a leading manufacturer of wheelchair and occupant securement systems.

mechanisms, etc. so the presence of a single checkmark for staff who were rated as successful for "Occupant/Wheelchair Securement Observation" made it difficult to determine whether or not all of the steps involved in wheelchair and occupant securement were taught, observed, and successfully completed by staff. Completed checklists were missing for 4 of 54 staff listed on staff schedules as of the date of the Justice Center site visits, and 18 of the completed checklists were missing documentation of portions of the training as seen in the photo below where the year 2 column did not reflect a review of all elements of wheelchair securement training. Additionally, documentation of training was inconsistent with some years marked as completed with a checkmark and other years marked with an "S":



| | COMPLETED | | | | | | | | UNSAT. (must comment) |
|---|---|---|---|---|---|---|---|---|---|
| | SATISFACTORY | | | | | | | | DATE of review: |
| YEARLY Review – (check and date at right) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| (1) Hands on Safety Pre/Post Check/Safety Equipment location | S | ✓ | | | | | | | |
| (2) Wheelchair Van Lift Operation – Powered Chair & Manual | S | ✓ | | | | | | | |
| (3) Occupant/Wheelchair Securement Observation | S | ✓ | | | | | | | |
| (4) Create Fold – Out Seats | S | | | | | | | | |
| (5) View Wheelchair van Lift & Securement DVDs | S | ✓ | | | | | | | |
| (6) Proper Procedure for Reporting Strap Problems | S | ✓ | | | | | | | |
| (7) Thorough Review of WNYDDSO Vehicle Safety Book | S | | | | | | | | |
| (8) Thorough Review of WNYDDSO Driver Standard of Practice (Policy) 4A 19.0 | S | ✓ | | | | | | | |
| Comments: | | | | | | | | | |

**Note – Each staff member's checklist must be kept in a separate binder.**

WNY Misc. 27 Revised 2/2017; page 1 of 2

*Photo of completed WNY MISC 27 Annual Operator Review Checklist from Beattie Avenue IRA*

Staff at all sites visited for the Western New York DDSOO identified a "train the trainer" model when asked about wheelchair securement training. However, the only documentation of training for the trainers was completed *WNY MISC 27 Annual Operator Review Checklist* forms that reflected staff trainers as the student rather than the instructor. There was no documentation to support the type of training provided to the trainers or the amount of training provided and staff responsible for the training could not identify whether they had ever been observed providing training to their staff.

The directions page of the *WNY MISC 27 Annual Operator Review Checklist* indicated that checklists were to be retained at the work location or site for each

staff member for a period of 10 years. However, none of the Western New York DDSOO homes visited for this review had documentation of wheelchair securement training for all of their staff on site and accessible at the time of the Justice Center site visits. Also, contrary to the instruction at the bottom of the checklist seen in the photo above, completed *WNY MISC 27 Annual Operator Review Checklist* forms were not kept in a separate binder for each staff.

## IPOPs and Staff Training on IPOPs

**2. Create a template for IPOPs for use in state operated residences that identifies supports and safeguards, including the use of postural supports, required for the safe transportation of people receiving services who use wheelchairs.**

All IPOPs were reviewed at all sites for identification of supports and safeguards related to wheelchair securement. While all sites had IPOPs for people receiving services and some form of a system for staff training on the IPOPs, the forms were different at each DDSOO, identification of transportation related supports and safeguards were inconsistently documented or omitted from sections of the plan pertaining to transportation at each DDSOO, and none of the plans consistently provided guidance for the use of postural supports in conjunction with wheelchair tiedown and occupant restraint systems.

***Capital District DDSOO***

IPOPs were reviewed for all Capital District DDSOO sites and found to vary in their content and structure despite appearing to use the same form. Some IPOPs detailed transportation supports in the section for "Staffing/Community Inclusion" while others included that information in the "Positioning/Mobility Supports" section. The level of detail for transportation supports varied and only a few plans provided a listing of special equipment required for transportation. For example, the plan for a person who required a wheelchair for transportation at the Bogh Road IRA only stated, "staff are responsible for fastening his seat belt" and made no mention of any special equipment requirements or even a wheelchair tie down or occupant restraint system. At the Schuylerville IRA, IPOPs were inconsistent in the terminology used to describe the wheelchair and occupant restraint systems. The plan for one person residing at that residence directed staff to "secure 4-point tie downs and occupant restraint systems. Ensure wheelchair belt is fastened" while the plan for a different person at that home stated, "wheelchair requires a 4 pt restraining system during transport" and made no mention of an occupant restraint system or ensuring that the wheelchair belt was fastened.

***Taconic DDSOO***

The Taconic DDSOO *Travel Safety* policy required that, for routine and periodic travel, the IPOP must identify the "information on specific supports, adaptive equipment and supervision the individual needs to identify and safely board the correct vehicle; to travel safely inside the vehicle; and to exit safely upon arrival at

the destination." However, the transportation supports section of the IPOPs reviewed routinely did not identify the specific supports and adaptive equipment required for the person receiving services to travel safely inside the vehicle. For example, the IPOP for a person receiving services at the Marlin IRA stated that the person required the constant use of oxygen and must use their wheelchair for ambulation and evacuation, yet the IPOP did not identify any transportation supports. IPOPs at the Olivett Lane IRA noted that staff would assist people receiving services in the van with a lift and secure their wheelchair in the van but did not mention securing the person receiving services themselves using a seatbelt or other occupant restraint system. Overall, IPOPs did not provide detail about the particular wheelchair tiedown and occupant restraint systems used for people receiving services.

***Western New York DDSOO***

The format for the IPOPs in the Western New York DDSOO region appeared to be consistent across the sites visited during this review with a format that included sections for "mobility/transfers", "transportation", and "mechanical support/adaptive needs". However, information relevant to wheelchair securement was not consistently, or completely, identified in any of those sections. For example, an IPOP for a person at the Jamestown Street IRA noted in the "mobility/transfer" section that the person used foot rests when transported in a vehicle yet this information was not included in the "transportation section" of the document. An IPOP for a person from the Beattie Avenue IRA referenced the use of a wheelchair with a side release buckle lap belt, buckle cover, head rest, chest harness, tray and anti-slide belt, and foot buckets in the "mobility/transfer" section, while the "mechanical supports/adaptive needs" section referenced the specific use of a Tilt-in-space wheelchair. However, none of this information was included in the "transportation" section of the document so it is not clear which adaptive equipment the person actually required for transportation. None of the IPOPs reviewed at Western New York DDSOO sites specifically identified the need for wheelchair tiedown and occupant restraint systems during transportation for people receiving services who used wheelchairs nor did they address any specific securement equipment that would be required for specialized equipment such as the Tilt-in-space wheelchair referenced above.

3. **Provide staff training on the IPOPs that is frequent, interactive, and documents training objectives, content, modality of training, and duration of training.**

Even if IPOPs clearly identified transportation safety and supports, the current staff training on IPOPs is insufficient. Documentation of staff training was missing, illegible and/or relied heavily on a "read and sign" modality of training. Concerns related to training of relief staff were identified at the Capital District and Taconic DDSOO.

***Capital District DDSOO***

The Capital District DDSOO was missing documentation of staff training on IPOPs for 25 of 53 staff. Staff identified a "read and sign" method for training where staff were assigned to an independent review of information and signed a cover sheet once they completed the review. Staff interviewed at Capital District DDSOO sites stated that they were overwhelmed by the volume of information they were responsible to review via this method.

Staff at each site visited in the Capital District DDSOO reported challenges with staffing shortages, vacancies and subsequent sharing or "floating" staff between cluster or sister houses. However, there was no formal training system for staff from other houses to review IPOPs or site-specific documents such as the fire evacuation plan. Rather, relief/float staff relied on regular house staff to informally teach them this information and there was no documentation to confirm this informal approach of staff training.

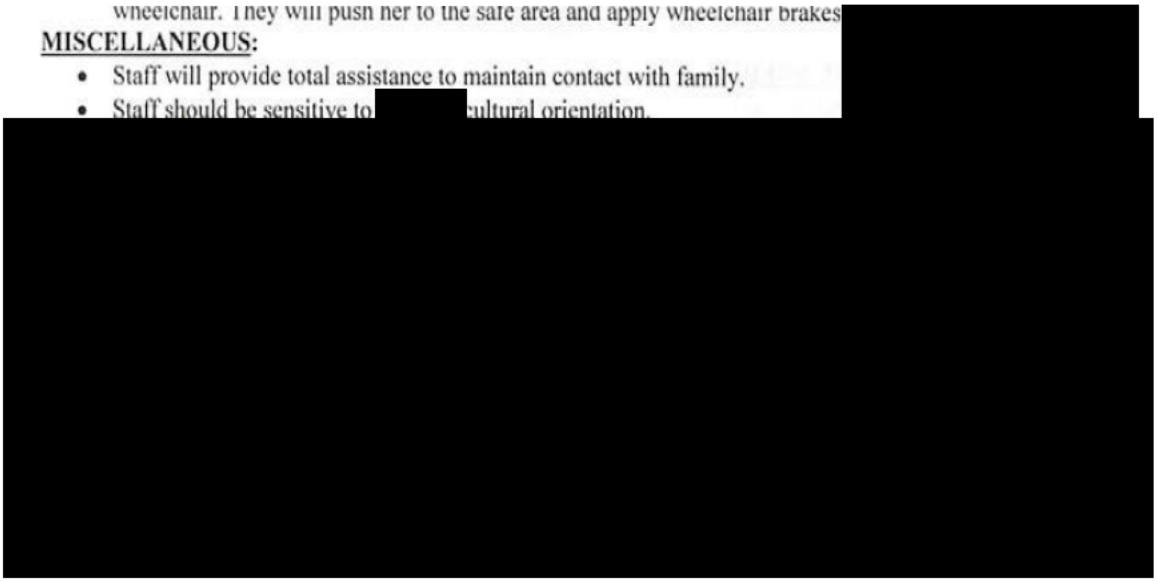
***Taconic DDSOO***

The Taconic DDSOO was missing documentation of staff training on IPOPs for 33 of 41 staff. Staff at each site visited in the Taconic DDSOO region stated that training on IPOPs was only provided when there was a change in the plan itself, except for the house manager at the Marlin IRA who said that training on the IPOPs, or the written site-specific plan of protection for the residence, was not a staff requirement. Although some team members met annually to discuss and review service plans, interviews with Taconic DDSOO staff revealed that direct support professionals were not always included at those meetings and therefore did not receive regular retraining on critical information to support and safeguard people receiving services. Additionally, some of the IPOPs themselves required that staff receive frequent retraining. For example, the IPOP for a person receiving services at Olivett Lane stated, "staff will review [name of person receiving services] plan on a regular basis" but training documentation showed that although that person's IPOP was updated on October 11, 2018, staff were last trained on the plan on May 18, 2018. Also, there was no definition of what frequency the term "regular" referred to.

One system that was consistently observed at each Taconic DDSOO site was the use of a float book. This book was used to provide quick access to important information on both site-specific plans of protection and individual supports and safeguards for float staff. Staff who worked as float staff at a home other than their primary location were expected to review the information in this book at the beginning of their shift. While this system could be a useful and effective training tool, the books were either missing IPOPs or behavior support plans (BSPs) or had outdated or discontinued plans. For example, at the Olivett Lane IRA, staff found a discontinued BSP for a person receiving services in the float book, and at the Wiltwyck IRA, the IPOP for one of the people receiving services was not in the float book.

***Western New York DDSOO***

While all sites visited for the Western New York DDSOO had a system in place to capture documentation of staff training, there did not appear to be any consistency between the systems. Staff training on IPOPs was documented via staff signatures on the plan itself except for the Bernadette Terrace IRA which used a separate cover sheet to document staff training. However, none of the documentation of staff training included training objectives, duration of training or training content. Additionally, the modality for staff training on IPOPs relied on a "read and sign" system where staff signed a cover sheet or the plan itself once they read and/or reviewed the plan. Of the documentation of training on IPOPs reviewed, there was no explanation as to what, specifically, the signatures of staff on the plan meant, and staff signatures were frequently not legible as seen in the photo below. Of note, the Beattie Avenue IRA was not able to provide any documentation of staff training in IPOPs. During the Justice Center site visit, the Beattie Avenue manager stated that staff only received training on the IPOPs when there was a change in the plan itself yet there was no documentation of staff training on IPOPs other than training provided and documented on orientation sheets completed at the time of staff hire or transfer to the site, some of which dated back to 2016.


wheelchair. They will push her to the safe area and apply wheelchair brakes

MISCELLANEOUS:

- Staff will provide total assistance to maintain contact with family.
- Staff should be sensitive to [redacted] cultural orientation.

*Staff signatures from a plan of protective oversight from the Jamestown Street IRA.*

## Equipment

**4. Document routine inspections of vehicles, lifts, and wheelchair securement equipment, and maintain equipment according to manufacturer guidelines, in order to ensure equipment remains in good working order.**

Each of the DDSOOs had vehicles or equipment required for transporting people receiving services who used wheelchairs that were not functioning at the time of

the Justice Center site visits and lacked documentation of routine inspections of vehicles or equipment related to wheelchair securement including wheelchair vans, wheelchair lifts, and wheelchairs. Wheelchair securement equipment did not appear to be maintained according to manufacturer guidelines at the Capital District and Western New York DDSOOs.

***Capital District DDSOO***

During Capital District DDSOO site visits, the wheelchair accessible van for the Webster Avenue IRA was not available on the date of the Justice Center site visit as it was at a service shop for repairs. Staff at the Webster Avenue IRA reported the van was not starting and required multiple visits to the garage for service. While on site at the Schuylerville IRA, the lift for one of the wheelchair accessible vans stopped working midway through lifting a person receiving services onto the van. The lift had to be lowered and the person receiving services could not be transported until staff were able to borrow a vehicle from a nearby program. Staff at the Boght Road IRA reported that their vehicle had just returned from being repaired but continued to malfunction with the wheelchair lift sporadically stopping during operation.

The Capital District DDSOO *Safety in Transportation (Car, Van and Bus)* policy included a requirement to document monthly inspections of wheelchair securement equipment and wheelchair lifts on a monthly vehicle preventive maintenance checklist, yet none of the staff interviewed were aware of the checklist as a tool for completing or documenting monthly inspections of securement related equipment. The *Safety in Transportation (Car, Van and Bus)* policy also stated that removing the wheelchair securement retractors from the floor tracks and putting them in pouches after each use was a best practice, yet this was not done in any of the vehicles observed by Justice Center staff during site visits. Moreover, dirt and debris were visible in floor tracks which could affect proper securement, as seen in the photo below:

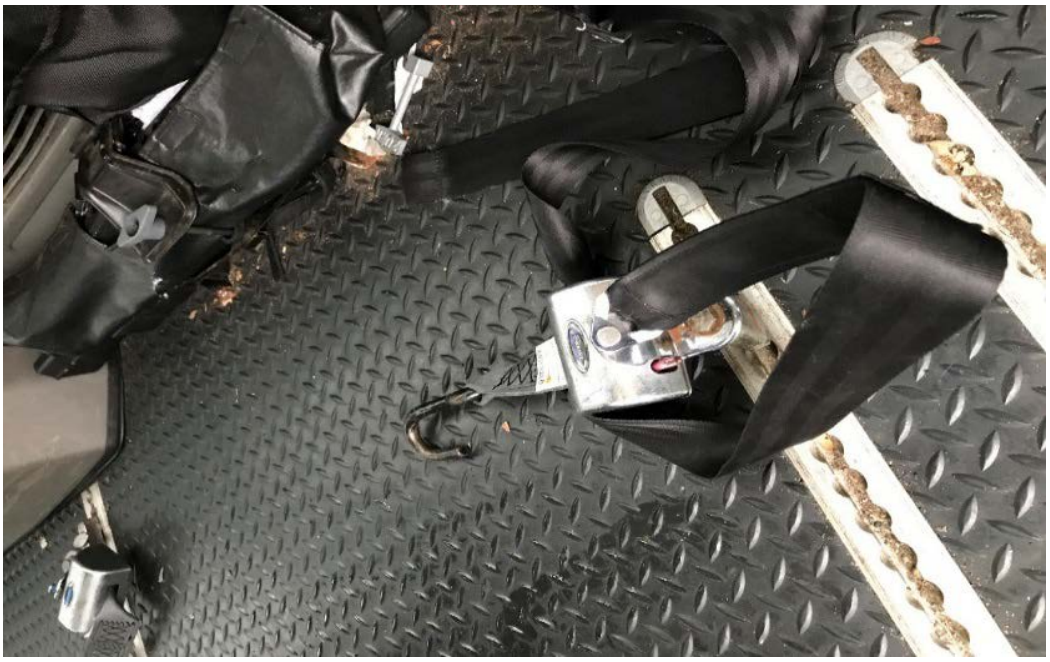


*Photo of wheelchair securement equipment in the Bogh Road IRA wheelchair van*

The Capital District DDSOO had no policy for routine wheelchair checks for safety and signs of wear or damage. Such checks are an important part of the wheelchair securement system to ensure the safe transportation of people in care. Though each site was asked, only one site, the Bogh Road IRA, was able to provide documentation of regular cleaning and inspection of wheelchairs. Other sites, such as the Schuylerville IRA, had a weekly checklist that listed cleaning of wheelchairs, however there was no documentation that cleaning was completed.

***Taconic DDSOO***

At the Taconic DDSOO, one of the two wheelchair vans at the Marakill IRA was a new wheelchair van that was on loan to them while the agency waited for a part to replace a broken wheelchair lift system. Though the van was drivable, it could not be used to transport someone in a wheelchair. Staff reported that the vehicle had been broken for several months while waiting on the part.

The Taconic DDSOO *Travel Safety* policy required the *Vehicle Safety Checklist* to be completed on a weekly basis. Copies of the checklist were located in the van binders at each residence visited by Justice Center staff yet only the staff at the Marlin IRA and the Marakill IRA had documentation of completed checklists. Also, although the Taconic DDSOO *Wheelchair and Adaptive Life Equipment Cleaning Protocol* identified a task assignment on the residential utilization assignment sheet of cleaning wheelchairs at least weekly, there was no documentation of wheelchair cleaning on the assignment sheets reviewed at the Wiltwyck and Marakill IRAs.

***Western New York DDSOO***

All four sites visited in the Western New York DDSOO region review followed a system of using a binder in each vehicle to track and store pertinent documents

and forms related to vehicle use, including the *Western NY DDSO Vehicle Monthly Safety Checklist.* This checklist was used to document monthly inspections of vehicles, including items pertaining to wheelchair securement such as ensuring each securement station was properly equipped, ensuring securement straps and belts were in good working order with storage pouches available, ensuring floor tracks for anchoring equipment were free of debris and checking lift equipment. However, there was not documentation to support that monthly inspections were routinely completed. There was no documentation to support monthly inspections of wheelchair vans for February 2019 at the Jamestown IRA, for December 2018 at the Bernadette Terrace IRA, and for every month in 2018 except for July at the Heather Hill Road IRA. There was no documentation on any of the checklists to indicate who completed the checklist or the date the inspection took place. Additionally, vehicles at Jamestown Street IRA and Heather Hill Road IRA had strong odors of mold and/or mildew and the front floorboard on one of the wheelchair vans at the Heather Hill Road IRA was warped and ripped as seen in the photos below:

*Photo of wheelchair accessible van at Heather Hill IRA*

None of the Western New York DDSOO sites ensured that wheelchair securement equipment, notably floor four-point securement equipment, was stored after use. Rather, the equipment was left out on the van floor where it could be stepped on by staff or rolled over by a wheelchair potentially causing damage to the securement equipment or to the wheelchair itself. Although all of the wheelchair vans at each site were equipped with storage pouches specifically designed to hold wheelchair securement equipment, none of the sites used them and one site, the Heather Hill IRA, was found to be using the storage pouch to hold windshield wiper fluid. In addition, there was visible dirt and debris in the floor tracks used to secure wheelchair securement retractors in the wheelchair vans and some of the securement equipment was beginning to rust. Each of the wheelchair vans

observed during this review used some form of a Q'Straint brand wheelchair securement product and, although the Western New York DDSOO *Driver Policy #4A.19.0* policy failed to address staff responsibilities for properly maintaining, storing, and cleaning the securement equipment, that information was available from the Q'Straint manufacturer.

Although each of the Western New York DDSOO sites used a system of staff assignment sheets to delegate and monitor staff responsibilities, cleaning and inspecting wheelchairs was not included as one of those responsibilities. The Bernadette Terrace and Jamestown Street IRAs had wheelchair cleaning listed on a general assignment sheet as a weekly responsibility for the overnight staff, but staff did not sign or initial the sheets to indicate completion of the assignment.

## POLICY

**5. Develop a comprehensive policy for all DDSOOs regarding the safe transportation of people receiving services, including those who use wheelchairs, that identifies training requirements and addresses training for people receiving services.**

The policies regarding the safe transportation of people receiving services were different at all three DDSOOs involved in this review, and none of the policies individually contained sufficient information to ensure the safe transportation of people receiving services who used wheelchairs. Moreover, none of the policies were revised to include recommendations from the Justice Center that were included in June and July 2018 determination letters regarding substantiated neglect against the DDSOOs for unsafe and dangerous wheelchair securement and transportation practices. The policies varied in their content regarding descriptions of the wheelchair securement process, identification of staff training requirements, and terminology used to describe wheelchair tiedown and occupant restraint systems and current terminology for people with disabilities. None of the policies included any recommendation or requirement to include people receiving services in safety training, education related to transportation safety, or active involvement in the securement process. Additionally, the Capital District DDSOO and Western New York DDSOO policies both used the term "handicapped" in their policies and in supporting documents; a term no longer accepted by people with disabilities and inconsistent with person first philosophy.

***Capital District DDSOO***

The Capital District DDSOO *Safety in Transportation (Car, Van and Bus)* policy, revised in July 2018, had the most recent revision date of the transportation related policies of the three DDSOOs. This policy was also the most comprehensive and included requirements for initial staff training on wheelchair securement along with a detailed procedure for the wheelchair securement process. The policy identified the staff responsible for providing training on wheelchair securement, however, it did not identify the training requirements for staff trainers or retraining requirements for staff. The policy used inconsistent terminology when referring to wheelchair

tiedown and occupant restraint systems. Throughout the policy, the terminology used to describe the equipment or systems used to secure the wheelchair of a person receiving services, or to secure the person receiving services themselves, was inconsistent and confusing. Wheelchair tiedown and occupant restraint system equipment was alternately referred to as “security straps and tie downs”, “four (4) point tie downs and the occupant restraint system”, “seatbelts/wheelchair restraint system”, “vehicle lap belt, shoulder belt and brakes” and “lap seatbelt”.

***Taconic DDSOO***

The Taconic DDSOO *Travel Safety* policy was last revised in November 2016. Although the policy stated that “staff must be trained and familiar with the correct operation and maintenance of the vehicle including all special equipment such as wheelchair safety restraints, buckle buddies, etc.”, the *Travel Safety* policy did not identify training requirements, training curriculum, or training timeframes for staff specifically related to wheelchair securement. Additionally, although training on wheelchair securement was provided by a staff who was trained to be a trainer, the policy itself did not identify who was responsible for providing training on wheelchair securement, or include information on the qualifications of, or training requirements for, staff trainers who provided staff training on wheelchair securement. Taconic DDSOO staff in Talent and Development and in Quality Improvement described a more detailed process of staff training on wheelchair securement; however, it was not reflected in the *Travel Safety* policy.

***Western New York DDSOO***

The Western New York DDSOO *Driver Policy #4A.19.0* had not been revised since November 2011. This policy did not address any staff training requirements for wheelchair securement as recommended by the Justice Center. In fact, the policy contained only a single sentence regarding wheelchair securement, that “a wheelchair and its occupant must be properly secured using straps, securement tracks and attachment points provided on the chair and within the vehicle prior to departure.” The policy made no reference to wheelchair vans, wheelchair lifts or other equipment that could be required to safely transport a person receiving services who used a wheelchair. The policy did not identify who was responsible for providing staff training on wheelchair securement or the requirements to be a staff trainer.