# A Review of

# Broome Developmental Services

by

New York State
Commission on Quality of Care
for the Mentally Disabled

April 1979

## PREFACE

This Commission undertook this review of Broome Developmental Services at the request of Assemblyman James W. McCabe and the Board of Visitors, and in response to complaints of staff members as reported in local newspapers.

Commission staff inspected Broome Developmental Center and ancillary services in the Fall and Winter of 1978. A joint survey of the educational services was made in conjunction with a representative of the State Education Department. Numerous staff and administrative personnel of the Center were interviewed. Commission staff consulted with the Board of Visitors and the president of the Parents Group. Randomly selected records were reviewed.

A draft of the Commission's report was shared with the Acting Facility Director, the Board of Visitors and the Commissioner of the Office of Mental Retardation and Developmental Disabilities. Where appropriate, their comments are included in the text of the report.

The findings, conclusions and recommendations contained herein represent the unanimous opinions of the members of this Commission.

Clarence J. Sundram

CLARENCE J. SUNDRAM
Chairman

Mildred B. Shapiro

MILDRED B. SHAPIRO
Commissioner

I. Joseph Harris

I. Joseph Harris
Commissioner

## Commission Staff

Mary Wilbur
Director
Quality Assurance Bureau

David Levy
Mental Hygiene Facility Review Specialist

Thomas McGuinness
Patient Abuse Investigator

# SUMMARY and RECOMMENDATIONS

## SUMMARY

This report is the result of visits to Broome Developmental Center (BDC)[1] by several staff members in response to concerns and allegations raised by the Board of Visitors, the Parents Group, Assemblyman James W. McCabe, facility staff members, members of the community and newspaper reports.

In reviewing the total picture at Broome Developmental Services (BDS)[2] the major issues that emerged were associated with staffing.

Problems of staffing appear to be related to two areas: (1) the changing population of residents who are now more multi-handicapped and may require more staff to meet their needs, and (2) the allocation of staff throughout the facility.

The Office of Mental Retardation and Developmental Disabilities (OMRDD) asserts that Broome has a slightly higher staff/resident ratio than the standard set by OMRDD for upstate facilities. The advocate groups, on the other hand, feel strongly that the facility is understaffed and because of this a number of other problems in client care have developed.

There are seven physical and occupational therapists on the staff to serve 248 clients, 93 of whom are multi-handicapped.

---

1. Broome Developmental Center (BDC) refers to the inpatient facility.
2. Broome Developmental Services (BDS) refers to both facility and community services.

The room arrangements in the buildings appear to create difficulties in monitoring. When multi-handicapped residents are comparatively isolated, the element of risk is increased accordingly.

The advocate groups contend that the facility is overcrowded.

The overcrowding is small in actual numbers (over capacity of five as of October 1978). However, it does mean that new admissions and respite care must be severely curtailed. In this connection, it should be remembered that, according to the Acting Director, all transfers to Broome under the repatriation program are residents needing total care.[3] While the demand for respite beds should be diminished when a half-way house is opened in Oneonta, the problem of other admissions from the community will remain.

An adversary position that developed between the administration of BDS and the Central Office of OMRDD seems to have had repercussions throughout the facility. At the time of our September visit, however, the relationship seemed to be improving as evidenced by a decrease in staff turnover and favorable comments by the Acting Director and staff.

## RECOMMENDATIONS BY THE COMMISSION

We recommend that:

A. The Commissioner of OMRDD review the staffing formula for the multi-handicapped population who require total care.

---

3. i.e., residents who are profoundly retarded, multi-handicapped, non-ambulatory and need total assistance in eating, dressing

(Findings D, E, and G.3 - multiple needs of total care clients and number of professional staff.)

OMRDD Response:

Staffing for the multiply handicapped is constantly under review in connection with the annual budget submissions. We believe the basic formulas we have proposed are adequate, and we are working toward 100 percent implementation of these ratios by June 1, 1981.

Commission Comment:

Although budgetary constraints affect the pace at which changes can be made, the Commission feels that OMRDD should establish a plan for this specific population and target dates for implementation. OMRDD should inform all concerned parties, including parents, on the current staffing ratios--identifying the number and types of direct care staff and how and when the staffing formulas will affect the programs at Broome Developmental Center designed for the multiply disabled.

B. The Commissioner of OMRDD consider the possibility of allocating a pool of staff members at BDC who would be available to fill in on the units when other staff members are absent from work. This

is particularly important when one or more staff members on a unit are on extended leave - for example, for maternity, education, disability.[4] (See Findings D, E, and G.3 as above.)

*OMRDD Response:*

*The use of a pool of staff members to fill in for absent personnel presents a number of difficulties:*

(1) *the role of these staff members when full staff is available;*

(2) *the inability to hold staff on call so that all three shifts could be served;*

(3) *the inability of the pool members to know the needs and programs of all clients at the Center;*

(4) *the inability of the pool members to know the routines and rhythm of all units; and,*

(5) *the need of the unit staff to orient the members of the pool when they are assigned to the various units. Staff have commented that "pulling" staff to cover units is frequently more time-consuming, due to lack of experience on the unit and knowledge of the residents and their programs, than functioning without the extra staff member.*

Commission Comment:

The Commission understands that a pool of staff members for the purposes stated in the recommendation has been initiated at Staten Island Developmental Center (SIDC). Apparently SIDC has

4. While we are aware that this problem is endemic throughout the system, the visit to SDC highlighted its effect. We also note that Staten Island Developmental Center through its clinical control unit draw from a pool of staff especially assigned to fill in for absentee staff.

has been able to cope with the issues raised in the response and we suggest that SIDC be asked to share its design with BDC. Additionally, consideration ought to be given to hiring part-time staff to cover peak periods when demand for staff is high, e.g., morning grooming, feeding, etc.

C. The Commissioner of OMRDD assess the need for a special convalescent type unit for the chronically ill and severely disabled population at BDC. (See Finding A - needs of severely disabled.)

*OMRDD Response:*

*The number of chronically ill individuals at Broome Developmental Center does not warrant the establishment of a "convalescent type" unit. This form of isolation merely removes individuals from the mainstream of life and limits their potential for growth and development. Severely disabled individuals have the potential for growth and development and should not be segregated on non-program oriented units. The Office of Mental Retardation and Developmental Disabilities and the Willowbrook Consent Decree make provision for medical exemptions for individuals who in fact are physically ill and unable to complete programming. These exemptions are time limited and require thorough documentation by the physician.*

D. The Commissioner speedily select a new permanent Director. (See Finding B - resignation of director - October, 1978.)

OMRDD Response:

We recognize the urgent need for a permanent director at Broome, and anticipate the selection of a director in the near future.

Commission Comment:

The position of Director of Broome Developmental Center has been vacant since October 1978. Information to all interested parties, including parents, on the stage reached in the search for a new Director and whether input has been obtained from the Board of Visitors would be welcome. The situation seems of particular significance in view of the fact that the Acting Director at Broome Developmental Center is also the Deputy Director, Clinical, at Syracuse Developmental Center.

E. The Director of BDS consider moving toward a transdisciplinary approach in programming. This would increase the time spent on the units by professionals who could both train and work with therapy aides on special skills to use with residents. In addition to increasing service to clients, it might well lift the morale of therapy aides. (See Finding G.3 - vocational rehabilitation and E - staff shortages.)

OMRDD Response:

Completed in November 1978; however, the need to reorient all staff members to the Interdisciplinary Treatment Team approach continues. Inroads have been made regarding the movement of professional and paraprofessional staff onto the units.

F. Contracts with a variety of local business and industry be sought in order that the clients in the vocational rehabilitation program may work at meaningful tasks and be paid. (See Finding G.3 - vocational rehabilitation.)

OMRDD Response:

Broome Developmental Center is negotiating now for space for a community-based workshop. Plans are being developed to provide adult individuals with a full spectrum of programs from basic ADL skill training to prevocational training to community-based vocational programming.

G. The Commissioner of OMRDD review the education services at BDS with a view to meeting the education requirements of the State Education Department and OMRDD. Particular deficiencies seem to be in paraprofessional staffing and teacher certification.

OMRDD Response:

Many of the education deficiencies noted were the result of new laws and policies recently enacted by the Legislature and the Department of Education. There was

not time in the two to three month period between enactment and the Commission's visits to comply with these changes. The number of paraprofessional staff in the Education Department is being addressed, and the two teachers who are not fully certified will be so by the end of the semester. This area is being addressed by the Broome Developmental Center staff.

H. The Director use the services of foster grandparents, volunteers and college students to add further support for classroom activities since there is little for them to do on the living units if all the children are in program during the day. (See Finding G.1 - education services.)

OMRDD Response:

The use of foster grandparents is presently being implemented and plans are being completed to assign therapy aides to each classroom. Broome Developmental Center is currently recruiting additional volunteers; however, their use would not be limited to the educational program.

Commission Comment to Responses F, G, and H:

The Commission and other interested parties, including parents, would like to be kept informed on the timetable for these developments.

I. Occupational, speech and physical therapy staff spend some time working in the classrooms in an interdisciplinary approach. Therapists who already have input through the evaluation process should assist in preparing Individual Education Plans (IEP). Therapy is an appropriate part of the IEP and consequently of the daily education program for the resident. The therapists and teachers should also give each other in-service training in their particular fields to facilitate interdisciplinary planning and treatment. (See Finding G.1 - education services.)

*OMRDD Response:*

*This area has been addressed with the establishment of the Interdisciplinary Treatment Team. Therapists have had input into the development of the IEPs which are not segregated from the total goal plan identified for the individual.*

J. Copies of the children's case records be kept in the classroom. Relevant information which should be readily available includes IEPs, medical limitations, allergies, medication, therapy goals, Social Service reports and other material helpful to the teacher as mutually agreed upon. The IEP should be a joint effort of the teacher and members of other disciplines who are concerned with the child. (See Finding G.1 - education services.)

*OMRDD Response:*

*The material requested in this recommendation would require the duplication of case records which are available to all staff. IEPs and goal plans are currently retained in the educational area.*

Commission Comment:

It is not clear where the case records of the children are kept so that they are available to all staff. It is recommended that copies of those elements of the case records which are important for the teacher to know be kept in the education area with the IEPs, goal plans, e.g., medical limitations, medications, Social Service reports.

K. The Children's Habilitation Program (CH) and the Education Program either merge or function together much more closely. The records of these programs should be integrated. A combined program could result in better service to the child without any increase in cost. (See Finding G.1 and G.2 - children's education and children's habilitation services.)

*OMRDD Response:*

*Children's Habilitation Program is a psychologically-based program site available to the teacher who has difficulty with specific individual behaviors which affect the other students or the classroom environment. The need to function more closely based on the individual's need is valid. The records of all programs are integrated in each individual's case record.*

L. BDC launch an agressive campaign to get the Bureau of Cooperati Education Services (BOCES) to provide programs for more of the

children presently in BDC programs. In comparing the local BOCES to others in the State, the Commission staff believe that children with a higher level of disability should be served while maintaining a high quality system. In the spirit of the "least restrictive setting", there is much room for improvement in meeting education goals for children attending BDC. (See Finding G.1 - education services.)

OMRDD Response:

*The staff at Broome Developmental Center has met with BOCES and has received a commitment to provide educational services for 40 to 60 severely and profoundly retarded students from Broome Developmental Center by September 1979. It should be noted that BOCES is not required to develop education programs for special interest groups until they have received requests from two school districts they serve. Since the Developmental Center is not a school district, we were limited in our requests to BOCES until two school districts make a similar request.*

I. REASON FOR VISIT

The visit to Broome Developmental Center (BDC) was in response to a letter from Assemblyman James W. McCabe dated August 30, 1978 asking the Commission to separate fact from fiction in newspaper reports of allegations about staff shortages, overcrowding and lack of services for residents at BDC. There were specific allegations about birth control pills being given to residents, vasectomies being considered and an abortion which took place. Also, complaints of long waiting lists, dangerous conditions at the facility and lack of compliance with State and Federal standards. In addition, reference was made to undue use of restraint and to a patient who was unable to get proper treatment because of lack of staff.

As well as specific allegations in the press, the Assemblyman commented on the controversy between the parents, Board of Visitors, employees and the administration of BDC on one side and the Central Administration of the Office of Mental Retardation and Developmental Disabilities on the other.

II. ACTION TAKEN

A. The Commission made two visits to the facility.

The first visit was made on September 15 and 16, 1978, and extended over three (3) shifts - from 12 noon to 6 p.m. on September 15, and from 6:40 a.m. to 8 a.m. on September 16.

A second visit was made on November 2 from 9 a.m. to 5:30 p.m., and November 3 from 9 a.m. to 12:30 p.m. accompanying a State Education Department representative who planned to review education services at BDC. According to the usual practice, educational specialists from OMRDD also accompanied the State Education Department representative.

B. Prior to the visits, the Commission staff reviewed the newspaper articles about Broome, the correspondence from Assemblyman McCabe and from the Office of Mental Retardation and Developmental Disabilities and the legislation relating to education for children residing in mental hygiene facilities. A representative of the Commission spoke to Dr. John E. Denny, the Acting President of the Board of Visitors, on the telephone and met with Assemblyman McCabe earlier in the same morning of the site visit.

C. Individuals Interviewed

Facility Employees

Richard J. Thamasett - Acting Director (as of September 1978)
Donald Kamerowski - Director Vocational Rehabilitation
Gerard Lynch - Supervisor Education Services
Ethel Williams - Nursing Administration
Fred Alexander - Social Worker
Rich Clouthier - Occupational Therapy Supervisor
Gail Brownell - Director Children's Habilitation Program

Various M.H.T.A.'s, Foster Grandparents, and Food Service Workers

| | |
|---|---|
| Vincent DiMaio | - Member of Board of Visitors |
| Raymond W. Delaney | - Board of Visitors (term expired) |
| Robert Sturdevant | - Board of Visitors (term expired) |
| Kay Paddock | - President of Parents Group |
| Erich Mamlok | - Director Broome Developmental Services (Resigned October 1978, but on leave from the facility from the end of August) |

D. Locations Visited

During the September review all the wards were visited as well as the education classes, Rehabilitation Department and the combined Occupational and Physical Therapy Departments.

The Acting Director, Mr. Thamasett, accompanied the Commission representatives on part of the tour and the nursing administrator accompanied them on part. The heads of departments showed us their own departments. We talked to residents and the staff, and when we did so, we were not in the immediate company of the administrators although they were in the general area.

We visited the wards before, during, and after mealtimes.

During the November review, a Commission representative visited the Education Department, Children's Habilitation, Children's Units 4A, 4B and Vocational Rehabilitation.

E. Records Reviewed

The records of four residents residing on the units were randomly selected and reviewed, as well as the records of children in the education and habilitation programs.

## III. FINDINGS

### A. Physical Facility

BDC has been staffed and providing services since 1970. However, the present facility which has a modern physical plant, has only been open since 1974. According to the staff, it was designed for ambulatory residents. The staff we interviewed, members of the Board of Visitors and the president of the Parents Group are unanimous in declaring the building unsuitable for residents who require total care.

Fred Finn, Deputy Commissioner of OMRDD, however, told the Commission that the facility was originally planned for total care residents. He said there are two other developmental centers similarly designed which give service to similar type residents.

It may be that staffing is the issue rather than architectural design. In some facilities it is possible for one nurse to observe a fairly large ward population which is constantly visible to him/her. It is not possible at BDC because of the arrangement whereby there is one nursing station to several smaller rooms.

Each of the ten units in use at Broome is planned for 24 beds. The design provides for two and four bedded rooms in two wings branching off from the nursing station. The staff say this may be appropriate for certain types of patients but creates supervising difficulties for severely disabled residents who require constant monitoring. The Acting Director told us that there were 93 multi-handicapped clients out of a total of 248 residents.

At the time of our September visit, both swimming pool and bowling alley were unusable. The pool was being repaired and the bowling alley attendant had left.

The units and approaches were clean, pleasant, odor-free and appropriately decorated.

B. Residents

There was not much programming evident on the wards, most of the activity was in the special departments. We observed good adaptive equipment to assist residents in independent eating. The residents looked well cared for and were dressed with individuality. When asked about press allegations of too much restraint being used, the Acting Director said that restraint is only used to prevent a resident from harming him/herself. The principal officer of the MHIS for Binghamton, Mr. James Brosnan, said he felt Broome was sensitive to the negative aspects of restraint and sparing in its use. He added that in his opinion restraint was only used when all else failed. No specific complaints have been made to MHIS. Dr. John Denny, President of the Board of Visitors, said no complaints have been made to the Board.

Commission representatives reviewed the restraint records from April 1977 to September 1978. According to the records there were twice as many restraint orders for the nine months in 1977 as there were during the nine months in 1978. Most orders were written because of a resident's self abusive behavior.

C. Records

BDC uses problem oriented type records. Four records were reviewed, superficially, on the total care ward for children. All contained treatment plans and were up-to-date. The location of the records is discussed in Section G on programs and services.

D. Overcrowding

Ten wards, each with 24 beds, were open at the time of the visit.

Mr. Thanasett said in September that the overcrowding began in March with the repatriation program. Since then, he said, 93 intensive care residents had been transferred from other developmental centers: 60 from Rome, 23 from Newark, and 10 from Craig. While the overcrowding was not apparent, it was pointed out to us that one extra resident who requires total care obviously places a heavier burden on staff than a resident who can take care of most of his or her own needs.

The census report of September 13 indicates there were 242 residents for a total of 240 beds. (In November, there were 248 residents.) The distribution, however, was uneven because of the need to place residents in wards appropriate to their age and disability. Of the "overcrowding" wards, one had 27 residents, one had 26, and two had 25. As for the other wards, two had 23, three had 24, and one had 21 residents.

Mr. Thamasett said that no new residents had been admitted since March 6 (apart from residents repatriated from other centers) and there was a current waiting list of 15 individuals from the community. He said emergency cases and readmissions from family care, hostels, etc., are accepted but this creates further overcrowding. He also said that placing five residents in a four bed unit and three residents in a two bed unit makes the facility out of compliance with Federal ICF/MR regulations, which require 60 square feet per client for up to four clients sharing a room.

E. Staff Shortages

The staff/resident ratio is a confused issue.

In his letter of September 11, Mr. Walter Schofield, Associate Commissioner of OMRDD, states that the staff/resident ratio is 1.66. He adds that this is better than the Federal standard of 1.28 and OMRDD standard for upstate facilities of 1.51 residental care staff for every resident. According to the Acting Director, however, the 1.66 figure is based on the total staff for Broome Developmental Services which include 86 who are totally occupied in community services. The administration considered 1.58 (based on staff actually at the facilit a more accurate ratio.

In conversations with the Commission staff Fred Finn, Deputy Commissioner for Program Operations for OMRDD, said that the staff/resident ratio (excluding Community Services' staff) was 1.61. As of November 1979, the administration of BDC and Central Office of OMRDD agreed on the figure of 1.61.

The administration, Board of Visitors' members, and the Parents Group president all state that there are too few staff to provide the residents with the care they need. They say the multiple needs of total care clients cannot be adequately met and the situation is causing low employee morale. Board of Visitors' member, Mr. Delaney, said that on a recent announced visit to the facility at 6:30 a.m., he found only two employees trying to get 24 total care infants dressed and prepared for breakfast.

A parent said that children were being given the wrong pills because the staff were over extended. This allegation appeared to refer to a particular incident and the Commission staff reviewed the incident report of this medication error which took place on June 14, 1978. Ten (10) doses of Dimetapp (in place of Dimetane which was ordered) were given to a patient before the error was picked up by the night nurse. It was reported that there were no adverse reactions sustained by the resident and no treatment was necessary since the two drugs are of similar action. The nurse who made the error was counseled to ensure greater care and caution in dispensing medications.

Another complaint was that the residents could rarely go swimming or bowling because there were not enough staff to take them.

Still another concern was the relatively high rate of staff turnover, particularly of nurses, within the past six months. The administration said it was difficult to assess the reasons for the high turnover of nurses because of the variety of factors related to their leaving. The high rate of turnover of therapy aide staff is attributed by the administration to the ready availability of jobs elsewhere in the community.

According to Mr. Thamasett, the turnover rate for staff has diminished in the last four bi-weekly payroll periods.

Dr. Erich Mamlok, who was the Director of BDS until October 1978, says he resigned because he felt the staff shortages created a potentially dangerous environment for the residents. Doctor Mamlok was not at the facility when we visited it, but was seen on October 4 at his request.

Mr. Thamasett said in September that the addition of seven new staff members had augmented the night shift and thus ameliorated the problem of staff shortage on that shift.

On our visit in September 1978, we did not find any of the total care wards with less than three or four staff on duty on any shift. In addition, there were volunteers and foster grandparents helping out. We did not observe dangerous conditions.

A newspaper article reported allegations that there had been an increase in injuries and accidents to the staff this

year because of staff shortages. We reviewed the summaries of health occurrences for July and August 1978, as well as incident statistics for 1977 and 1978. The reports support the contention of the Central Office of OMRDD which reported that incidents had increased by 14 percent this year, while the number of residents had increased by 35 percent. In addition, we reviewed facility statistics of incident reports which support the Broome administration statement that 48 percent of employee injuries were not patient related and in general were due to carelessness on the part of employees.

Auditors of the Department of Audit and Control who did a recent survey of financial procedures at the facility said they did not observe a shortage of staff when they went through the wards.

F. Quality of Staff

The Board of Visitors' members and the president of the Parents Group spoke highly of the staff.

In our observation, the occupational and physical therapists, the teachers and the nurses seemed involved in what they were doing and showed enthusiasm for the work. On the other hand, the therapy aides did not, in general, seem as responsive to clients. There was little interaction with the residents. At mealtimes the therapy aides fed the adult residents competently, but with little warmth or physical contact.

On Unit 4 we observed foster grandparents at the children's lunch time and found that the foster grandparents knew the children and their diets. They were warm and perceptive of the children's needs.

G. Programs and Services

A complaint by newspapers, Board of Visitors and the staff is that residents are being denied adequate programming because of staff shortages.

(1) There are approximately seventy children between the ages of five and twenty-one attending classes at BDC. Fifteen other children are attending BOCES classes (at a facility adjacent to BDC). Those attending BOCES were reported to be ambulatory, mildly or moderately retarded and without serious behavior problems. SUNY (Harper) educates six BDC children in a reportedly individualized one-to-one program which is a special project. Chester B. Lord, a school for the physically and multiply disabled children, has two children enrolled who reside at BDC.

At BDC there is an Education Department. There is also a Children's Habilitation Program under the direction of a psychologist, which offers "educational services". This is not a branch of education and the project director does not report to the Supervisor of Education Services. Both the Children's Habilitation Program Director and the Supervisor of Education report to the Chief of Children and Adolescent Services.

In each of the ten classes (with between four to twelve children enrolled) there was a teacher. The State Education Department representative checked teacher certification as part of her investigation and a copy of her report is attached. Gerald Lynch, the Supervisor of Education Services, reported that of the ten teachers, three were permanently certified in Special Education, five were provisionally certified and two others were CETA staff (one certified in speech and hearing). Mr. Lynch reported that of the ten teachers there were five State personnel items, three CETA items, and two Title I items (funded under 89-313 grants from State Education). In addition, there were one and one-half aide items filled and several foster grandparents (working under senior citizen grant funds).

A Commission staff member and a representative from the New York State Education Department visited each classroom either in the morning or in the afternoon. The system requires the teacher to work with one group of children in morning and a different group in the afternoon. Since Commission and Education Department representatives did not visit each classroom both morning and afternoon, they did not see every child. Children attend classroom sessions in the morning from 8:30 a.m. to 11:30 a.m. They return to the units between 11:30 a.m. and 1:30 p.m. for lunch and rest and return to classroom between 1:30 p.m. and 3:30 p.m. Nine of the classrooms are in the education area; one class is on Unit 4A.

Each classroom is specifically described in the State Education Department's report on the visit. All the classes have severely and profoundly disabled children, most of whom are multi-handicapped. During the visit, teachers were observed working one-to-one while other children received no attention. One teacher reported that her children received one hour of occupational therapy services per week for the entire class. Another teacher reported that she devoted approximately one hour of individual attention to each child and the other children were seen to roam the room at random.

One class is designed as a "communication" class. The teacher said, however, that only two children get daily speech therapy while the other four get none. Speech therapists in the education program are supervised by the Chief of Children and Adolescent Services; the Speech Therapy Supervisor, on the other hand, reports to a different chief of service.

On living Unit 4A there is an area designated as a classroom. Six multi-handicapped children receive educational services, as well as positioning by the occupational therapist. These children are severely or profoundly retarded and have serious health deficits; none are ambulatory.

The children's records are decentralized. The primary record is kept on the living unit and the education records are kept in the education office. The education records include the children's IEPs and other educational information such as psychological tests and periodic reports. There is also some clinical information. The Medical Records Department has all of the historical data required by law. During the

visit, Commission staff reviewed files the teachers had on each child in the classroom, but these contained little information. IEPs were not present and medical problems and other necessary data were generally absent from the classroom files.

The teachers who worked with children in the morning session had the responsibility for preparing IEPs and were consequently aware of the general nature of the IEP for a given child. The afternoon classes on the other hand, were staffed by teachers who had not prepared the IEPs and these teachers were less familiar with the material filed in the education office. Although teachers reported that they received input from therapists, this was not recorded. Only the teachers prepared the material.

The teachers (with one exception), teacher aides and other staff, present during the visit to classroom areas, were enthusiastic, concerned, and willing to do whatever they could for the children. The teachers said there was a need for more staff to provide program and supervision. They also said there was a need for more contact with the various therapy disciplines for planning programs, assessing needs and to get in-service training.

For a short time occupational and physical therapists were providing children with therapy in the classroom. This, however, was discontinued and now therapy is only given in the specific discipline area.

There is no interdisciplinary team approach. The teachers said that parents who come for IEP conferences meet with the education supervisor and the teachers. No occupational or physical therapy staff have participated in these conferences.

(2) The Children's Habilitation Program (CH) is a discrete program under the direction of a psychologist who reports to the Chief of Children's and Adolescent Services. The Commission staff observed what seemed to be a rivalry between the two programs, and the CH director and the education supervisor do not appear to relate well to each other. CH is staffed by four therapy aides (MHTA staff who have had some teacher experience or training) five foster grandparents and four other helpers who are volunteers. CH admissions are referred by the unit staff, however, all children are screened by the CH staff as part of the intake team evaluation. There are reportedly 60 clients receiving five hours a week of one-to-one programming. Of the 60, six are community status clients. Three children also come from school districts which pay for these children's staffing needs.

The CH staff prepares Developmental Plans (DVP) and uses the OMRDD goal forms and formats. This information is not filed with education records, but is filed in the children's unit record. The emphasis of Children's Habilitation is behavior modification with the incentive of reward for positive activity. Because of the one-to-one nature of CH,

the records are comprehensive and current. The CH staffing is supported by volunteers, staff obtained through grants, agreements with school districts and cooperative projects with area colleges. It is significant that several of the children attending CH for five hours per week also attend the educational program. The CH records are not incorporated into the education records although the IEP could appropriately contain the goals and objectives proposed by the CH team.

(3) Adult education is a function of the Vocational Rehabilitation Department (VR). There are nine staff members (two from CETA) reportedly serving approximately 80 adults with a waiting list of 30 to 40 persons. Most of the activity is make-work, for which the residents do not earn any money and is considered pre-vocational. The staff said that one reason there is no sheltered workshop in Broome is the facility's reluctance to compete with workshops run by agencies in the community.

The BDC pre-vocational area appeared well planned with task areas designed to minimize distraction. At the time of the September visit, there were about 30 residents participating plus five staff. Community placements are limited and 35 residents were waiting for openings. The supervisor pointed out that the paucity of workshops in the community, combined with the fact that a number of residents may not be able to move beyond the pre-vocational services offered by Broome effectively, prevents other

residents in the facility from taking advantage of their vocational rehabilitation services.

A house on the grounds is used for training in the activities of daily living (non-residential) and is run by one staff and one full-time volunteer.

(4) There are few physical therapists. The total resident population in September was served by three physical therapists (an additional physical therapist was hired in October). Services are mostly provided in the Physical Therapy and Occupational Therapy Department. Some range of motion instruction is provided on two wards, and the professionals are on call for therapy aides who need help. At the time of the September visit, two professionals were providing therapy to three residents in the Physical Therapy Department. The therapist said they were planning to move out into the Education Department for some hours during the day in order to provide services there. They also planned to start feeding programs on the wards. The November visit showed that this attempt had begun, but already had been terminated.

In response to a comment on the small number of therapists in proportion to the multiple needs of the population, the Acting Director referred to the facility's limited resources. He said the administration had decided that within their limitations they could best serve the residents by increasing the number of therapy aides. There is a waiting list for all therapies.

A BDC social worker gave us information on clients in the community, some of whom are members of the Willowbrook class (126 according to Doctor Mamlok). There are 600 clients in family care, eight community residences and a total of one thousand individuals receiving services in the community. The social worker said 86 staff members are distributed among four regional centers and BDC itself. Programming for a patient does not always fulfill required mandate of the Consent Judgment of six hours a day. This is due in part to geographic conditions, for example, travel for a patient to a workshop may be as much as two hours a day. In addition, 93 clients are over age 65 and not all members of this latter group want programs. Some of the community workshops are filled and the number of services vary from county to county. According to the social worker, the geographic area of responsibility is larger than the State of Connecticut.

A transitional living program has been approved for Onecnta. This will take care of 24 clients and will be geared to those who have behavioral problems. It will be a quarter-way or half-way station and will prepare a client for a permanent community placement. It will also provide respite care for a client experiencing behavior problems in the community.

A major area of disagreement between Doctor Mamlok and the Central OMRDD has been the distribution of staff.

Doctor Mamlok says it is essential to maintain services in the community and particularly to provide genetic counseling which he considers the best approach to reducing the number of retarded in the community.

In conversations with Deputy Commissioner Fred Finn of OMRDD, we were told that in the past the Facility Director has had a great deal of latitude in allocating his staff. This, however, is to be changed in the new budget 1979-80 in which staff will be specifically identified as facility or community-based.

## IV. OTHER ISSUES

### A. Board of Visitors

The members of the Board of Visitors and the president of the Parents Group said they were dissatisfied with the membership of the Board. They said there is difficulty in getting a quorum, partly because of the wide geographic distribution of members, partly because the terms of two members (both parents) expired this year (January and June) and partly because two members have not attended meetings for many months. We were told that there are only three involved members who attend meetings: Dr. John Denny, Acting President; Mr. Vincent DiMaio, parent; and Dr. Roger Battistela. They are all anxious to see that the Board reaches its full membership with the appointment of two parents.

They also said there is lack of feedback to the monthly reports issued by the Board. These reports have indicated staff shortages over a period of two years and also recommended removal of a non-attending member of the Board. The Board also said it would like a more active response from CMRDD other than vague promises that things will be improved.

B. Response of Mr. Thamasett to Additional Allegations Reported in the Press

(1) Birth control pills are not provided indiscriminately, but only to residents who have the approval of their relative or guardian.

(2) There is no plan to consider vasectomies.

(3) The abortion mentioned in the newspaper took place in 1977. The resident concerned had been returned to the Center from a trial community placement because of behavior problems. A physical examination at that time did not indicate pregnancy. Two months later a physical examination showed the resident to be pregnant. The resident's family wanted her to have an abortion and along with the Department of Social Services, which had jurisdiction, went to court and received approval. The abortion was performed at Wilson Memorial Hospital.

Appendix: Report of N.Y.S. Education Department Region II

ess: Glenwood Road

Binghamton, New York 13905

ne: (607-772-6911

ons Interviewed:

Acting Chief Administrator:
Ms. Charlene Soule

Educational Director:
Mr. Gerald Lynch

| | Position: |
|---|---|
| Mr. Richard Thomasett | County Director, Administration |
| Mr. Gerald Lynch | Education Supervisor |
| Ms. Charlene LaBeau | Director, Bureau of Education, C |
| Mr. Raoul Gagne | Bureau of Education, CMR/DD |
| Ms. Gail Brownell | Psychologist, Children's Habili Pro |
| Ms. Elizabeth Grajewski | Teacher |
| Ms. Karen Reynolds | Teacher |
| Ms. Barbara Eglesion | Teacher |
| Ms. Joan Sucinaro | Teacher |
| Ms. Sandy Stack | Teacher |
| Ms. Alicia Van Wagenen | Teacher |
| Ms. Coleen Merion | Teacher |
| Ms. Beth Crearley | Teacher |
| Ms. Helen Thomson | Teacher |

DENT POPULATION:

1) Number of Students
   A. Handicapped 72
   B. Non-Handicapped 0
2) Age Range 5 - 21
3) Handicaps served: Mentally Retarded with additional handicaps: deaf, hearing impaired, cerebral palsy, blind, visually impaired, non ambulatory, non-verbal, severe behavioral disorders, seizures, HD carriers.

Instructional Program

1) No. of Days Instruction/Year or Month: 182
   A. Full Time Residents 248 (Including Adults)
   B. Part Time Residents 0

2) Length of School Day 8:30 - 4:00

3) How is Educational Program organized: The 72 residential students educated at the Broome Developmental Center are divided into 10 general education groupings. These groupings are based primarily on a student's handicapping condition or combination thereof and on a basic evaluation of level of functioning. As virtually all students are multiply handicapped, age is not considered a significant factor in grouping.

The services of 10 FTE teachers are supported by 1.5 FTE Teacher Assistants, a foster grandparent program, and a few Unit staff. Supervision and education direction is provided by a full time Education Supervisor.

The day is divided into 3 instructional periods: 8:30-11:30; 1:30-3:00; and 3:00-4:00. The morning session, from 8:30-11:30, encompasses the most intensive period of instruction, and the morning session teacher is considered the primary instructor. As the primary teacher, the morning instructor is responsible for developing the IEP, theoretically with the involvement of the afternoon teachers.

The lunch program encompasses 2 hours which includes lunch and rest. These hours potentially provide time for special education staff consultation.

The major afternoon session runs from 1:30-3:00 every day except Wednesday, when the educational staff has in-service staff meetings. During these afternoon hours, students from morning classes are instructed by different teachers, with the exception of Room 8 students and 6 students in Unit 4A. Afternoon sessions appeared to be largely involved with physical education and recreation activities.

The Unit 4A program differed. The teacher had 9 students assigned in the morning. In the afternoon, 4 of these 9 who were higher functioning students, were taught in Room 3 while the 7 students from Room 4 joined the remaining 5 from the morning session for a total of 12 profoundly multiply handicapped students.

From 3:00 to 4:00, 20 selected students from the early sessions received extra instruction from 4 teachers. All other handicapped returned to their residential unit. The other 5 teachers instructed 29 adults in basic skills and attitudes to prepare residents for deinstitutionalization in the community.

A) Number of teachers

1) Certified 10 (including 3 CETA teachers)

2) Non-certified 2 (certification eligibility to be completed by June, 1979)

B) How much supervision is provided: The Education Supervisor is responsible for the supervision of the education staff. Mr. Lynch indicated that he typically visits each classroom for a short time each day. In addition, he provided OMR/DD mandated teacher evaluation using a written checklist format. Evaluation is based largely on changes in child progress throughout the period.

4) Number of Classes

A) Non-handicapped 0

1) No. of children in each class 0

H) Handicapped 10

1) Type of Class Multiply Handicapped

2) No. of children in each class 6-12

3) Age Range of Children in each class varies

The 10 classes are organized as follows:

| CLASS | SIZE | AGE RANGE | COMPOSITION OF CLASS |
|---|---|---|---|
| Room 1 | 4 | 10-18 | Severe Retardation, with HB carriers and Severe Behavior Disorders. |
| Room 2 | 6 | 13-21 | Severe Retardation, with Severe Behavior Disorders and some autistism. |
| Room 3 | 6 | 17-21 | MR, with Behavior Disorders |
| Room 4 | 7 | 7-11 | Profoundly Retarded |
| Room 5 | 5 | 11-20 | Severely Retarded |
| Room 6 | 6 | 14-20 | Profoundly Retarded |
| Room 7 | 6 | 5-15 | Severely/Profoundly Retarded, Autistic, Blind |
| Room 8 | 8 | 11-20 | Profoundly Retarded |
| Room 9 | 6 | 7-13 | Severely/Profoundly Retarded, Blind |
| Room 4A | 10 in a.m.<br>12 in p.m. | 5-14 | Profoundly Retarded/Multiply Handicapped |

5) Description of Curriculum - There is no uniform curriculum used in the program as instructional strategies and individual goals and objectives are based on IEPs.

An evaluation checklist has been developed by the Education Department with an 0-4 rating scale, and is divided into 4 general areas: Social Behavior, Communication, Self-Care, and Coordination and Fitness. In addition, the Department had developed a Pre-vocational Skills profile. The Education Department should be commended for both of these task-based checklists.

However, these evaluation instruments were prepared for a higher functioning population than that presently at the Broome Developmental Center. Presently, the IEP and teacher subjective assessment of individual needs serves at the primary curricular approach. The staff has had limited experience teaching multiply handicapped students, and based on the IEPs, had difficulty establishing appropriate goals and instructional strategies. It would appear that staff visitations to on-going programs for severely to profoundly multiply handicapped children would be a valuable aspect of staff and program development, as would a study of curricular approaches developed for such students. One such approach, SPRING (Severely and Profoundly Retarded Individual Needs Guide), was developed by the West Seneca Developmental Center and should be available through OMR/DD.

A) Is Health Education provided? Only as it relates to self-care.

B) Is Safety Education provided? Only as it relates to self-care.

C) What ancillary or related services are provided: Clinical psychological evaluation; Children's Habilitation Program Intervention; Speech Therapy; Occupational Therapy; Physical Therapy; Recreation; Physical Education.

Particularly commendable was the related service through the Children's Habilitation Program which provided 1-1 instruction to individual students based on meticulous goal planning and goal evaluation. However, these goals were not incorporated in IEPs and special education teachers were typically unaware of these goals. This fragmentation of programming was also apparent in the provision of Physical Therapy services. While the quality of Physical Therapy services was appropriate, they were limited and had little relationship to the IEP. Speech therapy was exceedingly limited for the school age population.

D) Are Health and Physical Education Teachers Certified? No

Have certification requirements been waived? No

E) Is instruction equivalent to Education Law 3204 and Part 100 of the Commissioner's Regulations? No

6) Pupil Records

A) Are attendance records maintained? Yes, by classroom teacher.

B) Are individual student records maintained? Yes, in:

1. Teacher's room - (IEP)
2. Education Office (Education records, psychological, IEP)
3. Unit (residential area) - current educational, psychological and medical.
4. Medical Records Office (cumulative and most complete)

C) Is the confidentiality of pupil records maintained? largely

D) Do parents have access to records? Only Educational

7) What health services are provided: Services: Dental, Nursing, Emergency, Drug Administration, Physical Therapy, Occupational Therapy.

A) Who delivers these services?

Drugs: Nurse in Unit

Dental: On contractual basis

Physical: 4 Broome Developmental Center Doctors

Audiological: Broome Developmental Center Audiologist

Emergency: Wilson Hospital and 4 staff doctors.

I. Educational Plans

1) Does the facility have a Long Range Educational Plan: Not equivalent to to Commissioner's Regulations 115. It only consists of a 5 paragraph narrative prepared in response to Commissioner's Regulations 116.

A) Does it include:

1) Projection of future enrollment? Only 1979-80 (62)

2) Fiscal information showing expenditures and revenues for the last three years? - Yes, but only through Maintenance of Fiscal Effort form for P. L. 89-313 and includes salaries, fringe benefits, supplies and equipment.

3) Projection for expenditures for the next three years. - Reportedly in Business Office.

4) Narrative Description of future Educational Plans. No

5) Other items of a planning nature, such as goals + objectives, needs assessment, program analysis, etc. no .

2) Is there an annual Education Plan developed for the facility? - Only on P. L. 89-313 application.

A) Does it include?

1) The number and grade span of pupils and their handicapping condition? no (except for P.L. 89-313 component)

2) Is there an evaluation component that will measure the program objectives? no (except for P. L. 89-313 component)

3) Is the estimated budget needed to implement program included. - Only P. L. 89-313 component.

Has it been cleared by the Division of Budget? No

II. Programs for Handicapped Pupils

1) Does the facility have a committee to identify handicapped children? No

A) Who are its members? - The Chief Administrator does not have a Committee in accordance with the Commissioner's Regulations 116.4. The only committee is the Intermediate Treatment Team (ITT) which develops the Individual Service Plan within three weeks after admission. The composition varies according to individual cases and persons involved appear to be based on the Unit (residential area) to which the client is assigned. Typical members, usually QMRPs (Qualified Mental Retardation Professionals) may include:

Chief of Service

Social Worker

Clinical Psychologist

Teacher

Physical Therapist

Occupational Therapist

Speech Therapist

Education Supervisor

Nutrition Aide

Physician

Unit Nurse

Primary Therapist

2) Are procedural due process provisions provided to the child and parent? - Procedural due process is not provided according to 200.5 of the Commissioner's Regulations. However, OMR/DD has a state-wide due process procedure for objections to client movement (attached) issued by T. A. U. (Technical Assistance Unit or presently the Consent Decree Office)

3) Do classes for the handicapped meet the requirements of section 200.4 of the Commissioner's Regulations? No -These classes are for the multiply handicapped. 8 of the 10 teachers are certified and 2 teachers are to be eligible for certification by June, 1979. The largest class size is 12. The most serious area of non-compliance regarding classes is the lack of paraprofessionals. Only 1.5 FTE teacher assistants are assigned to the 10 classes, augmented by a few foster grandparents and Unit Staff who arrive in the classroom at unspecified times. Clearly the Broome Developmental Center does not provide 1 paraprofessional for each 3 severely/profoundly multiply handicapped students.

4) Are Individualized Education Programs developed for each child? Yes
The IEP form developed by OMR/DC consists of 3 pages:

Page 1 - A survey sheet, a copy of which is sent to OMR/DD, indicates the multiplicity of handicapping conditions for each child, age range, class size, and classroom staff. It also includes provided amount and recommended amount of special education and related services. Services addressed on the survey are:

1. Special Education
   a. Physical Education
   b. Vocational Education
2. Speech Pathology and Audiology
3. Psychological Services
4. Physical Therapy
5. Occupational Therapy
6. Recreation
7. Counseling Services
8. Other (specify)

Page 2 - A cover sheet, encompassing Parent contacts, IEP conference information, extent of participation in regular class, and long term goals.

Page 3 - The basic instructional IEP. It includes subject skill/supportive services, current instruction level, short-term goals, person writing goals, materials or strategies, initiation, duration and evaluation.

Do they fulfill the requirements of the Commissioner's Regulations for IEPs? Minimally - Each student was provided an IEP by September, 1978. All parents were invited, in writing, to attend an IEP planning conference at their convenience. The Education Department should be commended for its immediate response to this mandate. A survey of IEPs indicated that several parents did indeed attend the IEP planning conference. This same survey, however, pointed out that only the parent and the teacher or only the teacher developed the IEP, without the mandated third person. Uniformly, the instructional aspect of the IEP only included a 1 page abbreviated document and related services were not indicated in terms of goals or objectives. While Broome Developmental Center has demonstrated a significant attempt to comply with IEP procedures and objectives were behaviorally oriented, the following non-compliance issues surfaced:

1. Long term goals were far too general.
2. Indications of participation with non-handicapped children was interpreted as amount of participation in special education in Broome Developmental Center, rather than assuming such special education services were basic.
3. While occupational therapy, physical therapy, the Children's Habilitation, and other related services were mentioned in the IEP, little relationship among the various services was apparent. Much of this appeared to be the result of disciplinary separation. The services of the Unit Staff, the medical staff, the clinical psychology staff, the occupational therapist and physical therapist staff, recreation staff, and the educational staff had no central coordination. If special and related services are to be educationally relevant, coordination of goals objectives and evaluative procedures are crucial.
4. While morning teachers were responsible for developing IEPs, it was evident that teachers serving the same students in the subsequent hours were not knowledgeable of student IEPs.
5. Short term goals were not sufficient.
6. Typically, there were none, or very limited evaluation procedures indicated.
7. Only individuals writing goals, but not individuals responsible for implementing goals, were delineated.

5) Is a copy of the Individualized Education Plan provided by the facility to the Committee on the Handicapped in the school district where the child resided prior to residential placement? - A copy of the IEP is not provided the district of origin, unless requested. The stated reason relates to Broome Developmental Center's concepts of confidentiality.

Has the facility designated one professional educator on its' staff who shall maintain contact with the school district Committee on the Handicapped? Yes, Mr. Lynch.

6) Does the facility have procedures for appointing surrogate parents? - Reportedly only 3 school age children are wards of the state. Nevertheless, children whose parents are not available or who are wards of the state are not protected by any defined procedure of provision of surrogate parents.

The sole exemption for such children are those protected by Chapter 66 where the Johnson City School District has appointed a surrogate parent. This surrogate parent is reportedly available for Broome Developmental Center's other residents, if necessary.

IV. Physical Facilities

1) Buildings

A) How many? 1

B) Description - Broome Developmental Center consists of a modern complex with residential and educational units emanating from a central reception area. All aspects of the unit seem to be in compliance with Section 504 of the Rehabilitation Act of 1973. 10 of 22 residential units are presently occupied.

2) Classrooms

A) How many? 10

B) Description - 9 to 10 classrooms provide spacious, cheerful, and appropriate environments of adequate space. 1 classroom, Unit 4A is exceedingly limited for 12 profoundly handicapped children.

3) Special facilities (i. e. restrooms, library, cafeteria, etc.) - Special facilities appear to be adequate and accessible to the handicapped. A professional library is available in the Education Department and a library exists in the residential areas with books and audio visual materials.

4) Are buildings accessible to handicapped persons? Yes

V. Summary and Recommendations

The Education Department of Broome Developmental Center has made commendable effort to work with the Johnson City School District to provide community based educational programming for 23 of 95 school aged children residing at the Center. The Education Supervisor has worked closely with the district and apparently has received excellent cooperation from the Johnson City Committee on the Handicapped. Furthermore, the Department has provided more appropriate educational services to its profoundly handicapped residents than it has in previous years. All students are scheduled for 4½ of instructional services and 26 students are scheduled for 6 hours of instruction. The Broome Developmental staff was most receptive and cooperative during 1½ day site visit. It should be noted, however, that the Deputy Director for Administration had not been informed of our scheduled visit and was unaware of our presence until the afternoon of November 2.

The following non-compliance issues are apparent:

1. Staffing -

a. A paraprofessional was not provided for each 3 multiply handicapped children.

b. 2 teachers were not certified in special education..

2. IEPs (See Page 7)

   a. Related services delineated on the IEPs were not incorporated in goals and objectives.

   b. Related services delineated on individual IEPs were not being provided to several students.

   c. IEPs and/or educational progress reports were not provided to the district of origin according to Commissioner's Regulations 116.4 (c).

   d. Fragmentation of services, special and related, resulted in ineffective IEPs.

3. Procedural Due Process

   a. A committee has not been established according to Commissioner's Regulations (116.4).

   b. Procedural Due Process is not provided according to Commissioner's Regulations (200.5).

   c. Provision is not made to surrogate parents according to Commissioner's Regulations [116.4 (d)].

4. Confidentiality

   a. The Center does not maintain a list of staff members with access to records of individual students.

5. Education Plans

   a. The Center does not have an education plan equivalent to the Commissioner's Regulations (115).

6. Occupational Education

   a. Occupational Education programs were not provided to students in education programs.

7. Hours of Instruction

   a. Some students do not receive their required 5 or 5½ hours of instruction.

Submitted by: Carol M. Kendall
Regional Associate
Region II

November 15, 1978

The New York State Commission on Quality of Care and Advocacy for Persons with Disabilities is an independent, New York State government agency charged with improving the quality of life for New Yorkers with disabilities, protecting their rights, and advocating for change.

New York State
Commission on Quality of Care and Advocacy
for Persons with Disabilities

401 State Street
Schenectady, New York 12305-2397

1-800-624-4143 (Voice/Spanish/TTY)

www.cqcapd.state.ny.us