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## *A Review Of The Barbara Downes Family Care Home*

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

June 1980

CLARENCE J. SUNDRAM. *Chairman*

MILDRED B. SHAPIRO  
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COMMISSION ON QUALITY OF CARE  
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COMMISSIONERS

July 31, 1980

From: Clarence J. Sundram  
Chairman

Subject: Review of the Barbara Downes Family Care Home

Enclosed is an informational copy of the final report of the Commission review of the Barbara Downes\* family care home, located in the catchment area of Binghamton Psychiatric Center. The Commission undertook the review of this home following the death of a resident and in response to allegations of inadequate supervision and improper medication practices at the home. These allegations were brought to the Commission's attention by Binghamton Psychiatric Center's Board of Visitors.

The findings, conclusions and recommendations of the Commission report represent the unanimous opinion of the members of the Commission. The report cites findings indicating: lack of compliance with OMH health standards for family care; chronic unwillingness on the part of the provider to comply with standards of care routinely expected of family care providers; and a failure by Binghamton Psychiatric Center to monitor and take corrective action, despite its awareness of the Downes home deficiencies.

A draft of this report was shared with the Office of Mental Health, the Director of Binghamton Psychiatric Center and the Binghamton Psychiatric Center Board of Visitors. In response to Commission recommendations, the Central New York Regional Office resurveyed the Downes home and, subsequently, decertified it as a family care provider. A copy of the response letter from the Director of Binghamton Psychiatric Center is appended to the report. The Regional Office is currently reviewing the policies, procedures and operations of the Binghamton Psychiatric family care program. The Commissioner of the Office of Mental Health and the Director of Binghamton Psychiatric Center are required under the Mental Hygiene Law to report to this Commission within 90 days on the actions taken in response to our recommendations. The Commission will monitor such actions.

This report is being filed in accordance with Article 6 of the Public Officers Law and is considered a public document.

Enclosure

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\*A pseudonym for the name of the family care home provider.

## PREFACE

This review of the Barbara Downes\* family care home, administered by Binghamton Psychiatric Center, was undertaken by the Commission following the death of Cleo B., a resident of the Downes home and in response to allegations of inadequate supervision and improper medication practices at the home. These allegations were brought to the Commission's attention by Binghamton Psychiatric Center's Board of Visitors.

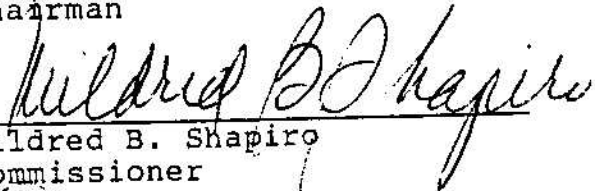
The findings, conclusions and recommendations set forth in the report represent the unanimous opinion of the members of the Commission.

The contents of this report have been shared with the Commissioner of the State Office of Mental Health, the Director of the Central New York Regional Office, the Director of the Binghamton Psychiatric Center, and the Binghamton Psychiatric Center's Board of Visitors.

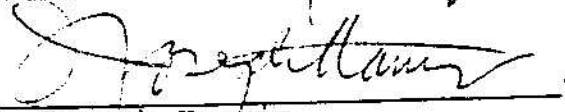
In response to Commission recommendations, the Central New York Regional Office resurveyed the Downes home, and subsequently decertified it as a family care provider. The Regional Office is also reviewing the policies, procedures and operations of the Binghamton Psychiatric Center family care program. A copy of the response letter, received from the Director of Binghamton Psychiatric Center, is appended to this report.



Clarence J. Sundram  
Chairman



Mildred B. Shapiro  
Commissioner



I. Joseph Harris  
Commissioner

\*A pseudonym for the name of the family care home provider

## PURPOSE AND SCOPE OF REVIEW

The Commission on Quality of Care for the Mentally Disabled undertook the review of the Barbara Downes family care home, supervised by Binghamton Psychiatric Center, following the death of Cleo B., a resident of the home who was struck by a truck while crossing the road on the morning of October 8, 1979. While the October 8 incident was duly reported to the Commission's Mental Hygiene Medical Review Board for the purposes of investigating the cause of and circumstances surrounding the death, allegations of inadequate supervision and inappropriate medication practices in the home prompted the Commission to initiate a separate review of the home itself. These allegations were brought to the Commission's attention by Binghamton Psychiatric Center's Board of Visitors.

During the course of the review, members of the Commission's investigation and Quality Assurance Bureaus conducted site visits to the Downes family care home on December 7 and 8, 1979 and January 7, 1980. A fourth visit was made on February 21, 1980 following the receipt of a January 9, 1980 site visit report by staff of Binghamton Psychiatric Center (BPC) which detailed findings inconsistent with those revealed during earlier Commission visits. In addition, Commission staff reviewed all BPC's records pertaining to the home and its residents (including the late Cleo B.) and conducted numerous interviews with individuals associated with the home including Mrs. Downes and the residents of the home, the Director of BPC, BPC staff previously or presently associated with the home and former BPC staff.<sup>1</sup>

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<sup>1</sup>A listing of individuals who were interviewed by Commission staff is offered in Appendix A.

## FINDINGS

The Commission's findings pertain essentially to two areas: the Downes family care home; and BPC's role in monitoring the home.

### 1. The Downes Family Care Home

The Downes family care home, located on a fairly well-used rural highway outside Binghamton, New York, has a certified capacity of eight residents. The home has always served a geriatric female population and presently has six female family care clients in residence whose ages range from seventy-three to ninety-one. All of these frail and elderly women exhibit, according to their medical records, moderate to severe organicity and many are frequently incontinent.

The clients sleep on the second floor of the house where two bedrooms house three clients each and a third bedroom is furnished for two additional clients. A half bathroom is also located on the second floor off of one of the bedrooms.

The women socialize or watch TV on the first floor in a sitting room off the kitchen. Also located on the first floor is a large dining area and a full bathroom. Mrs. Downes' bedroom and living room are also located on this floor.

During the four visits by Commission staff to the home, one of which was announced, a number of deficiencies were noted.

The first deficiency noted immediately upon arrival was the level of supervision provided by Mrs. Downes for the residents in her home. On the morning of December 7, 1979 when Commission staff made their first unannounced site visit, Mrs. Downes was not home. A handyman, Mr. M., and his wife were found in Mrs. Downes' basement doing some electrical work in a remodeled area. Neither were approved substitute care providers and neither had any idea of Mrs. Downes' whereabouts or when she would return. Commission staff found all of the clients, except one, upstairs sitting around the television;

The other client was in the bathroom on the second floor. No one was found supervising the clients. A subsequent review of BPC's records on the Downes' home revealed that this was not an isolated incident and that Mrs. Downes had on at least one occasion locked the residents in the home unattended. While family care regulations do not prohibit clients being left unsupervised, in this case the clinical need for constant supervision of the clients was clearly documented in the records.

During this and subsequent visits to the home other deficiencies were noted pertaining to medication administration practices, the management of clients' finances and the general environment.

With regard to medication practices, a number of irregularities were found. On all visits, including the announced, medications were found stored in an unlocked tool box. Additionally, it was found that Mrs. Downes' personal medications were stored in the same tool box. While comparing the medications prescribed during the clients' most recent physical examinations with the medications in the box a number of discrepancies were found including medications being stored which were no longer prescribed. It was also found that Mrs. Downes does not keep records regarding the time and date of medication administration or the person supervising the administration of medication as required by section 10.6.6 of the Family Care Manual.

Deficiencies were also noted in the area of managing client finances. During the course of the Commission's visits, the clients were interviewed about their personal funds. They reported having no money and did not recall being given any money by Mrs. Downes. When questioned about the clients' monthly allowances, Mrs. Downes indicated that she never gives the women their money; instead she pools the allowances with her own personal funds and whenever anyone needs anything it is paid for by Mrs. Downes.



In reviewing Mrs. Downes' copies of Form 603 DMH on which the family care provider, pursuant to section 10.6.8 of the Family Care Manual, is to indicate monthly how a client's personal allowance was spent and how much remained unused, it was found that Mrs. Downes had each client sign her name in the column indicating how the money was used and at the end of the month entered a balance of zero in the column indicating the amount left unused.

In short, it was found that not only are the clients not given their monthly allowances but Mrs. Downes keeps no record of how the money is spent although she reports that it is spent each month.

With regard to the clients' living environment, Commission staff found the clients' bedroom areas untidy with a strong and pervasive stench of urine and dirty clothes. While all the beds were made, articles of clothing were piled on the floor and noticeably hanging from dressers and headboards and between box-springs and mattresses. Although Mrs. Downes indicated that she has a cleaning service, it was obvious that, as the deplorable conditions found in the sleeping areas remained unchanged from one site visit to the next, little effort was being made to keep the women's bedrooms neat and clean. The women themselves on all four visits were found in their sitting room silently watching TV and were noted to have strong body odors.

In summary, while Commission staff found numerous deficiencies in the Downes' home, it should be noted that these deficiencies existed not because Mrs. Downes was ignorant of Family Care policies or procedures. On the contrary, Mrs. Downes seemed knowledgeable of these standards and in interviews with

staff indicated that she could not be "bothered with" things such as paper work or the troubles of giving the women their money. In short, on these issues and others, Mrs. Downes indicated no willingness to correct the deficiencies in the home even with the assistance of the facility.

## 2. Binghamton Psychiatric Center's Role in Monitoring the Home

While the deficiencies found in the Downes' home during the Commission's review and Mrs. Downes' attitude regarding those deficiencies raise serious doubts about Mrs. Downes' ability and willingness to provide a standard of care routinely expected of family care providers, they also raise questions regarding BPC's role in monitoring the home.

In reviewing BPC records on the home and its residents and in interviews with former and present BPC staff it was found that many of the deleterious conditions found in the home during the Commission's review existed for the past three years and were known by BPC's administration. As early as the Spring of 1977 deficiencies in the areas of supervision, medication practices and financial management in the Downes' home were noted in BPC records.

With regard to supervision, Commission staff found that BPC records contained numerous references to concerns expressed by neighbors of the Downes' home and employees of BPC about the fact that clients were at times left unattended in the home and that at other times clients were found walking alone or in pairs precariously along the side of or in the middle of the highway on which the home is located. One such incident documented in the record recounts an occasion when BPC staff reported to the home for an announced visit only to find six residents locked in the home while Mrs. Downes was in town with two other residents.



In another incident a BPC employee reported finding two residents walking along the road in the midst of a torrential rainstorm totally oblivious to and unprotected from the elements. In yet another incident documented in the record, a neighbor reported having witnessed a car accident which was caused by a driver who, in an effort to avoid hitting one of the elderly clients walking on the highway, swerved off the road and crashed into a guardrail.

Irregularities in medication practices in the Downes' home were also documented in BPC records. In April of 1977 BPC Out-of-Hospital Care Unit staff, who at that time were responsible for supervising the Downes and all family care homes, reported that medications in the Downes' home were not stored in a locked box. They also reported that Mrs. Downes was not properly documenting the administration of medications and in fact was not giving the clients the medications as prescribed. Similarly, BPC Out-of-Hospital Care Unit staff documented the fact that clients in Mrs. Downes' home reported that they were not receiving their monthly allowances.

In short, Commission staff found that with the exception of the general environment in the Downes' home, all of the deficiencies noted in the home during the Commission's review were known by BPC and documented in the records as early as April 1977.

Although the conditions of the home were known by BPC's administration and in fact, on the motion of the Deputy Director Clinical, the BPC Family Care Committee on April 8, 1977 placed the home on probation for thirty days, Commission staff found that BPC essentially abdicated its responsibility to effectively monitor the home during the following months and years.

BPC's records indicate that in visits to the Downes' home subsequent to its being placed on probation, Out-of-Hospital Care Unit staff found little substantive change in the home's

conditions. Although BPC staff familiar with the home recommended its closure, the Family Care Committee voted in June, 1977 to extend the probationary period.

BPC records do not indicate that conditions in the home were ever corrected to the point of compliance nor do they indicate that the probationary period was ever terminated. Rather, the records indicate that Out-of-Hospital Care staff continued to find deficiencies in the home until the fall of 1977 at which point the staff were instructed to refrain from contacts with Mrs. Downes.

In the fall of 1977, responsibility for monitoring the Downes' home was transferred from the Out-of-Hospital Care Unit to the Geriatric Intensive Treatment Unit (GITU). When questioned by Commission staff on the rationale for such a transfer the Director indicated that in their vigilance and frequent site visits, the Out-of-Hospital Care staff might have been harassing Mrs. Downes.<sup>2</sup>

In reviewing records on the home after the transfer, Commission staff found that in transferring the responsibility for supervising the Downes' home to the GITU, which is staffed to operate an intensive inpatient treatment program, BPC abdicated, although perhaps unintentionally, its responsibility to monitor a family care home which was in a critical state of non-compliance. Subsequent to the transfer, staff visits to the home were made less frequently and for a four-month period in late 1978 and early 1979 monthly visits stopped altogether. It was clear to Commission staff that, although GITU staff was able to operate a very successful inpatient geriatric program, due to staffing constraints and unfamiliarity

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<sup>2</sup>Commission staff reviewed the records of six other family care homes and their clients under the jurisdiction of the Out-of-Hospital Care Unit and found that these homes were visited and inspected by the OHCU team at the same frequency as the Downes' home.

with family care procedures the ability of GITU staff to monitor a family care home was severely limited.

The inability of the GITU to adequately monitor the Downes' home was reflected in a report of a January 9, 1980 site visit conducted by GITU staff.<sup>3</sup> In this report it was stated that medication "is distributed as prescribed according to hospital regulations" and that Mrs. Downes "maintained an up-to-date accounting of her finances." A visit to the home by Commission staff after receipt of this report revealed that medications continued to be stored in an unlocked tool box and that Mrs. Downes' method of documenting medication administration and the clients' finances continued to be inconsistent with family care policies and procedures. It was also found that the GITU had no record of medications prescribed by the community-based physician treating the residents of the Downes' home and, therefore, had no means of ensuring that medications were up-to-date and being dispensed as prescribed.

The only plausible explanation of discrepancies between the GITU findings and Commission findings is that GITU staff conducting the site visit were unfamiliar with family care policies and procedures.

In summary, Commission staff found that while serious deficiencies were noted in the Downes family care home as early as 1977, BPC made little effort, with the exception of the Out-of-Hospital Care Unit's endeavors, to effectively deal with the situation. In fact, in transferring the responsibility for monitoring the home from the team responsible for supervising all family care homes to a unit whose primary responsibility was operating an inpatient program, BPC compromised its ability to ensure that the home was effectively supervised and its deficiencies corrected.

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<sup>3</sup> The January 9, 1980 memorandum to the Director from a psychiatric social work supervisor regarding "Downes Family Care Home Evaluation and Recommendations" was requested by Dr. Dozoretz at the request of the Regional Office.

## CONCLUSION AND RECOMMENDATIONS

Based on its review of the Barbara Downes family care home the Commission concluded that:

- \* The Downes family care home has been and is presently out of compliance with Office of Mental Health standards for family care;
- \* Mrs. Downes presently exhibits no willingness to bring the home into compliance and has in the past shown complete disregard for standards of care routinely expected of family care providers;
- \* Binghamton Psychiatric Center, aware of the deficiencies in the home, abdicated its responsibility to monitor the home effectively and take corrective action; and
- \* As a result, the residents of the home have been and continue to be exposed to hazardous living conditions---conditions below the standards generally found in institutions.

As such, the Commission recommends that the Downes family care home be decertified by the Regional Office and that BPC, recognizing the potential trauma for residents in closing the home carefully plan for the residents' transfer to other living arrangements and provide all the necessary support services which may be required during this process.

The Commission also recommends that the Regional Office undertake a review of BPC's policies and procedures regarding the placement of family care homes on probation and the transfer of family care home monitoring activities to units with little or no practical experience in family care administration.

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Individuals Interviewed

by Commission Staff

Barbara Downes and the clients in her home

Director---BPC

Deputy Director Clinical---BPC

Psychiatrist, Geriatric Intensive Treatment  
Unit---BPC

Former Chief of Out-of-Hospital Care Unit---BPC,  
presently Broome County Commissioner of Mental  
Health

Chairman, Family Care Committee---BPC

Family Care Coordinator---BPC

Psychiatric Social Work Assistant---BPC

Psychiatric Social Worker---BPC

Chief Supervising Nurse---BPC

Psychiatric Social Work Assistant---BPC

Program Analyst, Bureau of Alternate Living,  
Office of Mental Health

President, Family Care Association---BPC

Vice-President, Family Care Association---BPC

Broome County Sheriff's Department

APPENDIX B  
NEW YORK STATE  
OFFICE OF MENTAL HEALTH

ENCLOSURE

RECEIVED  
MAY 20 1980

May 20, 1980

Mr. John R. Collier  
Regional Director  
Central New York Regional Office  
Office of Mental Health  
645 Cedar Street  
Syracuse, NY 13210

**DOWNES**

RE: [REDACTED] Family Care Home Inspection  
Application for Recertification

Dear Mr. Collier:

Enclosed please find report on the above Family Care home. You are aware that, following receipt of an unfavorable safety inspection on Thursday afternoon, May 15, I arranged to have those patients who were willing, to be returned to the facility for medical and psychiatric evaluation and for placement in the future in another Family Care home appropriate to their needs.

Accordingly, on Friday, May 16, the following four patients were returned with their acquiescence to the facility: Mildred P. [REDACTED], Sylvia G. [REDACTED], Frances P. [REDACTED] and Viola T. [REDACTED]. The other patient, Josephine S. [REDACTED], was examined by Dr. Undavia since she was unwilling to leave the Family Care Home and was found suitable for discharge, which disposition was accomplished.

In accordance with the recommendations of Dr. Undavia, Unit Chief of the Out of Hospital Care Unit, I am not recommending the recertification of this Family Care home. The recommendations #2 and #3 also have been accepted.

Yours very truly,

LOUIS COOPERSTEIN, M.D.

LS/ea  
Enclosed  
sent [REDACTED] to [REDACTED] of [REDACTED]



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  
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