An Investigation of Selected Incidents at The Otsego School

by

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

January 1982

Clarence J. Sundram
Chairman

Mildred B. Shapiro
I. Joseph Harris
Commissioners

Designated by Governor Hugh L. Carey as the agency to administer New York State's Protection and Advocacy System for the Developmentally Disabled pursuant to Public Law 94-103, as amended.

FOREWORD

This report represents the findings, conclusions and recommendations of the Commission on Quality of Care following an investigation into various allegations, by a former employee, of abusive and other incidents at the Otsego School (the School).

A draft of this report was shared with the Office of Mental Retardation and Developmental Disabilities and with the School. In addition, at the request of the School, the Commission met with the School's Director and their attorney. The responses to our recommendations have been incorporated into the report following the recommendations.

This report represents the unanimous opinions of the members of the Commission.

The response of the Board of Directors of the Otsego School is attached as an Appendix.

Clarence J. Sundram
Chairman

Mildred B. Shapiro
Commissioner

J. Joseph Harris
Commissioner

NOTE: The incidents under investigation allegedly occurred at the Otsego School from November 1979 through July 1980. The School is currently operating as Pathfinder Village Otsego School.

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EXECUTIVE SUMMARY

The investigation of incidents at the Otsego School (now called Pathfinder Village), a private school certified by the Office of Mental Retardation and Developmental Disabilities, (OMRDD) was initiated in August 1980 when a former employee of the School contacted the Commission to register her concern over certain of the School's operations. She alleged that clients were abused, and when such incidents were reported, the School made little attempt to investigate or take corrective action. She also alleged that untoward medical incidents occurred as a result of poor staff training in the areas of medication administration and care of the special needs of diabetic clients. The specific incidents she cited had occurred over a period of time commencing on Thanksgiving Day 1979 up to mid July 1980.

After interviewing the former employee, in October 1980 the Commission referred the allegations to the Office of Mental Retardation and Developmental Disabilities for its investigation. OMRDD forwarded an investigative report to the Commission the following month which indicated that the allegations were unsubstantiated. This report was prepared by the Director of the Otsego School at the request of OMRDD and its findings were accepted by that Office.

A review of the report, however, revealed serious deficiencies in the methodology of the School's investigation, and six incidents, reportedly investigated by the School's Director, were selected for Commission review for the purpose of independent verification.

The Commission investigation of these selected incidents indicates there existed evidence of sufficient credibility to warrant recording and investigation to determine whether patient abuse had, in fact, occurred; that although some of these incidents were reported verbally to superiors,

no incident reports were filed nor is there any record of prompt investigations having been conducted; and that due to the passage of time, the absence of records, the conflicting and sometimes changing statements of witnesses, it is not now possible to conclusively determine whether the alleged abuse did, in fact, occur.

As a result of this investigation, the Commission questions the appropriateness of staff-client interactions at the School, the ability of nursing and supervisory staff to provide direct care personnel with the guidance they require, and the adequacy of the School's recordkeeping and incident reporting, investigation and review practices.

While the Commission's investigation did not support the allegation that poor training practices resulted in untoward medical incidents -- in fact we found that staff responded appropriately when medical problems or emergencies arose -- it was found that certain medically related incidents, described by the former employee and denied by the School's Director, had indeed occurred; yet no record of these incidents remains.

In the final analysis, it is the Commission's conclusion that the School has serious but correctable problems in the areas of staff orientation and supervision, record keeping and incident reporting, investigation and review. Furthermore, when serious charges regarding the quality of care provided the facility's residents were brought to the attention of the facility's Director, inadequate attempts were made to investigate and take corrective action.

Finally, it must be noted that OMRDD regulatory practices in responding to the allegations of alleged abuse and deficiencies at one of the facilities it supervises were insufficiently thorough. Too much of the responsibility for

the investigation was delegated to the Director of the facility itself, and the process for verifying the results of that investigation was deficient.

Therefore, the Commission recommends that:

1. The Office of Mental Retardation should closely monitor the operations of this facility for a period of one year during which:
   A. the School's recruitment, orientation, training and supervision practices must be carefully reviewed to ensure that the staff employed by the School are sensitive to the needs of the clients they serve. It is particularly important that all staff are made to recognize and accept their duty to continually assure the welfare of the residents in all of their interactions with them;
   B. a formalized incident reporting and investigation procedure must be put in place to assure that in the future, allegations of client abuse or neglect will not be casually dismissed. We recommend that OMRDD closely review the filing and investigation of all incident reports during this period.
2. The Office of Mental Retardation and Developmental Disabilities should strengthen its monitoring of investigations by a licensed facility of serious allegations of client abuse or neglect, and pursue more vigorous independent investigations of such allegations where warranted.

[The Commissioner of OMRDD Responds:

I agree with each of your recommendations, and we have begun to implement them. Staff of the private schools unit as well as my Deputy for Quality Assurance have begun periodic visits to Pathfinder Village and have been directed to provide special attention to the school's recruitment,

orientation, training and supervision practices and the need for Pathfinder to establish a formalized incident reporting and investigation procedure. We will closely review the filing and investigation of all incident reports during this one year period. We will also ask Pathfinder to report to us actions taken with respect to such incidents.

We have not and will not rely exclusively upon a licensed facility to investigate itself. Likewise, I am conducting a more extensive internal review of how my staff review similar allegations.]

[The Board of Directors of the School responds:

...[T]here is considerable disagreement with respect to both the Findings and Conclusions. We do, however, adopt and agree with your Recommendations, since we feel the closer contact with and assistance of both OMRDD and the Commission on Quality of Care can only further the achievement of our near and long-term goals for Otsego School.]

I. INTRODUCTION

The Pathfinder Village Otsego School, Inc. is a private school for mentally retarded individuals operated by a not-for-profit corporation. Located on Route 80 in the rural community of Edmeston, New York, the school has a certified capacity of 60 and as of October 1980 was providing services for 58 children and adults with Down's Syndrome. It is the only agency in New York State which provides service to the Down's Syndrome population exclusively and attracts a number of out-of-state residents (approximately 21).

Pathfinder Village is the new campus of the Otsego School which was formerly located in two buildings on West Street in Edmeston. The programs and residents moved to the new site in July 1980. In the course of a recertification and inspection conducted by the Office of Mental Retardation and Developmental Disabilities in October 1980, the Pathfinder Village campus was described as one of the five strengths of the agency. The attractiveness and versatility of the campus are noteworthy and the seven colonial style residences, which house between seven and ten clients each and were built exclusively for this purpose, offer a neat, clean and personalized environment for the School's residents.

Also located on the campus is a school building which provides room for educational programs for the School's 30 school age children as well as a gym and auditorium for all the School's residents.

Workshop programs for the School's adult population are conducted in two of the seven residences and a number of the adults attend an Association for Retarded Children day program in Oneonta. Future plans for the Pathfinder Village campus include the building of a small inn and gift shop to increase the interaction between the School's residents and the surrounding community.

Nature of Investigation

The Commission's investigation into incidents which allegedly occurred at the Otsego School was initiated in August 1980 when a former employee of the School contacted the Commission to register her concerns over certain operations of the School.

In general, this former employee alleged that clients were abused by staff members, and when such incidents were reported there was little attempt to investigate the incidents and to take any necessary corrective action; and that as a result of poor medication administration and training practices, untoward medical incidents had occurred. She also questioned the propriety of her termination from the School and suggested that the termination was the result of her frequent complaints to the School's administration regarding the care of clients.

In October 1980, after interviewing the complainant, the Commission forwarded a synopsis of her general allegations, replete with specific incidents as described by her, to the Office of Mental Retardation and Developmental Disabilities for its investigation. (See Appendix A.)

In November 1980, OMRDD forwarded to the Commission an investigative report which in essence indicated that the complainant's allegations were unsubstantiated. This report (Appendix B) was prepared by the School's Director at the request of OMRDD and its findings were accepted by that Office.

A review of the Director's report, however, revealed that for the most part the findings were based on entries in records, or the lack thereof, and that no staff members identified in the Commission's synopsis as either witnesses

to or participants in various incidents, were apparently interviewed by the Director. Concerned over the adequacy of the Director's investigation and report, the Commission selected six specific incidents for indepth review for the purpose of establishing the veracity of either the complainant's charges or the findings of the School's investigation into those charges.

The findings of the Commission's review, which consisted of site visits, record reviews and extensive interviews with employees of the School, are presented in the next chapter.

II. FINDINGS

A. Client Abuse

To support her allegation that clients were abused, and that when such occurrences were reported the School made little attempt to investigate, the complainant cited details of a number of incidents. These alleged incidents, summarized by the Commission and forwarded to OMRDD, were reportedly investigated by the Director of the School and found to be without substance. For the purpose of verifying the Director's findings, which were accepted by OMRDD, three were selected for indepth Commission review:

* an alleged client assault incident;
* an alleged employee sexual abuse incident; and
* an alleged client abuse incident.

The Alleged Client Assault Incident

With regard to this incident, the complainant alleged that sometime during the summer of 1980, an employee held one client and encouraged another client to punch him. Ultimately, according to the complainant, the first client was punched so hard in the groin that a nurse was called to examine him.

In her investigation into this incident, the Director found no evidence to substantiate this allegation as the school's nurses could not recall the incident and no entries pertaining to the incident were found in any records.

Although the nurses first denied any knowledge of this incident in interviews with Commission staff, Commission interviews with other direct care staff revealed that indeed one of the clients named by the complainant had punched the second client in the groin and that a nurse was summoned to examine him. These statements by direct care staff were

corroborated by one of the nurses who indicated that the statements given by direct care staff had refreshed her memory.

There is also credible evidence that an employee was involved in this incident. This employee informed Commission staff that she was wrestling with one of the clients for about five minutes when the second client impulsively jumped on the first and punched him in the groin. (Wrestling or horseplay of this type is not uncommon, according to staff.) According to another employee witness, however, the employee involved in the wrestling invited one of the clients to take her place and wrestle with the other client. Subsequently, this employee witness changed her statement to indicate that while there was some wrestling going on involving an employee, the client was punched by a sudden and unanticipated action of the client and not at the invitation of the employee.

It is not possible at this time to conclusively establish what actually occurred in this incident except that, without a doubt, one client was punched in the groin by another client, and despite the fact that a nurse was summoned to examine the injured client, no entries were made in any records and no incident report was completed. There was no prompt investigation into this incident, nor was the employee involved in wrestling with the client counseled on appropriate interactions with clients.

The Alleged Employee Sexual Abuse Incident

The absence of incident reports and the inadequacy of investigations and corrective action was also found in the second incident reviewed by the Commission -- the alleged employee sexual abuse incident.

According to the complainant, in May 1980 she witnessed a male employee at the school put his hand down a female client's pants. She further indicated that she immediately reported the incident to her supervisor. In her response to this allegation, the School's Director stated that the male employee was "reported to be quite interested in the children in a suggestive, teasing way...he was immediately removed from child care and put under the constant supervision of the physical education teacher." The male employee left the school in July 1980.

According to the complainant's supervisor, the complainant did not report that the male employee touched a female client inappropriately. However, this supervisor stated that on a number of occasions staff reported to her that this employee encouraged a male client to masturbate and engage in "other light sexual acts." According to the Assistant Director for the School, she received reports from the nursing staff and the complainant's supervisor that this employee was holding male clients inappropriately on his lap, and after it was alleged that he touched a female client inappropriately he was transferred from the residential program to the school program to be afforded closer supervision.

In short, although her supervisor denied being informed of the complainant's allegations that the male employee touched a female client inappropriately, she was nevertheless aware that other serious allegations had been made by more than one staff person. Yet no incident reports were filed, nor was there a prompt investigation to determine if there was any truth to the allegations. The male employee was transferred to afford closer supervision by the facility.

It is not possible at this time to establish whether these incidents actually occurred a year and a half ago.

The Alleged Client Abuse Incident

The complainant informed the Commission that when she received a "Counseling Conduct Statement" for poor work performance on March 20, 1980, she prepared a written rebuttal in which she reported a number of allegations regarding sexual and verbal abuse of residents and poor medication practices. One of these incidents selected for review by the Commission involved a female employee who allegedly sexually abused a male client. The complainant indicated that she heard of this incident from an employee who alleged being a witness to the incident and who has since left the School.

The response to this specific allegation prepared by the School's Director for OMRDD indicated that when this and other allegations were received by the Director, supervision was increased and unscheduled visits were made by supervisory staff but no evidence of abuse was found.

The Commission's review, however, indicated that little was done to investigate this incident.

In interviews with Commission staff, the Director informed the Commission that when she received the written allegations in March she asked the complainant's supervisor to investigate the allegations, and that the supervisor reported that she could find no substance to the allegations. The supervisor informed Commission staff that she was not sure how definite the Director was in her request for an investigation; however, she believed that it was the Director's intention that they should be investigated. The supervisor also indicated that she did not report that the incidents did not occur or could not have occurred -- she regarded them to be "too small to be seriously considered except through closer supervision." The Commission found no

evidence that the allegations were investigated; in fact, the complainant's written statement was never kept in any School records. Rather, the Director kept the statement at her home because, as she told Commission staff, the statement contained negative remarks about the School, and the School had no file cabinet which would lock.

With regard to the specific incident involving the alleged abuse, the former employee who allegedly witnessed the incident denied any knowledge of it. To date, despite numerous requests, this former employee has not given the Commission a written statement denying or affirming any knowledge of the alleged incident.

B. Untoward Medical Incidents

The complainant's general concern in the area of medical care at the School was that staff are poorly trained in the areas of medication administration and the special needs of diabetic clients. As a result, according to her, potentially harmful incidents occur.

The School's response to this charge indicated that the allegation is not true and that there is no evidence to support the incidents cited as examples. To verify the School's findings, three specific medically related incidents were selected for review by the Commission:

* the hospitalization of a diabetic client;
* an insulin reaction incident; and
* a June 1980 medication error.

The Hospitalization of a Diabetic Client

Generally, the Commission's findings do not support the allegation that medically related incidents occur due to poor staff training. The hospitalization of a diabetic client illustrates this point. The complainant had questioned whether the client's hospitalization in early 1980

was necessitated by poor care or neglect. The Commission's review of the January 1980 hospitalization of this client, whose diabetes is very difficult to control, revealed findings consistent with those of the School's Director. It was found that the hospitalization was necessitated because of the client's hypoglycemia, and the care afforded her by School staff before the hospitalization, in the opinion of both Commission and hospital staff, was appropriate.

The Commission generally found no basis to question the adequacy of staff training in medication administration and care of diabetic clients -- in fact it was found that staff responded appropriately when problems arose in these areas.

The Insulin Reaction Incident

The insulin reaction incident exemplifies a lack of appropriate recordkeeping. The complainant claimed that on Thanksgiving Day 1979, an insulin-dependent diabetic client was taken to the home of a staff member for dinner. However, because he was upset, crying and refusing to eat, he was returned to the School at 1:30 p.m. The complainant claimed that as a result of not having been fed lunch at his usual time (i.e. 11:30 a.m.) and not having anything to eat for the next two hours, the client had an insulin reaction* soon after his return to the School.

The investigation by the Director of the School indicated that, as the client is a well controlled diabetic and as there was no documentation of an insulin reaction in the records, there was no evidence to support the incident described by the complainant.

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*Insulin reaction, or hypoglycemia, is manifested by varied symptoms including mood changes, anxiety, sweating and increased pulse rate. If left untreated it can lead to loss of consciousness and convulsions.

Written statements from the complainant, the staff member to whose home the client went and a School nurse received during the Commission's investigation, however, indicate that in fact on Thanksgiving Day 1979 both the complainant and the staff member appropriately treated the client for an insulin reaction upon the advice of the nurse. Furthermore, according to the statements received, they recorded their actions and the client's condition in the medical record. This record is unavailable. (The Director stated that at the time old notes were routinely summarized in a permanent record and then discharged; however, presently all notes and records are kept by the facility.)

The June 1980 Medication Error

A medication error of June 1980 further illustrates the appropriateness of staff actions yet the inadequacy of incident reporting and record keeping. According to the complainant, on June 21, 1980 two young and relatively new and inexperienced staff members were the only staff on duty and, in the process of distributing medications, confused the medications of two clients who were both on Mellaril, but on different dosages.

The investigation conducted by the School indicated that there was no substance to this incident as five staff were scheduled to be on duty on the day in question; nursing staff could not recall the incident; and no incident report was filed.

Initially, in interviews with Commission staff, both the School's nurses denied any knowledge of such an incident. In fact, upon reviewing time records it was found that neither of the staff members cited by the complainant were on duty on the evening in question. However, it was

found that for a brief period (9-10 p.m.) on June 21, 1980 two other staff members were the only staff assigned to be on duty.

In an interview with the only one of these two employees still on staff, she admitted that she had confused the medications of the two clients cited by the complainant. However, she indicated that upon realizing her error she, on a nurse's advice, took appropriate corrective action. She also indicated that she documented the error and corrective actions in a medical record which is no longer available.

However, it was also found that while a medication error similar to the one described by the complainant had occurred and was corrected, it could not have occurred on June 21 as cited by the complainant as one of the clients involved did not become a resident of the school until June 25, 1980.

Shortly after this interview, one of the nurses approached Commission staff and, indicating that she had talked with the employee who made the error after the Commission interview, revised her earlier statements and said that the medications of the two clients had been confused, that she was consulted, and that corrective action was taken immediately.

III. CONCLUSIONS AND RECOMMENDATIONS

Based on the Commission's investigation of these selected incidents, a number of conclusions can be drawn.

The Commission investigation indicates there existed evidence of sufficient credibility to warrant recording and investigation to determine whether client abuse had, in fact, occurred; that although some of these incidents were reported verbally to supervisors, no incident reports were filed nor is there any record of prompt investigations having been conducted; and that due to the passage of time, the absence of records, the conflicting and sometimes changing statements of witnesses, it is not now possible to conclusively determine whether the alleged abuse did, in fact, occur. It is also clear that the School has grossly inadequate incident reporting, investigation and review procedures and practices, and serious problems in record keeping.

The practice of staff engaging clients in wrestling, which is apparently not an uncommon occurrence, is highly inappropriate and bespeaks a serious deficiency in staff orientation, training and supervision in the performance of their duties.

Furthermore, the fact that supervisory and nursing personnel were aware of certain untoward incidents, and failed to fully investigate raises serious questions regarding the ability of these employees to provide direct care personnel the supervision and guidance they need. Despite reports of highly inappropriate sexual contact between a staff member and male and female residents, supervisory staff failed to respond to this situation with the sense of gravity it warranted.

While the Commission found no evidence to support the allegation that untoward medical incidents occurred as the result of poor staff training in the areas of medication

administration and the care of diabetic clients, it was found that certain medically related incidents described by the complainant and denied by the School's Director had indeed occurred -- a finding which further illustrates the inadequacy of the School's record keeping and incident reporting and investigative practices.

Additionally, on the basis of the Commission's findings, it can be concluded that when confronted with serious allegations regarding the quality of care provided the facility's residents, the School's Director's investigation was inadequate.

Finally, it must be concluded that, to the extent the Office of Mental Retardation and Developmental Disabilities accepted the investigative report prepared by the School's Director which omitted statements from individuals involved in the incidents, that Office failed to adequately fulfill its responsibility to oversee the operations of one of its licensed agencies.

In light of these findings, the Commission recommends that:

1. The Office of Mental Retardation and Developmental Disabilities should closely monitor the operations of this facility for a period of one year during which:
   A. the School's recruitment, orientation, training and supervision practices must be carefully reviewed to ensure that the staff employed by the School are sensitive to the needs of the clients they serve. It is particularly important that all staff are made to recognize and accept their duty to continually assure the welfare of the residents in all of their interactions with them;

B. a formalized incident reporting and investigation procedure must be put in place to assure that in the future allegations of client abuse or neglect will not be casually dismissed. We recommend that OMRDD closely review the filing and investigation of all incident reports during this period.

2. The Office of Mental Retardation and Developmental Disabilities should strengthen its monitoring of investigations by a licensed facility of serious allegations of client abuse or neglect, and pursue more vigorous independent investigations of such allegations where warranted.

[The Commissioner of OMRDD Responds:

I agree with each of your recommendations, and we have begun to implement them. Staff of the private schools unit as well as my Deputy for Quality Assurance have begun periodic visits to Pathfinder Village and have been directed to provide special attention to the school's recruitment, orientation, training and supervision practices and the need for Pathfinder to establish a formalized incident reporting and investigation procedure. We will closely review the filing and investigation of all incident reports during this one year period. We will also ask Pathfinder to report to us actions taken with respect to such incidents.

We have not and will not rely exclusively upon a licensed facility to investigate itself. Likewise, I am conducting a more extensive internal review of how my staff review similar allegations.]

[The Board of Directors of the School responds:

...[T]here is considerable disagreement with respect to both the Findings and Conclusions. We do, however, adopt and agree with your Recommendations, since we feel the closer contact with and assistance of both OMRDD and the Commission on Quality of Care can only further the achievements of our near and long-term goals for Otsego School.]

APPENDIX A

80-195

October 2, 1980

Mr. Donald Hanson
Deputy Director
Northern County Service Group
New York State Office of Mental
Retardation and Developmental Disabilities
44 Holland Avenue
Albany, New York 12229

Dear Mr. Hanson:

With regard to our recent telephone conversation concerning allegations made by about the care and treatment of residents at the Otsego School, enclosed please find:

- A March 30, 1980 statement by in which she cites several incidents of abuse; and

- A synopsis of the allegations based on an interview I had with on September 11, 1980.

Although is no longer an employee of the School and is upset over her termination she has identified former and present employees who, she states, witnessed some of the incidents and may be willing to be interviewed. In fact, a , who is currently employed at the school, was present during part of my interview with and supported many of her statements.

Your investigation and report of findings regarding these allegations would be greatly appreciated. If the Commission can be of any further assistance in this matter please do not hesitate to call.

Sincerely,

Thomas R. Harmon
Assistant Director
Quality Assurance Bureau

TRH/dlb
cc: C. Sundram
J. J. Harris
M. Shapiro
M. Wilbur
J. Samson
P. Stavis
G. Masline

Synopsis of

Allegations

I. Medication Practices

Allegation: Medications are dispensed and dietetic meals prepared by inexperienced staff. As a result incidents occur which negatively affect client care. Furthermore, incident reports on accidents such as medication errors are not completed.

Specific Incidents:

1. , who has no nurse's training, routinely administers insulin by injection.

2. On Thanksgiving Day, 1979, staff member brought , a diabetic client, home for dinner. Not knowing a diabetic's dietary needs, he was not fed lunch. The client did not want to eat dinner and within ten minutes after being brought back to the school had an insulin reaction. brought the client out of his semi-comatose state with an orange juice and sugar drink and documented the incident as well as her difficulty in notifying a nurse in the Log Book and Medical Book.

3. On a Sunday in March or April of 1980, , another diabetic, was brought to Basset Hospital in a coma. Is it possible that there was an overdose of insulin? Or was the coma induced by high blood sugar? states that the twice daily urine tests for sugar levels are not none on a consistent basis.

4. Two staff members, and who are seventeen years old and have no medication training, informed that on the weekend of June 21, 1980, as they were the only staff members on duty, they gave out medications. However they confused the medications of two residents who are on Mellaril and as a result one resident got twice his normal dose and the other half. When they notified the nurse ( ) she said to double the dose given to the resident who received the half dose. No incident reports filed. Residents involved and medications:

, 50 mg. Mellaril
25 mg. Mellaril

5. Staff member does not administer 's skin medication--"hydro cortisone."

6. Generally, staff on the evenings and weekends when there is no nursing coverage are afraid to administer meds as they have no training.

II. Physical and Psychological Abuse

Allegation: Certain staff routinely abuse clients and when such incidents are reported, nothing happens.

Specific Incidents:

1. , a client, was stabbed in the hand with a fork by . Although can't remember the date of the incident, this was one of the incidents reported verbally to , 's supervisor, on a Sunday in January.

2. Client has been sexually abused by on a number of occasions. These incidents have been witnessed by other staff and reported them verbally and in writing to her supervisor. One staff member who witnessed these incidents and has since resigned is .

3. has been involved in other incidents of physical and verbal abuse. In July, she held client on the floor and encouraged another client, to punch . was punched so hard in the scrotum that employee called a nurse to have him examined. In front of residents and staff alike, calls "scabby" because of his serious skin disease.

4. witnessed , an employee, with his hand down client 's pants and reported it to her supervisor in May, 1980. In July he was fired, for reasons unknown; however, he has since had residents stay overnight at his house.

5. --25 years old, made to stand in corners as punishment. Dragged upstairs on her back in May, 1980.

6. --slapped in face on a number of occasions by during March and April and witnessed by . Dragged by his feet on his back by a teacher whose last name can't remember but whose first name is . This incident was verbally reported by to her supervisor in April.

Clients in general are often slapped and pulled by the hair.

III. Termination

's allegation is that she was terminated because:

- She was unliked because she was an Italian from New York City. (The director of education, , once said this to her); and
- because she reported abuses.

was actually terminated for being found sleeping on the job on two occasions. This is what she was told; however she never received this in writing. She denies that she was sleeping and stated that she has heard that the two employees who found her sleeping, and , have admitted that they "framed" her at the request of the LPN, .

STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

44 HOLLAND AVENUE • ALBANY • NEW YORK • 12229

JAMES E. INTRONE
Commissioner

KEVIN M. TRAVIS
Deputy Commissioner
Division of Quality Assurance

November 19, 1980

Mr. Thomas R. Harmon
Assistant Director
Quality Assurance Bureau
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue
Albany, New York 12210

Dear Mr. Harmon:

We have investigated the allegations regarding Otsego School which were transmitted in your October 2 letter to Mr. Donald Hanson of our Northern County Service Group.

In our review of this case, OMR/DD recognized that we absolutely could not tolerate these serious allegations if they were in fact true. On the other hand, we were very sensitive to the fact that the publicity of a full scale investigation based on the allegations of a fired employee could have had a devastating impact on the School, the residents, the parents, the employees, and the entire rural community of Edmeston.

Mr. Hanson and Dr. Barbara Kenefick, who is responsible for the inspection of Residential Schools, inspected Otsego School on October 3 as part of the OMR/DD certification process for the new campus. They inspected records relating to the specific residents named in the allegations. We also asked the Director of Otsego School, to respond to all of the allegations presented in your letter. 's October 31 response to Mr. Hanson is attached. Under the circumstances we asked her to determine whether there was any basis in fact for each of the allegations.

We feel that has satisfactorily addressed each allegation and has in many cases taken or proposed actions which will provide increased assurance that such alleged incidents would not be likely to occur in the future. Our inspection of the records showed that the daily testing and medication of the three diabetic residents was carried out as required and we found no record of the alleged injuries.

Otsego School has served the mentally retarded for sixty years and, to our knowledge, this is the first time we have received any complaints or allegations regarding this facility. Otsego School has moved from its old facility to its newly-constructed Pathfinder Village campus. The staff of the Northern County Service Group has been working closely with this agency to assure that the new facility and the services provided to the mentally retarded are of the highest quality and meet all of the OMR/DD's standards. This close relationship will continue over the next two years as the next phases of the construction of the new campus are undertaken.

It is our opinion that the allegations presented are not substantiated by the facts. We are also confident that OMR/DD's close involvement with this agency during the development of its new campus will assure the continued high quality of care and service to all of the residents.

We appreciate the continued interest of the Commission in our mutual concern to provide every developmentally disabled individual in the State with the quantity and quality of services to meet all of his or her needs.

Sincerely,

Kevin M. Travis
Deputy Commissioner

Enclosure

cc: Mr. Schofield
Mr. Hanson

Pathfinder Village

.... that each life may find meaning.

Mrs. Marian Mullet, Director
Route 80, Box 31
Edmeston, New York 13335
Phone: 607-965-8377

October 31, 1980

Mr. Donald L. Hanson
Deputy Director
Northern County Service Group
44 Holland Avenue
Albany, New York 12229

Dear Mr. Hanson:

The allegations by concerning the care and treatment of residents at the Otsego School have been carefully reviewed by me.

I have interviewed the nurses (and). The transportation records, medical records, activity records and incident reports have been reviewed. In addition, I would like to state that I personally make unannounced visits to all residences and on all shifts. I was the nurse at Otsego School from 1963 until I became Director in 1976 so I am well acquainted with all residents and their needs.

During the past nine months I have worked with , Residential Supervisor and , Board member, in attempting to solve the problems was causing. We tried very hard to help become a good employee. Her continued failure to meet the standards of a child care worker resulted in her suspension in March 1980 and her dismissal on August 25, 1980.

Allegations

I. Medication Practices

Allegation: Medications are dispensed and dietetic meals prepared by inexperienced staff. As a result, incidents occur which negatively affect client care. Furthermore, incident reports on accidents such as medication are not completed.

Answer: Please note in service schedule which includes preparation of diabetic meals and diabetes. Also, note that the excellent presentations on diabetes by specialists have been taped. This tape is used for orientation purpose. The complete medical orientation outline is included.

Medication is dispensed by nurses or carefully trained staff. No one is allowed to give medication until he or she has been employed at least one month and has had medical supervision in giving medication.

Dietetic meals are prepared by trained staff.

To my knowledge all incident reports are filed.

Specific Incidents

1. who has had no nurses training routinely administers insulin.

Answer: , mother of a diabetic, has had careful training both by her doctor and by Otsego School nurses.

She does not routinely administer insulin. She has given insulin on the rare occasion when a nurse is unavailable.

Insulin is given to three diabetic residents once daily in the morning. Infrequently, on a Sunday morning, has given insulin when no nurse has been available.

2. On Thanksgiving Day, 1979, staff member brought , a diabetic client, home for dinner. Not knowing a diabetic's dietary needs, he was not fed lunch. The client did not want to eat dinner and within 10 minutes after being brought back to school, had an insulin reaction. brought the client out of his semi-comatose state with orange juice and sugar drink. The incident was documented as well as our difficulty in notifying a nurse in the log book and the medical book.

Answer: is well acquainted with diabetic dietary needs. She observes this every day and has had several in-service programs.

was taken home on Thanksgiving Day. is a shy and reticent boy. It soon became apparent that was unhappy among so many of 's family members. He refused to eat his lunch and started to cry. brought him back to School at 1:30 P.M.

There is no documentation that had an insulin reaction. He was glad to be home.

has a very easily controlled diabetic condition. He has never had either a coma or insulin reaction. vigorously participates in all athletics with no side effects. , Nurse, states that it is highly unlikely that could have had an insulin reaction.

3. On a Sunday, in March or April of 1980, , another diabetic was brought to Bassett Hospital in a coma. Is it possible that there was an overdose of insulin? Or was the coma induced by high blood sugar? states that the twice daily urine tests for sugar levels are not done on a consistent basis.

Answer: was not taken to Bassett Hospital in March or April in a coma. She was taken by ambulance on January 13, 1980, for hypoglycemia. Note transportation record. Also records from 2/11/80 to 6/2/80 show no such transportation. The letter to the parents is self-evident. suffers from many problems and she has enjoyed unusual good health because of the careful management of her difficult case. The hypoglycemia resulted from severe diarrhea which is subject to. She was not admitted to the hospital.

4. Two staff members, and who are 17 years old and have no medication training informed that on the weekend of June 21, 1980, as they were the only staff on duty, they gave out medication. However, they confused the medications of two residents who are on Mellaril and as a result one resident got twice his normal dose and the other half. When they notified the Nurse ( ) she said to double the dose given the resident who received the half dose. No incident report was filed.
50 mg. 25 mg.

Answer: Every one who gives medication must have supervision and training before they are given this responsibility.

There were five people scheduled for that shift. It is highly unlikely that only two people could have been on duty.

No incident report was filed. It should have been if the incident happened.

was taken off Mellaril in July due to his very dramatic improvement after a month at Otsego School.

5. Staff member does not administer 's skin medication "hydro cortisone."

Answer: contradicts herself. See page 1 of hand written allegations.

6. Generally staff on the evenings and weekends when there is no nursing coverage are afraid to administer meds as they have no training.

Answer: I have found no evidence that staff are afraid to give medications. Excellent staff training is given by the nurses.

II. Physical and Psychological Abuse

Allegation: Certain staff routinely abuse clients and when such incidents are reported, nothing happens.

Specific Incidents

1. , a client, was stabbed in the hand with a fork by . This was one of the incidents reported verbally to 's supervisor on a Sunday in January.

Answer: No support for this allegation has been found. follows up on all complaints. No evidence of stabbing was seen nor reported on the medical records.

2. Client, ,has been sexually abused by on a number of occasions. These incidents have been witnessed by other staff and reported them verbally and in writing to her supervisor. One staff member who witnessed these incidents and has since resigned was

Answer: The alleged sexual abuse was reported to in a written report on March 20, 1980, in response to the two week suspension of

and I both supervised and made unscheduled visits and found no evidence of abuse. I did find outside of the building on one occasion when she should have been working.

3. has been involved in other incidents of physical and verbal abuse. In July she held client on the floor and encouraged , another client, to punch . was punched so hard in the scrotum that employee called a nurse to have him examined.

Answer: The nurses do not recall this incident. It is not recorded anywhere in the records. never showed any evidence of pain or swelling. I can find no confirmation to substantiate this allegation.

calls "scabby" because of his skin condition.

I can not get information to substantiate this accusation.

4. witnessed , an employee, with his hand down 's pants and reported it to her supervisor in May, 1980. In July, he was fired for reasons unknown; however, he has since had residents stay at his house.

Answer: , a CETA employee, was reported to be quite interested in the children in a suggestive, teasing way. He was immediately removed from child care. His CETA advisor was called to discuss a change in his position.

It was decided to put under the constant supervision of the physical education teacher. He worked with her as an aide. He did a good job and no untoward incidents occurred. His CETA work period ended in July and he left.

No residents have ever stayed in his home. Complete, signed activity forms are kept by Otsego School.

5. - 25 years old, made to stand in a corner as punishment. Dragged upstairs on her back May 1980.

Answer: I find no evidence to support this allegation. is sometimes sent to her room as punishment. This rarely is necessary.

6. - slapped in face on a number of occasions by during March and April and witnessed by . Dragged by his feet by ( ), a teacher. This incident was verbally reported by to her supervisor in April.

Answer: I find no evidence to support the slapping allegation.

could not possibly drag by his feet anywhere. He is very strong and bigger than she. was one of our most respected teachers and did exemplary work in the school program. She left to get married.

Client slapping and hair pulling are against all rules. I find no evidence of this occurring. Our residents "tell all" and they have not complained of this type of action.

's Handwritten Allegations

1. Name calling of residents:

Answer - I have been unable to determine whether or not this is true.

2. Incident regarding :

Answer - This was reported on March 20, 1980, as previously detailed. Increased supervision and unscheduled visits did not reveal any untoward incidents or abuse.

3. Medication given improperly:

Answer - I have investigated all records and find no evidence to support the allegation.

The accused employee has worked for Otsego School since 1977. She has unusual rapport with the most difficult residents. In fact, she has coincidentally recently been moved to an all girl house because of her ability to guide difficult youngsters. Since she has been scheduled in that house it has become quiet and serene. The children's behavior has improved dramatically.

will continue to be supervised with special care.

Conclusion

It should be pointed out that the move from two old victorian buildings to 7 beautiful homes has markedly improved the quality of life for all residents.

Individual homes with 24-hour staffing under ideal circumstances has made Otsego School a resident's dream.

In order to assure continued resident safety and happiness, I have hired an additional supervisor on the evening shift. The nurses have been advised to give all insulin injections.

We are in the process of increasing staff training and unscheduled inspections. The rights of the residents will be stressed. Monitoring of the care of the residents will be increased.

I have investigated the allegations to the best of my ability and I am satisfied that there is no evidence of abuse at Otsego School. Continued careful supervision will be stressed.

Sincerely,

Director

Norwich-Eaton Pharmaceuticals

B. J. Schulte
Associate General Counsel

October 1, 1981

Mr. Clarence J. Sundram, Chairman
New York State Commission on Quality
of Care for the Mentally Disabled
99 Washington Avenue, Suite 730
Albany, New York 12210

Re: Investigative Report - Otsego School (Pathfinder Village)

Dear Mr. Sundram:

Attached is the Response on behalf of the Board of Directors of the Otsego School to the proposed final Report of the Commission on Quality of Care. We appreciate the cooperation by you and your staff in allowing us this opportunity for response.

We trust that you will find the attached Response to be accurate and responsive to your proposed final Report even though there is considerable disagreement with respect to both the Findings and Conclusions. We do, however, adopt and agree with your Recommendations, since we feel the closer contact with and assistance of both OMRDD and the Commission on Quality of Care can only further the achievement of our near and long-term goals for Otsego School.

Respectfully submitted,

By _____
B. J. Schulte
Member of the Board of Directors
Otsego School

BJS/mr
Attachment
cc: Board of Directors - Otsego School
Mrs. Marian Mullet - Director
Jeffrey Sherrin, Esq.

BOARD OF DIRECTORS RESPONSE

INVESTIGATIVE REPORT - COMMISSION ON QUALITY OF CARE

Each member of the Board of Directors of the Otsego School (Pathfinder Village) has received a copy of the proposed final report of the Commission on Quality of Care following their investigation into various allegations, by a former employee, of client abuse at Otsego School (Pathfinder Village), and each member of the Board of Directors joins in this response to the proposed final report of the Commission.

INTRODUCTION

It is important that the Commission fully understand that all members of the Board of Directors of the Otsego School, a not-for-profit corporation, have been giving their time and talents with the goal of building Pathfinder Village at Otsego School into the foremost care facility in the United States for both children and adults afflicted with Down's Syndrome. As characterized in Section 1, Introduction, of your report, the staff of the Otsego School with the full support and assistance of the Board of Directors has, through the generosity of the parents, charitable foundations and through individual contributions, successfully relocated the school to provide an attractive and versatile campus setting consisting of 7 Colonial residences, a school, and a planned meeting hall and vocational facilities. At present, the meeting hall, which will also provide dining facilities, is under construction and hopefully construction of the vocational buildings will begin next year. It is estimated that the total construction cost and furnishings for Pathfinder Village when fully completed will total approximately $3,000,000, and the construction of an 8th Colonial style residence to follow the vocational buildings is now in the early planning stages.

First and foremost in our plans, however, is not only to provide the residents with the very best in residential and instructional facilities, but to provide the very best quality of care available in the United States by trying

to duplicate as much as possible the life style available to the more fortunate children and young adults in upstate New York who have not been afflicted with Down's Syndrome or other mental or physical disabilities.

Publication of the proposed investigative report can only result in jeopardizing the goals which the staff and the Board of Directors hope to realize for Pathfinder Village in the near future.

Nature of Investigation

The Commission's investigation into the Otsego School was initiated in August of 1980 as a result of allegations filed by a former employee on the abuse of clients by members of the Otsego School staff. The report as currently drafted does not make it clear that the former employee alleging abuse of clients was terminated by the school for cause, i.e. sleeping on duty, nor the fact that she had been previously terminated by other institutions for cause, nor the fact that a closer investigation of the complainant would reveal a history of filing complaints and charges which were, at best, not supported by the evidence. Further, the report does not characterize the fact that the complainant upon termination by Otsego School had threatened to do everything in her power to see the school closed as revenge for what she considered to be an unjustified termination, and that it was only at this point that she proceeded to draft and submit formal instances of so-called client abuse at Otsego School.

Under these circumstances, it should be obvious that some restraint should have been exercised by the school's administrative staff in investigating the allegations, since confronting residents and staff with unsbustantiated and revenge oriented allegations could do more damage than good. Thus, the Director faced with this problem did attempt to investigate the allegations in such a manner as to prevent these unsubstantiated allegations from becoming a major

problem for both residents and staff, especially at a time that the move into the new facilities at Pathfinder Village was taking place. The Board feels certain that had allegations even halfway approaching the seriousness of the allegations lodged by the complainant been lodged by a less biased or prejudiced complainant that a more thorough investigation and confrontation of the employees and residents would have occurred.

The Commission's Findings

As stated in the Commission's report, the purpose of the Commission's investigation was to do an in-depth review of 6 of the allegations in order to verify Pathfinder Village's original investigation and report to OMRDD relative to the charges of abuse. The 6 instances of alleged abuse selected by the Committee for review were:

a. a "wrestling" incident,

b. an employee sexual abuse incident, and

c. a client abuse incident;

plus 3 alleged abuses of clients in the area of medical care:

d. hospitalization of a diabetic client,

e. an insulin reaction incident, and

f. a June 1980 medication error.

An independent review of these allegations with the Director and her staff by the Board assisted by outside counsel appointed by the Board leads the Board to the conclusion that certain findings of the Commission, as well as the characterization of these findings, are not supported by the evidence. Granted there is evidence which indicates that 5 of the above 6 alleged incidents did occur at the school, but under circumstances and in a manner which would certainly cast doubt as to whether the incidents were of such character as to be written up as client abuse and formally characterized as "so-called incidents".

a. Wrestling Incident

Our review of this so-called incident would lead one to question

whether or not its characterization as a "wrestling incident" is appropriate. After interviewing various members of the staff, the so-called "wrestling incident" might be better characterized as the type of "horseplay" often engaged in by parents with both male and female offspring, usually initiated by one or the other proceeding to hug or tickle the other as a display of warmth and concern. Apparently, a female employee of the school with no abusive or harmful intent did engage in such physical contact with a male client which was promptly joined in by another male client at the point where the employee begged off due to back pain. This "horseplay" was promptly terminated between the two male clients, however, when one of the clients suddenly without anticipation punched the other client in the groin. The client was immediately examined to determine if any injury resulted, and it was determined that no apparent groin injury did result. Employees have been counseled to refrain from any actions of the sort which could be interpreted as "wrestling with clients", but at the same time both the staff and the Board would like to foster a sense of true friendship and concern on the part of the employees for the physical and mental well/being of the residents. Thus, the Board feels that the Commission's report should delete any characterization of this so-called incident as "wrestling" and select a more appropriate and descriptive term. Further, it was established that no groin injury did occur and this statement should also be deleted from the findings.

b. Employee Sexual Abuse Incident

Our review of this allegation indicates that the former employee never reported the alleged incident until after her termination and some four months after the employee allegedly involved had left the facility. In our opinion, both the Commission's as well as our investigation of this

alleged incident establishes only that there were remarks and gossip relative to a specific employee and that the staff acted appropriately by transferring the employee from residential care to the school where his interaction with the residents could be closely monitored. We are sure that the Commission must realize that, in this day and age, an employer is at risk in terminating an employee without justifiable cause. Thus, the Board feels that this section of the Report should be redrafted to more accurately reflect the facts and delete the misleading and inflammatory title "employee sexual abuse incident" as well as the implication that the staff did not react appropriately.

c. Client Abuse Incident

Our review as well as the Commission's investigation of this incident indicates that a former employee (other than complainant), who presumably witnessed this incident, has verbally denied any knowledge of the incident. Yet, the Commission's findings seem to assume that it did occur because the former employee, who obviously doesn't want to become more involved, has refused to file a written denial. The Commission's findings then go on to criticize the staff and school for failure to increase supervision, etc., when in fact additional supervision was added at this point in time. Accordingly, the Board requests that this whole section of the Report be deleted and the allegation be correctly responded to on the basis that any knowledge of the incident was denied by the one and only former employee who reportedly witnessed the incident. To do otherwise indicates bias on the part of the Commission against the school and its staff and implies the allegation to be true in the face of an oral denial by the only witness.

d., e. and f. The Three Incidents of Alleged Improper Medical Care

Our review of the three alleged incidents of improper medical care does

generally coincide with the Commission's findings, i.e. that "Generally, the Commission's findings do not support the allegation that medically related incidents occur due to poor staff training". The Board and staff has noted the Commission's constructive criticism relative to the maintenance of medical records and has already instituted programs to improve its overall incident reporting, record keeping and investigative system.

Conclusions and Recommendations

The Board based upon its review does take strong exception to the statements in the Commission's Conclusions and Recommendations which question the competency of the school's Director and imply that the supervision staff and nursing personnel callously failed to investigate or take appropriate action with respect to rumored incidents of abuse of residents by employees. We believe that given all the facts, plus the vindictive, revengeful and often inaccurate source of the allegations, that the staff did act responsibly and did initiate corrective action purely on the chance that there might be any truth to what, at best, can be characterized as rumor and gossip.

The Board, despite its challenge to certain of the Commission's Findings and Conclusions, does adopt and endorse the Commission's Recommendations. The Board and the staff would appreciate the close review and assistance of the Office of Mental Retardation and Developmental Disabilities (OMRDD) in the recruitment, orientation and training of its employees and in the finalization of an improved formalized incident reporting and investigative procedure. The Board feels that this close monitoring on the part of OMRDD, if carried out in a spirit of cooperation, can only help the school in achieving our goals as previously set forth in this response.

Requests of the Board

The Board respectfully requests that; a) the Commission's Final Report be modified as suggested in both this response and by the school's Counsel in his

letter to the Commission's Chairman, Clarence J. Sundram, dated September 15, 1981, b) that the report as finalized be retained by the Commission as a confidential investigative report between the Commission, OMRDD and the school, c) that in the event it is the decision of the Commission that the Report should be made public that the school, its Board and Counsel, be given ample advance notice of said decision, d) that the proposed inclusion of Appendix A, Synopsis of Allegations, be deleted from the final Report in view of the source of the allegations and the prejudice that might result, and e) that should this Report be published that a copy of this, the Board's Response, be attached together with Counsel's criticism.

The Board in conclusion wishes to express its thanks to the Commission for giving us this opportunity to respond to the Report and the additional time that this Response warranted and required.

The Board of Directors
Otsego School

By _____
B. J. Schulte
Member of the Board

October 1, 1981