



**Justice Center for the
Protection of People
with Special Needs**

Prevention and Quality Improvement

Review of Food Choking Incidents in OPWDD Residences and Day Habilitation Programs

January 2023

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 people 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.

Table of Contents

Background 4

Review Recommendations 9

- Staff Training 11
- Plans of Care..... 17
- Identification and Mitigation of Choking Risks.....21

Appendices

Contact Information:

Tracey Sosa, Supervising Quality of Care Facility Review Specialist
Justice Center for the Protection of People with Special Needs
Prevention and Quality Improvement
161 Delaware Avenue
Delmar, New York 12054
(518) 549-0314

Background

This systemic review, conducted by the Justice Center for the Protection of People with Special Needs (Justice Center), was undertaken in response to abuse and neglect incidents involving people choking on food in residential and day habilitation settings licensed and operated by the Office for People with Developmental Disabilities (OPWDD).¹

Studies have shown that people with intellectual and developmental disabilities are nearly eleven times more likely to die from respiratory-related conditions, often linked with difficulties swallowing (dysphagia), choking and aspiration.² In a review of U.S. death certificates, choking is commonly listed as contributing to the cause of death among people with Down syndrome, intellectual disabilities, and cerebral palsy.³

A review of the Vulnerable Persons' Central Register (VCPR) for choking related incidents that occurred between January 2020 to June 2022 revealed that 960 incidents of choking in OPWDD settings were reported to the VPCR, approximately 90% of which occurred in a residential setting.⁴

Of the 960 choking incidents reported to the VPCR, 131, or 14%, involved an allegation of abuse or neglect. The Justice Center substantiated 56% of those allegations, finding that an individual staff member committed abuse and/or neglect or the provider agency had systemic issues that related to the choking incident. Additionally, a review of the choking incidents reported to the VPCR between January 2020 and June 2022 revealed that 25 of those incidents involved the death of a person receiving services due to choking and seven of those incidents involved an allegation of abuse or neglect.

Though the majority of choking related incidents involving the death of a person receiving services occurred in a residential setting, the Justice Center found that there was often poor communication between the residential and day habilitation settings about the needs of people receiving services pertaining to food preparation. The Justice Center found that often there was no formal process for verifying foods were prepared to the correct consistency.

¹ For the purposes of this review, the term choking refers to foreign body airway obstruction which most commonly results from food that gets stuck in the trachea.

² Truesdale M, Melville C, Barlow F, Dunn K, Henderson A, et al. "Respiratory-associated deaths in people with intellectual disabilities: a systematic review and meta-analysis." *BMJ Open*; 2021; 11:e043658. doi:10.1136/bmjopen-2020-043658

³ Landes, Scott D et al. "Cause of death in adults with Down syndrome in the United States." *Disability and health journal* vol. 13,4 (2020): 100947. doi:10.1016/j.dhjo.2020.100947; Landes, S D et al. "Cause of death in adults with intellectual disability in the United States." *Journal of intellectual disability research : JIDR* vol. 65,1 (2021): 47-59. doi:10.1111/jir.12790; Stevens, J Dalton et al. "Cause of death trends among adults with and without cerebral palsy in the United States, 2013-2017." *Annals of physical and rehabilitation medicine* vol. 65,2 (2022): 101553. doi:10.1016/j.rehab.2021.101553

⁴ The number of residential cases may be slightly inflated due to the closure of many day habilitation programs because of the Covid-19 pandemic.

This review includes residential and day habilitation programs from both voluntary and state operated provider agencies. The providers selected for this review had choking incidents that occurred between January 2020 and June 2022, including choking incidents that led to the death of a person receiving services. The Justice Center employed a “follow the person” model to observe people receiving services in both their residential and day habilitation settings.

The purpose of this review is to examine policies and procedures, staff training and individual protections related to the prevention of choking in OPWDD residential and day habilitation settings. The Justice Center identified factors that may contribute to choking incidents for people receiving services through conducting site visits during mealtimes, interviewing staff and reviewing documentation.

Based upon this review, the Justice Center offers recommendations to reduce the risk of choking related incidents thereby improving the health, safety, and welfare of people receiving services in OPWDD residential and day habilitation settings.

Program Descriptions

The Justice Center conducted 17 site visits between January 2022 and August 2022 at nine provider agencies operated or licensed by OPWDD.

██████████ (Provider 1)

The ██████████ Individualized Residential Alternative (IRA) (Location 1), located in ██████████, supported seven people receiving services at the time of the Justice Center site visit. Six of the people receiving services at this location required a modified food and/or liquid consistency and one person had a known history of choking. This provider agency had eight choking incidents that occurred between January 2020 and June 2022 including a January 31, 2021, choking incident that occurred at Location 1 involving a person receiving services who has a known risk for choking. The Justice Center conducted a site visit to Location 1 on February 24, 2022.

The ██████████ Day Habilitation (Location 2), located in ██████████, supports five of the people receiving services from Location 1, all of whom required a modified food and/or liquid consistency. The Justice Center conducted a site visit to Location 2 on February 24, 2022.

██████████ (Provider 2)

The ██████████ IRA (Location 3), located in ██████████, supported five people receiving services at the time of the Justice Center site visit. Three of the five people receiving services at the IRA required a modified food and/or liquid consistency. The people receiving services at Location 3 received day habilitation

services in the home and did not attend an offsite location for day habilitation. The Justice Center conducted a site visit to Location 3 on March 30, 2022.

██ (Provider 3)

The ██ (Location 4), located in ██, supported seven people receiving services at the time of the Justice Center site visit. A person receiving services at this IRA died after choking on food that was not prepared to the correct modified consistency. The people receiving services at Location 4 received day habilitation services in the home and did not attend an offsite location for day habilitation. The Justice Center conducted a site visit to Location 4 on March 31, 2022.

██ (Provider 4)

The ██████████ IRA (Location 5), located in ██, supported six people receiving services at the time of the Justice Center site visit. Four of the six people required a modified food consistency, a modified liquid consistency, and/or enhanced supervision while dining and two of those people had a known history of choking. This provider agency had 13 choking incidents that occurred between January 2020 and June 2022, including six that occurred at Location 5. The Justice Center conducted a site visit to Location 5 on May 3, 2022. This provider agency does not operate any day habilitation programs.

██ (Provider 5)

The ██████████ IRA (Location 6), in ██, supported 10 people receiving services at the time of the Justice Center site visit. Three of the people receiving services at the IRA required a modified food and/or liquid consistency. This IRA had three choking incidents in 2019 and this provider agency had six choking incidents that occurred between January 2020 and June 2022. The Justice Center conducted a site visit to Location 6 on May 4, 2022.

Two of the people receiving services from Location 6 who required a modified food and/or liquid consistency attended the ██████████ Day Habilitation (Location 7), in ██. The Justice Center conducted a site visit to Location 7 on May 4, 2022.

██ (Provider 6)

The ██████████ IRA (Location 8), located in ██, supported 10 people receiving services at the time of the Justice Center site visit. A person receiving services at the IRA had a history of choking and required a modified food and/or liquid consistency and enhanced supervision while dining. This provider agency had six choking incidents that occurred between January 2020 and June 2022. The Justice Center conducted a site visit to Location 8 on May 31, 2022.

Five of the people receiving services at Location 8 attended the [REDACTED] Day Habilitation (Location 9), located in [REDACTED]. A person receiving services had a choking incident at Location 9 in February 2022. The Justice Center conducted a site visit to Location 9 on June 1, 2022.

The person receiving services from Location 8 who required a modified food and/or liquid consistency and enhanced supervision while dining attended the [REDACTED] Day Habilitation (Location 10), located in [REDACTED]. The Justice Center conducted a site visit to Location 10 on June 2, 2022.

[REDACTED]
(Provider 7)

The [REDACTED] IRA (Location 11), located in [REDACTED], supported 12 people receiving services at the time of the Justice Center site visit. All of the people at this IRA required a modified food and/or liquid consistency and four of those people also required enhanced supervision while dining. The Justice Center conducted a site visit to Location 11 on June 28, 2022.

Five of the people receiving services from the Location 11 attended the [REDACTED] Day Habilitation (Location 12), located in [REDACTED]. All five of the people required a modified food and/or liquid consistency and two of the people also required enhanced supervision while dining. In May 2021 and September 2021, staff failed to check the lunches of people receiving services to ensure they were prepared to the correct consistency, resulting in people being served food that was not prepared properly. The Justice Center conducted a site visit to Location 12 on June 30, 2022.

The [REDACTED] IRA (Location 13), located in [REDACTED], supported 12 people receiving services at the time of the Justice Center site visit. Eleven of the 12 people required a modified food and/or liquid consistency and seven of those people required total assistance from staff to be fed. The Justice Center conducted a site visit to Location 13 on June 29, 2022.

Eleven of the people receiving services from Location 13 attended the [REDACTED] Day Habilitation (Location 14), located in [REDACTED]. The Justice Center conducted a site visit to Location 14 on June 29, 2022.

[REDACTED] (Provider 8)

The [REDACTED] IRA (Location 15), located in [REDACTED], supported five people receiving services at the time of the Justice Center site visit. One of the people required a modified food and/or liquid consistency and enhanced supervision while dining due to a choking incident that occurred in September 2021. The Justice Center conducted a site visit to Location 15 on August 3 and 4, 2022.

██████████ (Provider 9)

The ██████████ IRA (Location 16), located in ██████████, supported eight people receiving services at the time of the Justice Center site visit. Two of those people required a modified food and/or liquid consistency with one person also requiring enhanced supervision while dining due to a choking incident that occurred in December 2020. The Justice Center conducted a site visit to Location 16 on August 4, 2022.

Four of the people receiving services from Location 16 attended the ██████████ ██████████ Day Habilitation (Location 17), including the two people who required a modified food and/or liquid consistency and/or enhanced supervision. The Justice Center conducted a site visit to Location 17 on August 5, 2022.

Scope and Methodology

The Justice Center conducted a tour of each IRA and day habilitation site, observed food preparation and meals served to people receiving services during lunch or dinner, interviewed staff and people receiving services, and reviewed documentation. The Justice Center also checked the cleanliness and functionality of any equipment used to modify food.

Documentation Reviewed:

- Policies and procedures related to:
 - staff training requirements for choking prevention, CPR and First Aid
 - dining guidelines
 - swallow evaluations
- Individual Plans of Protection (IPOP), Safeguard Summary Plans (SSPs), Staff Action Plans (SAPs), Life Plans and Dining Guidelines for people receiving services
- Documentation of staff training on:
 - IPOP, SSP, SAP, Life Plans and Dining Guidelines
 - OPWDD's CPI
 - CPR and First Aid
- Training curriculum for sensitivity training and documentation of staff training on sensitivity
- Staff schedules and assignment sheets
- Mealtime observations from 2022
- Emergency response drills for life threatening events (other than fire) for 2021 and 2022

Exit Letters from each site visit and the individual Review Findings Letter sent to each provider agency are available as appendices and include policies and other documents referenced in this review.⁵

Additionally, in May of 2021 the Justice Center sent a survey to OPWDD provider associations related to choking prevention.⁶ The Justice Center asked providers about how mealtime observations and emergency response drills were conducted and documented, and asked providers to identify agency best practices to prevent food choking incidents. The Justice Center received 50 responses to this survey.

Lastly, since 2020 the Justice Center has conducted at least 20 audits of Corrective Action Plans (CAPs) from 20 different providers for cases involving an allegation of abuse or neglect related to a choking incident. The findings and recommendations from those audits were also considered for this review.

Recommendations

The Justice Center's specific recommendations are detailed below. While this review focused on nine provider agencies, the Justice Center recommends that OPWDD assess all programs with attention to these findings and apply the recommendations globally, as appropriate.

Staff Training

1. Improve staff's ability to prevent and/or respond to choking incidents by:
 - a. continuing to require practical hands-on training for the modification of foods and liquids in OPWDD's Choking Prevention Initiative (CPI);
 - b. requiring refresher training on CPI and that all staff be trained on CPR;
 - c. ensuring staff are trained on all dietary requirements and restrictions for people receiving services;
 - d. incorporating "right to risk" scenarios and sensitivity training for providing people receiving services with feeding assistance into PRAISE and CPI training; and

⁵ Please refer to Appendix A for the Exit Letters and Review Findings Letter for Provider 1, Appendix B for the Exit Letter and Review Findings Letter for Provider 2, Appendix C for the Exit Letter and Review Findings Letter for the Provider 3, Appendix D for the Exit Letter and Review Findings Letter for Provider 4, Appendix E for the Exit Letters and Review Findings Letter for Provider 5, Appendix F for the Exit Letters and Review Findings Letter for Provider 6, Appendix G for the Exit Letters and Review Findings Letter for Provider 7, Appendix H for the Exit Letter and Review Findings Letter for Provider 8, and Appendix I for the Exit Letters and Review Findings Letter for Provider 9.

⁶ Please refer to Appendix J for the Justice Center survey.

- e. offering resources and support for provider agencies for conducting and documenting emergency response drills involving choking scenarios.
2. Ensure all staff are trained on CPI and have the necessary tools and information to prevent choking incidents by:
 - a. revising the OPWDD agency survey protocols to include a review of all staff's CPI training documentation as part of the Bureau of Program Certification (BPC) survey process to ensure all staff are trained on CPI and that Part II of CPI includes practical, hands-on training as required by OPWDD's ADM #2012-04;
 - b. linking OPWDD Health and Safety Alerts that address choking risks to the OPWDD CPI page to increase visibility to these important documents;
 - c. identifying whether the use of CPI Liaisons is a current practice and if so, ensure an accurate list of liaisons is maintained and shared with provider agencies; and
 - d. posting information for ordering OPWDD "Stop! Choking Hazards" cutting boards and posters on the OPWDD website and ensure provider agencies are aware of how to order and re-order these items.

Plans of Care

3. Enhance the quality, consistency and continuity of plans of care that identify dining supports and requirements, including any requirements for modified food and/or liquid consistencies, for people receiving services by:
 - a. creating and implementing a standardized template for provider agencies to document dining supports required by people receiving services in a stand-alone "Dining Guidelines" plan; and
 - b. identifying a process for provider agencies to perform due diligence in reviewing plans of care to ensure they consistently identify food and liquid consistency requirements as well as supervision and supports people receiving services require while dining. Consider modifying the "Life Plan Gatekeeper Form for State Operations" to also be used to ensure plans of care are consistent with one another and share the form with all provider agencies.

Identification and Mitigation of Choking Risks

4. Provide people receiving services with foods and liquids that are prepared to the consistency required by plans of care by:
 - a. ensuring provider agencies have processes for verifying and checking all meals to ensure they are prepared to the correct food and liquid

consistency, including lunches that are prepared in residences to be consumed at day habilitation programs; and

- b. creating and providing agencies with sample mealtime observations forms to encourage provider agencies to provide managerial or administrative observations of programs during mealtimes. Encourage providers to document mealtime observations to include the name of the person providing the observation, the staff and people receiving services present at the time of the observation, and the supervision and food and liquid consistency requirements for each person receiving services.

5. Provide guidance to provider agencies for assessing people receiving services for choking risks upon admission to programs.

Staff Training

1. **Improve staff's ability to prevent and/or respond to choking incidents by:**
 - a. **continuing to require practical hands-on training for the modification of foods and liquids in the Choking Prevention Initiative (CPI).**

In 2012, OPWDD implemented the Choking Prevention Initiative (CPI) with standardized, consistent terminologies and definitions related to food consistencies and a training curriculum that “reviews preventative measures to decrease the risk of choking and aspiration.” OPWDD’s ADM #2012-04 identifies staff training requirements for CPI, noting that training is to be provided to staff within three months of their hiring date. Part I of the training, “Prevention of Choking and Aspiration”, provides an overview of dysphagia and is designed to increase staff awareness of the risks of choking and aspiration. Part II of the training, “Preparation Guidelines for Food and Liquid Consistency”, requires a best practice of “practical training in preparation of the defined food consistencies and liquid consistencies...to reinforce the knowledge and skills learned.”

The Justice Center finds this to be a robust training curriculum and encourages OPWDD to continue with the hands-on, practical application of training for this important topic.

- b. **Requiring refresher training on OPWDD’s CPI and that all staff be trained on CPR.**

CPI Training

Training on Part I of CPI emphasizes the “critical importance of choking prevention” for people receiving services and is required for all “applicable parties” to be completed within three months of hire. Part II of CPI is required for all staff who

“regularly prepare or serve food, assist with dining, and/or provide supervision of individuals at meals and snack times.”

OPWDD’s ADM #2012-04 notes that “best practice dictates that some type of choking prevention reinforcement training related to dysphagia, food and liquid consistency, PICA and choking hazards be provided every year to appropriate staff or applicable parties.” The ADM further notes that “...the online CPI Part I training may be used as an annual refresher if a need is identified by the agency.” However, the ADM specifically notes that there is no annual refresher required for Part I or Part II of CPI training. Further, though the ADM recommends a best practice of annual training on choking prevention to include “food and liquid consistency” and notes that Part I of CPI training may be used as an annual refresher, Part I of CPI does not include information on OPWDD’s food and liquid consistency terms and definitions.

Five of the nine providers included in this review identified a best practice of providing annual refresher training on CPI, though only three of the agencies had a policy to support the requirement for the refresher training. Approximately 30% of staff working at the provider agencies included in this review had not been trained in CPI in the last five years. Ten percent had not been trained since 2012, the year that the requirement for CPI training was implemented.

Staff working in day habilitation programs interviewed as part of this review told the Justice Center that due to the pandemic, their knowledge and understanding of CPI’s food and liquid consistencies and how to modify foods and liquids to different consistencies increased only because they were working in residential settings more frequently. Staff identified that since lunches were typically already modified to required food and/or liquid consistencies when sent to the day habilitation, there were fewer practical opportunities for staff to modify the meals themselves. An annual CPI refresher training requirement would be beneficial to ensure staff always have the knowledge required to modify foods and liquids safely and correctly as needed.

Of note, of the 50 agencies who responded to the Justice Center’s May 2021 survey, only seven indicated that they required annual staff training on CPI.

CPR Training

With respect to CPR, an OPWDD *Choking Prevention & Intervention Update November 2015* notes that “Best Practices include training staff members (and monitoring competency) in: First Aid and CPR...”. Documentation of staff training on CPR and First Aid was requested for this review. However, though each provider identified that training on First Aid and CPR was a required training, four of the nine providers had one or more staff who were either not trained in CPR or who had a lapsed CPR certification.

Further, without a specific requirement for all staff to be trained on CPR, provider agencies may not implement this best practice of requiring all staff to be trained on CPR. 14 NYCRR §633.10 reflects that provider agencies shall "...develop a plan for addressing the life-threatening emergency needs of the persons served. Such a plan shall be based on the needs of the persons in the facility, and shall address the availability of first aid, cardiopulmonary resuscitation (CPR) techniques and access to emergency medical services. When staff training is part of the plan, there shall be provision to keep such training up to date." However, the regulation does not specifically require provider agencies to train all staff on CPR.

For example, in July 2021, the Justice Center conducted an audit of a CAP for a case involving the death of a person receiving services. In this case, a person receiving services was found unresponsive and staff were unfamiliar with CPR and needed assistance being led through CPR by 911 staff. The provider's CAP noted that staff were not CPR certified and that, in medical emergencies "employment responsibilities do not include personal heroic activities; however, it is expected that the most timely and medically effective care be sought immediately."⁷

c. Training all staff on the plans of care for meal preparation and dining supervision for people receiving services.

Documentation provided for this review revealed that food and liquid consistency requirements and dining supervision requirements were documented in a variety of places by each provider including Safeguard Summary Plans, Staff Action Plans, IPOPS or in a separate Dining Guidelines or Dining Fact Sheet. Documentation of staff training on these documents was requested for this review, and 15 of the 17 sites included in this review did not have documentation to support that all staff were trained on these plans of care, or that they were trained in a timely manner following plan implementation or revision.

d. Incorporating "right to risk" scenarios and sensitivity training for providing people receiving services with feeding assistance into PRAISE (Promoting Relationships and Implementing Safe Environments) and CPI training.

Providers were asked to identify any requirements for sensitivity training and to provide any training curriculum for sensitivity training related to providing feeding assistance to people receiving services. Only two providers, Provider 3 and Provider 7, provided training curriculum to support that staff received training on being sensitive while assisting people receiving services while dining.

The training curriculum from Provider 3 emphasized that staff should be seated at the table with people receiving services while providing dining supervision. The curriculum also included guidance for staff titled "don't yuck someone else's yum"

⁷ CSN [REDACTED], MIN [REDACTED], CAP Audit Findings Letter issued July 30, 2021.

that encouraged staff to refrain from making negative comments or observations about people's food choices.

The training curriculum from Provider 7 included training exercises related to "dietary restrictions" that asked staff to think about eating or drinking their favorite foods and beverages modified to a different consistency, or to think about what it would be like to be fed by someone else.

OPWDD's Health and Safety Alert, *Balancing the Right to "Access to Food" with Protections for Individuals in Home and Community Based Settings*, dated July 2018, outlines important information addressing the right for people receiving services to have access to food while also mitigating individual risk, including choking risks for people who have a history of choking or are at risk for choking. The Health and Safety Alert acknowledges that modifications or limitations to a person's right to access food may be necessary to ensure the health and safety of others and notes that the "right to access food should not be misrepresented as a barrier to adequate safeguarding or be a reason to avoid responsible person-centered service planning."

However, "right to risk" scenarios or information regarding this Health and Safety Alert do not appear to be a component of either CPI training or PRAISE training to ensure staff understanding of the importance of balancing a person's right to risk by having access to food with ensuring that safeguards are in place to also mitigate the risk of choking.

In May 2022 the Justice Center issued a CAP audit that addressed concerns that a person receiving services who had dysphagia signed a "Right to Risk" consent form to not follow physician recommendations for a modified ground food consistency.⁸ The audit identified that the person was not educated on all the possible consequences that could occur from not complying with the recommended modified ground food consistency. Incorporating information and case scenarios in CPI and PRAISE addressing the importance of educating people receiving services of the possible consequences that accompany their right to risk could be beneficial to avoid similar situations from occurring.

e. Offering resources and support for provider agencies for conducting and documenting emergency response drills involving choking scenarios.

The OPWDD *Choking Prevention & Intervention Update November 2015* identifies a best practice of "practicing appropriate response to choking scenarios (e.g., practice choking 'drills')." However, none of the provider agencies included in this review provided documentation to support that they conduct emergency response drills for choking or other medical emergencies. Additionally, only 2 of the 50

⁸ CSN [REDACTED], MIN [REDACTED], CAP Audit Findings Letter issued May 17, 2022.

provider agencies who responded to the May 2021 Justice Center survey identified that they conducted emergency response drills for choking or other medical emergencies.

Given the number of provider agencies who identified that they are not conducting emergency response drills, it may be beneficial for OPWDD to create and offer resources and support for conducting and documenting emergency response drills.

2. Ensure all staff are trained on CPI and have the necessary tools and information to prevent choking incidents by:

- a. Revising the OPWDD agency survey protocols to include a review of all staff's CPI training documentation as part of the Bureau of Program Certification (BPC) survey process to ensure all staff are trained on CPI and that Part II of CPI includes practical, hands-on training as required by OPWDD's ADM #2012-04.**

OPWDD's 2019 *Agency Protocol Manual* outlines the details of the agency review process that is "intended to verify that agencies have procedures and act to facilitate compliance with regulatory requirements, emphasize quality services, and prioritize both compliance and quality organizationally." The manual includes guidance related to CPI, noting that documentation from a sample of staff is reviewed as part of an agency review to ensure that "sample employees have received, or are scheduled to receive, the required OPWDD CPI training within the required time frame." However, although all provider agencies reviewed identified a process for training staff in CPI, including requiring practical, hands-on training for Part II of CPI, one provider's training records showed that 11 out of 15 staff had not been trained at the residence, and there was no documentation to support that any staff of the day habilitation for this provider had been trained on CPI.⁹

Of note, only five of the nine providers included in this review formally identified staff training requirements for CPI in policy.

- b. Linking OPWDD Health and Safety Alerts that address choking risks to the OPWDD CPI page to increase visibility to these important documents.**

The "Service Provider" section of the "Provider" tab on the OPWDD web site has a link for "Health, Safety & Prevention" where OPWDD's Health and Safety Alerts can be found. OPWDD has issued multiple Health and Safety Alerts with valuable and important information to help prevent choking, however these Health and Safety alerts are not cross referenced in the "Choking Prevention" section of the

⁹ The staff training documentation from Provider 9 did not reflect that all staff were trained.

website and do not appear to be included in with CPI training. The specific Health and Safety Alerts relevant to choking prevention are:

- *Balancing the Right to “Access to Food” with Protections for Individuals in Home and Community Based Settings*
- *Sedation and Anesthesia: Risks and Safeguards*
- *Aspiration*
- *Support and Supervision of Individuals with Prader-Willi Syndrome*

c. Identifying whether the use of CPI Liaisons is a current practice and if so, ensure an accurate list of liaisons is maintained and shared with provider agencies.

OPWDD’s ADM #2012-04 reflects that “Each DDSOO has an assigned liaison responsible for implementing Choking Prevention Initiative training at their location. Additionally, there is a DDSOO staff member assigned as a CPI Liaison for the provider agencies within the catchment area of the DDRO. For your reference, a list of CPI Liaisons is attached.” However, there was not a list of CPI Liaisons attached to the ADM and it’s not clear from the ADM whether the role of the liaison was intended to be ongoing or solely intended to support the initial implementation of CPI.

Additionally, it’s not clear if a list of the CPI Liaisons has ever been updated or if an updated list was made available to provider agencies. The October 2020 *Choking Prevention Policy* for Provider 5 noted the provider “has been assigned a CPI Liaison through the DDSOO [sic] who will serve as a resource. The Director of Quality Assurance/designee is responsible for all communication with the CPI Liaison.” Provider 5 provided the Justice Center with a list of DDRO CPI Liaisons; however, the list reflected a “last updated” date of June 6, 2012. At least seven of the 17 liaisons on the list no longer appear in the statewide Microsoft Outlook directory and the central office contacts listed for the Director of Nutrition Services and Director of Nursing and Health Services are no longer accurate.

d. Posting information for ordering OPWDD “Stop! Choking Hazards” cutting boards and posters on the OPWDD website and ensure providers are aware of how to order and re-order these items.

OPWDD’s ADM #2012-04 noted that “OPWDD will be providing a flexible cutting board and a poster for each certified site. Both the cutting board and the poster provide a template and a description for each of the food consistencies defined by OPWDD. Images of both items are available on the website with the OPWDD CPI training materials.” However, while images of both the cutting board and the poster are available on the OPWDD website, information for ordering or requesting these items is not on the website.

Of note, six of the 17 sites visited for this review did not have an OPWDD “Stop! Choking Hazards” cutting board or had a cutting board that was worn and in need of replacement. Regarding the OPWDD “Stop! Choking Hazards” posters, 11 of the 17 sites either did not have any posters displayed or did not have them displayed in rooms where people receiving services ate their meals.

Plans of Care

3. **Enhance the quality, consistency, and continuity of plans of care that identify dining supports and requirements, including any requirements for modified food and/or liquid consistencies, for people receiving services by:**
 - a. **creating and implementing a standardized template for provider agencies to document dining supports required by people receiving services in a stand-alone Dining Guidelines plan to include:**
 - **Required food and liquid consistencies;**
 - **Supervision required while dining;**
 - **Adaptive equipment required while dining;**
 - **Pacing requirements;**
 - **Positioning requirements; and**
 - **Individualized risk factors for choking such as whether a person is edentulous**

An OPWDD *Choking Prevention & Intervention Update November 2015* noted that “service plans are to document the determined consistencies per OPWDD’s standardized food constancy language” and “individuals should be assessed to determine other strategies necessary to aid in safe eating. Strategies should be documented in their service plans.” However, the guidance did not specify which service plan(s) should contain this information and documentation provided for this review reflected that provider agencies were not consistent in how they chose to document the dining supports and supervision required by people receiving services. The documentation provided for this review revealed that, depending on the provider agency, food and liquid consistency requirements and dining supervision requirements were documented in either Safeguard Summary Plans, Staff Action Plans, IPOPS or in a separate stand-alone Dining Guidelines or Dining Fact Sheet.

Of the plans reviewed, the stand-alone Dining Guidelines or Dining Fact Sheets were typically the most thorough and included the most information regarding dining supports and supervision required by people receiving services. In particular, the Dining Fact Sheet used by Provider 1 was noted to include information that the Justice Center has observed to be important for inclusion in

dining plans.¹⁰ This Dining Fact Sheet included photos of adaptive equipment to assist staff in recognizing the equipment people need while dining and included definitions for the level of supervision included on the plan. The Dining Fact sheets also consistently identified the positioning requirements while dining for people receiving services, how foods and liquids should be “presented” and whether pacing or pacing equipment (such as a second plate) was required, identified the person’s communication abilities, whether they were right or left-handed and their dental status. Additionally, the Dining Fact sheets included example photos of the specific food consistency required by the person and included the Speech Language Pathologist’s contact information so staff could directly report any concerns with the person’s dining abilities.

In addition to differences in where providers documented requirements for food and liquid consistency and dining supervision, there were also inconsistencies in the types of information provider agencies included in the plans. The plans reviewed did not all consistently include requirements for supervision, pacing, positioning or adaptive equipment while dining, or whether the person was edentulous or used dentures while dining.

Further, as noted in the Review Findings Letters, all the providers were found to have one or more people receiving services whose plans of care were inconsistent with one another or were missing significant information, such as the supervision required while dining, as summarized by the examples in the table below:

Provider Agency	Plan of Care	Identified Concerns
Provider 1	Dining Fact Sheet	Although the February 3, 2021, Dining Fact Sheet for a person receiving services reflected that they required a modified food consistency of 1-inch pieces cut to size for meat, verbal, and physical cues to eat slowly and a pacing plate in the event they did not respond to verbal cues, the person’s May 12, 2021, IPOP reflected “N/A” in the section indicating whether the person was at risk for choking.
Provider 2	Dining Plan	Though the February 22, 2022, IPOP for a person receiving services noted that they required close supervision and pacing while dining due to the person’s inability to breathe through their nose and being edentulous, this information was not included in the person’s February 22, 2022, Dining Plan.

¹⁰ Please refer to Appendix K a sample Dining Fact Sheet.

Provider Agency	Plan of Care	Identified Concerns
Provider 3	Dining Plan	The March 23, 2021, IPOP for a person receiving services identified that the person needed reminders to sit up straight while dining and that staff needed to sit between that person and another person receiving services, however this information was not included in the person's Dining Plan.
Provider 4	IPOP	IPOPs used terminology such as "soft diet" and "mechanical soft diet" which are not consistent with OPWDD's CPI. Plans also did not identify the supervision required by people receiving services while dining.
Provider 5	IPOP	IPOPs used inconsistent terminology for levels of supervision. The IPOP for one person receiving services used terms such as "one to one", "field of vision", "range of scan" and "range of hearing", but the IPOP for another person receiving services used supervision terms such as "Line of sight supervision" "Periodic checks" and "independent with staff present."
Provider 6	Residential IPOP Day Program Safeguard Plan	The section to reflect the "type of monitoring and/or assistance needed" while dining was blank for six of ten people receiving services, and IPOPs did not identify the required food and/or liquid consistency for four of ten people. Four of five plans did not use food and liquid terminology consistent with OPWDD's CPI. The Safeguard Plan for one person receiving services did not include information from the person's Life Plan that staff should remain at the table with the person until they finished eating and drinking.
Provider 7	Dining Plans	Dining Plans reflected "exceptions" to the food and liquid consistencies required by people receiving services that were actually an additional requirement to process foods to a smaller, ground, or pureed consistency for the person to be able to safely eat it rather than reflecting that the people required a food consistency that was a combination of consistency types.

Provider Agency	Plan of Care	Identified Concerns
Provider 8	IPOP	The IPOP for a person receiving services did not note that staff should encourage the person to eat slowly, limiting bites of food to three to four bites with sips of water in between although this was noted in the person's Individual Plan of Nursing Services (IPNS).
Provider 9	Residential Safeguard Summary Plans (SSPs) Day Program Staff Action Plan (SAP)	The SSPs did not consistently identify the supervision required by people receiving services while dining using terminology that was consistent with the provider's defined levels of supervision. The October 26, 2021, SSP for a person receiving services reflected that they required a whole food consistency although the person had a physician's order from February 14, 2021, noting that the person required food consistency of ¼ inch pieces cut to size. The Day Program SAPs did not identify the supervision required by people receiving services while dining.

- b. identifying a process for provider agencies to perform due diligence in reviewing plans of care to ensure they consistently identify food and liquid consistency requirements as well as supervision and supports people receiving services require while dining. Consider modifying the “Life Plan Gatekeeper Form for State Operations” to also be used to ensure plans of care are consistent with one another and share the form with all provider agencies.**

Although not provided as part of this review, the Justice Center received a “Life Plan Gatekeeper Form for State Operations” from a DDSOO as part of a CAP audit.¹¹ The form was provided to support that DDSOOs perform due diligence to review the Life Plans for people receiving services upon receipt of the plans to ensure that provider assigned goals are appropriate and required signatures are present on the plan. The form also contains directions for follow up with care managers when concerns are noted.

¹¹ Please refer to Appendix L for the Life Plan Gatekeeper Form for State Operations.

However, the form does not provide specific directions for providers to review the safeguards noted in the Life Plan to ensure they are accurate and consistent with other plans of care. Adding a section to the Life Plan Gatekeeper Form for State Operations for provider agencies to specifically review the safeguards section of the Life Plan and compare that to other plans of care to ensure they are consistent could be an effective way to address the inconsistencies in plans of care noted in this review.

Identification and Mitigation of Choking Risks

- 4. Provide people receiving services with foods and liquids that are prepared to the consistency required by plans of care by:**
 - a. ensuring provider agencies have processes for verifying and checking all meals to ensure they are prepared to the correct food and liquid consistency, including lunches that are prepared in residences to be consumed at day habilitations.**

The Review Findings Letters for Provider 7 and Provider 9 both referenced incidents where people receiving services who required a modified food and/or liquid consistency were provided with a lunch that was not prepared to the required consistency. In addition to the residence failing to correctly modify the food and/or liquid, the day habilitation staff did not verify that the lunch was prepared to the correct consistency before serving it to the people receiving services.

None of the seven-day habilitation sites included in this review had a formal process for documenting that lunches for people receiving services were checked to ensure they were prepared to the correct food and/or liquid consistency. Provider 7 identified a corrective action that is considered a best practice, to place a laminated dining card/placemat that identified the required food and/or liquid consistencies and supervision requirements for people receiving services in front of the person's lunch as a visual aid to ensure the lunch was correctly modified. However, this practice was not implemented during the Justice Center's site visits.

Additionally, Provider 7 was the only provider agency with a process to document a residential verification that lunches sent to day habilitation programs were prepared to the required food and/or liquid consistency. The staff assignment sheets from Location 11 reflected an assignment for one staff to "make lunches for all individuals (Sun-Thurs nights)" and an assignment for a second staff to complete a "second check of lunches." However, the assignment sheets were not consistently initialed by staff to reflect that this second check was completed. Further, the "second check of lunches" was not also reflected on the assignment sheets from Location 13, also operated by Provider 7, although 11 of the 12 people receiving services from that location required a modified food and/or liquid consistency.

- b. creating a sample mealtime observation form for provider agencies to use to document managerial or administrative observations of programs during mealtimes to ensure people receiving services are provided with food and liquid prepared to required consistencies and are supervised as required by plans of care. The form should include the name of the person providing the observation, the staff and people receiving services present at the time of the observation, and to specifically identify the supervision and food and liquid consistency requirements for each person receiving services.**

Part I of OPWDD’s CPI notes that “Observation is the greatest incident prevention tool you have. When helping an individual eat or drink make sure your attention and focus stays on the individual.” In addition to personal observations, providing managerial or administrative observations of people receiving services during mealtimes is also an important tool to prevent choking incidents. OPWDD’s Site Review Protocols are structured to record the surveyor’s observations of people receiving services while they dine and to reflect whether people “receive their meal/food in the form and consistency required by their plan, according to their needs and per OPWDD Choking Prevention Initiative (CPI) specifications” and whether “individuals receive support while eating in accordance with their assessed and observed needs.”

For this review, the Justice Center requested that agencies provide any documentation of managerial or administrative mealtime observations. Documentation of observations was provided for six of the 17 sites. Location 2, operated by Provider 1, implemented a process for conducting mealtime observations after the Justice Center initiated its review of that agency. Of note, 38 of the 50 provider agencies who responded to the May 2021 Justice Center survey reported that they completed managerial or administrative observations during mealtimes.

The forms used by provider agencies to document mealtime observations varied. The forms did not all clearly or consistently identify the name of the person completing the observations or the names of the staff or people receiving services involved in the observation. Of note, several of the sites included in this review supported multiple people receiving services who had requirements for modified food and liquid consistencies, adaptive equipment, pacing, positioning, and supervision required while dining. However, mealtime observation forms were typically structured with a simple “yes” or “no” column to reflect whether people were served food prepared to the consistency required, or received adequate supervision without specifically identifying the consistency, supervision and other supports required while dining by people receiving services.

In light of the requirements that many people receiving services have for modified food and liquid consistencies, adaptive equipment, pacing, positioning and supervision requirements while dining, it may be beneficial to create an

observation form that is structured to specifically list those requirements for each person directly on the form to aide observers in verifying that people are supported as required by plans of care. The Justice Center received several blank mealtime observation forms in response to the May 2021 survey. The Justice Center used these to create a sample Mealtime Observation Form.¹²

5. Provide guidance to provider agencies for assessing people receiving services for choking risks upon admission to program.

The provider agencies included in this review were asked for documentation of any policies or procedures related to swallow assessments/evaluations. A swallow assessment, usually conducted by a Speech Language Pathologist (SLP), can help determine the likelihood that difficulty swallowing exists, whether a referral for further swallow assessments or video fluoroscopy is needed and also identify whether a person requires a modified food and/or liquid consistency, adaptive equipment or increased supervision while waiting for further assessments.

Six of the nine provider agencies had a policy or procedure that addressed swallow assessments. However, none of the policies addressed proactively providing swallow assessments for people receiving services newly admitted to programs to allow for early identification of swallowing difficulties. Further, though the policies typically provided guidance for responding to a choking incident and steps to follow immediately following a choking incident, six of the nine policies did not provide guidance for making immediate changes to a person's diet consistency to require a different modified consistency to reduce the risk of choking or aspiration while awaiting clinical follow up after a choking incident.

¹² Please refer to Appendix M for sample Mealtime Observation Form.



Office for People With Developmental Disabilities

KATHY HOCHUL
Governor

KERRI E. NEIFELD
Commissioner

ROGER BEARDEN, J.D.
Executive Deputy Commissioner

January 11, 2023

Denise M. Miranda
Executive Director
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, NY 12054

Dear Ms. Miranda:

Thank you for your correspondence, issued on November 15, 2022, that provides the Justice Center's recent systemic review of food and choking incidents within settings certified and/or operated by the Office for People With Developmental Disabilities (OPWDD) titled *Review of Food Choking Incidents in OPWDD Residences and Day Habilitation Programs*. OPWDD greatly appreciates our partnership with the Justice Center to protect and further enhance the health, safety, and welfare of the vulnerable individuals in our service system. The analysis, findings and recommendations provided in the report contributes to these efforts.

In that spirit, OPWDD's leadership team and subject matter experts have closely reviewed the findings and recommendations in the Justice Center's review. The report provided helpful input to better understand additional factors that may prevent choking incidents. OPWDD agrees that continuing to explore and refine quality improvement strategies and tools that enable competent delivery of dining supports to individuals at the staff and agency level will benefit the service delivery system.

OPWDD has placed a strong emphasis on systemic choking prevention through a variety of mechanisms. As referenced in your review, OPWDD implemented the Choking Prevention Initiative (CPI) in August of 2012. OPWDD appreciates the recommendation reflected in your report for continued implementation of the robust training curriculum and tools/resources designed to increase awareness of choking risks and prevent choking occurrences.

In addition to the CPI, OPWDD has also issued a health and safety alert that specifically addresses choking prevention and intervention. Additional alerts have been issued to address other health and safety topics that include guidance to prevent choking if applicable to the primary topic. Examples include alerts that address: supports/supervision of individuals with Prader-Willi Syndrome, and balancing individuals' right to access food while managing risks. For ease of reference, we have provided a comprehensive list of resources related to choking prevention available on the OPWDD website, opwdd.ny.gov. See attachment.

Key members of OPWDD's leadership, clinical and quality improvement teams have reviewed the recommendations provided in the Justice Center's review. The responses below provide OPWDD's current

Executive Office

44 Holland Avenue, Albany, New York 12229-0001 | 866-946-9733 | www.opwdd.ny.gov

status related to the recommendations, and/or considerations of actions to take in response to recommendations.

Justice Center Recommendation, Category - Training:

“Improve staff’s ability to prevent and/or respond to choking incidents by...”

OPWDD Response:

Hands-on and Refresher Training:

OPWDD’s Choking Prevention Initiative, inclusive of the hands-on training for food and liquid modification, will continue to be a key requirement of staff training. OPWDD subject matter experts are currently in the process of revising the choking prevention guidelines to provide additional clarification around each food and liquid consistency and have developed a fact sheet to issue to providers when the revised guidelines are distributed. They have been considering the appropriate frequency of CPI training, the content of training, and strategies for its implementation initially and as a refresher. OPWDD’s continued work on CPI training content will include discussion of the recommendations provided in your review.

Regarding the Justice Center’s findings on Cardiopulmonary Resuscitation (CPR) training, OPWDD’s Mortality Review Committee issued an updated CPR Health and Safety Alert in August 2022, that represents the initiation of CPR as a best practice and provides guidance to facilitate an effective emergency response using CPR.

Individual Specific Dietary and Mealtime Requirements Training:

Additionally, OPWDD continues to require staff to be trained to provide individuals’ specific needs for supports to ensure their safety and well-being. Individuals supported by OPWDD, per regulation, are assured the right to “services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual’s dignity and personal integrity.” Therefore, agencies are required to train staff on person specific safeguards, including dietary requirements, food and beverage consistency, and dining supports/supervision when activities during service delivery include dining. OPWDD continues to monitor agency training mechanisms and the effectiveness of training through activities included in DQI’s Agency Review, Site Review, and Person-Centered Review (PCR). More information on oversight of effective staff training, competency and implementation of dining safeguards will be discussed below.

Additional Training Resources:

OPWDD agrees that additional training resources may be helpful to agencies such as tools that provide right to risk scenarios and guidance on conducting emergency response drills. OPWDD will present these recommendations to the Statewide Committee on Incident Review and Central Mortality Review Committee for further analysis and practical application. These Committees are charged with developing and proposing requirements, guidance, and best practices to OPWDD leadership that will assist providers in improving the quality of their services.

Justice Center Recommendation, Category - Training:

“Ensure all staff are trained on CPI and have the necessary tools and information to prevent choking incidents by...”

OPWDD Response:

Agency Review Protocol:

Regarding oversight of CPI training documentation, Agency Reviews are conducted by the Division of Quality Improvement to verify agency compliance with training requirements, including the CPI. The

Agency Reviews utilize sampling strategies, which have proven to be effective in identifying systemic flaws in agency training mechanisms and/or maintenance of training records. DQI plans to increase the amount of Agency Reviews conducted, which will ensure the review of staff training documentation. A sampling strategy of training documentation will continue, paired with other DQI oversight that provides better evidence of staff competency to implement food consistency and other dining supports. The oversight implemented through the Site Reviews and Person-Centered Reviews provide the most accurate determination of staff knowledge of individuals' needs and the implementation of their supports. Meal observations and interviews have the most immediate and significant impact in improving outcomes for individuals' dining safety.

Health and Safety Alert Links:

OPWDD will ensure that links to resources addressing dining safety are provided on our CPI webpage, including the Health and Safety Alerts, so that all relevant information can be accessed from one webpage.

CPI Contact Information:

OPWDD is in the process of updating the Administrative Memorandum ADM 2012-04 to include the correct primary point of contact for CPI information and questions. This contact will be added to the CPI webpage. Additionally, OPWDD plans to update contact information and instructions for ordering our cutting boards. OPWDD is currently scouting companies that provide and manufacture more durable cutting boards to reduce the wear and tear and frequency of replacement that providers are experiencing.

Justice Center Recommendation, Category - Plans of Care:

“Enhance the quality, consistency and continuity of plans of care that identify dining supports and requirements, including any requirements for modified food and/or liquid consistencies, for people receiving services...”

OPWDD Response:

The Life Plan format provides a standardized template for the documentation of a person's needed supports and safeguards, including food and dining needs. In addition, OPWDD provides guidance on documenting the safeguard details in the content of the Staff Action Plan. OPWDD continues to review current documentation practices to ensure the Life Plan (Service Plan, Program Plan) and related service plans document all appropriate safeguards, with consistent content among an individual's service providers. OPWDD will consider the recommendation to develop a resource for providers that ensures all safeguards in the life plan are reviewed by the providers responsible for implementation. Additionally, as noted above, OPWDD oversight activities assess for provider knowledge and competent implementation of individuals' plans and safeguards.

Justice Center Recommendation, Category - Identification and Mitigation of Choking Risks:

“Provide people receiving services with foods and liquids that are prepared to the consistency required by plans of care...”; and “Provide guidance to provider agencies for assessing people receiving services for choking risks upon admission to programs.”

OPWDD Response:

Facilitating Correct Food and Beverage Consistency:

As mentioned above, OPWDD continues to review CPI training content. OPWDD plans to issue a revision to the training content and add new resources and tools to its CPI material to improve provider success with providing meals and snacks in the correct consistency.

As mentioned above, individuals have the right to services that are safely administered. Therefore, agencies are required to ensure staff competency on person specific safeguards, including dietary

requirements, food and beverage consistency, and dining supports/supervision delivered. OPWDD oversees the effectiveness of agency actions to facilitate staff competency.

The review activities implemented through the Site Review and PCR identify whether agencies do/do not have effective processes to verify that food and liquids are prepared and served correctly. Observation of mealtimes and staff interview are the key mechanisms used by DQI to verify correct food preparation and/or checking food for proper consistency before serving. These oversight activities ensure that the agency is aware of and will address any errors in preparation and presentation of meals. In addition, observation conducted during DQI oversight is a key tool to identify dining needs that have not yet been noted or addressed by the provider/facility, e.g., individual's eating pace, coughing during meals, struggling to use utensils. OPWDD identification of unaddressed dining needs, ensures that individuals not only receive dining supports already included in their plan, but also results in the addition of supports to individuals service plans to foster a safe and effective dining experience. DQI issues survey deficiencies when concerns are noted, requiring agencies to implement measures to correct unsafe practices.

Utilizing the Person-Centered Reviews, OPWDD verifies that safeguards and supports are identified and provided to an individual by staff of all the various agencies, services, and service settings supporting the individual. The PCR looks at every service plan for that individual and conducts observations in the certified settings, and interviews with staff delivering all services. This activity verifies that all agencies serving the individual know and implement the supports the person needs, including dining supports. For individuals residing in Intermediate Care Facilities, in addition to conducting mealtime observations and staff interviews to assess knowledge of an individual's needs, DQI conducts annual reviews of individuals' Comprehensive Functional Assessments, developed by the interdisciplinary team, which must include a qualified dietician who prescribes any special dietary accommodations in the individual's plan.

Guidance on Mealtime Observations and Assessing Risk:

OPWDD agrees that agencies may benefit from a sample mealtime observation tool to guide the content and quality of mealtime observations. A well conducted and documented observation will facilitate mealtime safety and identify opportunities for improvement. OPWDD will also consider guidance to agencies for assessing people receiving services for choking risks. Early identification of risk is key to choking prevention. These recommendations will be presented to the Statewide Committee on Incident Review and Central Mortality Review Committee for further analysis and practical application.

In addition to the strategies and considerations noted above, OPWDD will continue to implement its ongoing, routine quality improvement activities through the Statewide Committee on Incident Review (SCIR) and Central Mortality Review Committee (CMRC), referenced above. The duties of the SCIR and CMRC include review of information related to incidents, including choking, the events, contributing factors, trends and actions taken to prevent such incidents, as well as determining actions to take to educate and assist providers to prevent the occurrence of incidents. Activities include the review of trends or specific cases with the intent to identify any opportunities for improvement. OPWDD will issue recommended actions that providers should take to prevent reoccurrence of similar risks and events. Examples of recommendations provided related to choking prevention include policy and procedure revisions, training and training enhancements, guidance on meal preparation timeframes, communication enhancements among service providers, and participation, observation, and monitoring of subject matter clinicians. In addition, the Committees will determine when there needs to be action to improve the knowledge and competence of the broader provider community, and work to develop guidance, training or tools as needed.

OPWDD appreciates all initiatives focused on improving the lives of individuals served by both of our agencies. As evidenced by the specific descriptions above, OPWDD is committed to a conscientious review of the findings and recommendations described in the Justice Center's report. We thank you again for sharing this important information with OPWDD and your advocacy on behalf of individuals in New York State with developmental disabilities.

Sincerely,



Kerri Neifeld
Commissioner

cc: Jill Pettinger, OPWDD
Megan O'Connor, OPWDD
Barbara VanVechten, OPWDD
Karisa Capone, OPWDD
Meg Adams, OPWDD
Susan Prendergast, OPWDD
Laura Darman, Justice Center
Nadia Chanza, Justice Center
Davin Robinson, Justice Center
Jody Signoracci, Justice Center
Kim Affinati, Justice Center
Tracey Sosa, Justice Center
Rich Neaton, Justice Center

ATTACHMENT A:

List of resources on the OPWDD website www.opwdd.ny.gov, related to or addressing choking prevention.

Administrative Directive:

- ADM #2012-04 Choking Prevention Initiative

Guidance:

- OPWDD Preparation Guidelines for Food and Liquid Consistency Manual

Health and Safety Alerts:

- Choking Prevention and Intervention Update
- Balancing the Right to “Access to Food” with Protections for Individuals in Home and Community Based Settings
- Sedation and Anesthesia: Risks and Safeguards
- Aspiration Safety Alert
- Support and Supervision of Individuals with Prader-Willi Syndrome
- Cardiopulmonary Resuscitation

Tools/Training:

- Stop Choking Hazard Poster
- Stop Choking Hazard Cutting Board
- Food Consistency Terminology Physician's Reference
- Prevention of Choking and Aspiration Training
- Food and Liquid Consistency Demonstration:
 - Introduction
 - Whole Diet
 - 1/2 Inch Diet
 - 1/4 Inch Diet
 - Ground Diet
 - Pureed Diet
 - Liquid Diet
- Photos:
 - The Whole Diet
 - 1” Pieces Cut to Size
 - 1/2” Pieces Cut to Size
 - 1/4” Pieces Cut to Size
 - Ground
 - Puree