Life and Death at New Queen Esther Home for Adults

A Report

by the

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

and the

Mental Hygiene Medical Review Board

Life and Death at New Queen Esther Home for Adults

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NYS COMMISSION
ON QUALITY OF CARE
FOR THE MENTALLY DISABLED

Preface

Adult homes - congregate care facilities certified by the State Department of Social Services - have assumed a major role in New York State's efforts to reduce the census of State psychiatric hospitals. Today, approximately 10,000 individuals with mental illness, many former patients of psychiatric hospitals, reside in adult homes. And, in the near future, given the projected census reductions in State psychiatric centers, more persons with serious and persistent mental illness will reside in adult homes than in psychiatric centers.

This report provides a snapshot of conditions in one adult home - the 47-bed New Queen Esther Home for Adults - where, in October 1992, a frail, elderly, mentally ill woman was assaulted by another resident and subsequently died. Her death was ruled a homicide and the Commission's investigation into the death revealed serious problems affecting the safety and well-being of the residents. These included:

- The facility operator's inability to provide appropriate staff supervision of residents or to ensure that their needs for safe shelter and assistance in daily living were met;
- The discharge from State psychiatric hospitals of patients whose behaviors and needs the adult home was ill-equipped to appropriately address;
- Inadequate on-site mental health services which failed to meet the needs of residents, and whose staff turned a blind eye to the filth, idleness, and aberrant, even dangerous, behaviors which had become part of the residents' daily lives; and,
- The continued retention of residents in the adult home whose clinical states and unmet service needs led to acting out, assaultive behaviors, and chaotic conditions necessitating frequent calls for police intervention.

While the snapshot of conditions found was appalling, the larger picture is even more troubling. Since 1980, the New Queen Esther facility has received noncompliance ratings during 14 complete certification inspections conducted by the Department of Social Services. Its conditions were among the poorest found during the Commission's statewide study of 47 adult homes.[1] The report of the Commission's study prompted innumerable meetings between staff of the Department of Social Services and Office of Mental Health to determine ways to address the problematic conditions found at the New Queen Esther facility and other adult homes like it; and promises of corrective actions and vigilant follow up were issued by facility operators and State oversight agencies.

Yet conditions at New Queen Esther remain unchanged. As indicated by the Commission's site visits and investigation into the homicide, as well as a recent Department of Social Services inspection which revealed 135 violations of State regulatory standards, New Queen Esther Home for Adults continues to be a filthy, dehumanizing and unsafe place to live.

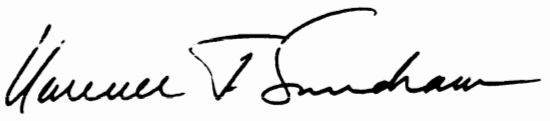
[1] *Adult Homes Serving Residents with Mental Illness: A Study of Conditions, Services, and Regulation* (Commission on Quality of Care for the Mentally Disabled; October 1990).

Appended to this report are responses to the Commission's findings from the Department of Social Services and the Office of Mental Health. Again, the promises of action are voiced. But if past performance is any reliable predictor of future accomplishments, there is little cause for optimism.

The residents of New Queen Esther, and other troubled adult homes like it, deserve more. As the State continues to reduce the census of its psychiatric hospitals, which have long offered asylum to needy and dependent persons, by discharging patients to adult homes, it has an obligation to ensure their safety is protected and basic needs met.

With this report, the Commission takes the opportunity to again urge the Department of Social Services and the Office of Mental Health to take action to implement the recommendations of its 1989 study and create models of adult home care appropriate to the needs of mentally ill persons, revamp the mental health services available to residents of such homes, and establish oversight and enforcement mechanisms which focus, first and foremost, on ensuring the quality of residents' lives, and which use the available tools to swiftly remedy or eradicate conditions which compromise that objective.

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



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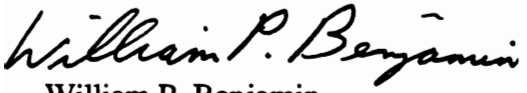

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Introduction

On October 12, 1992, Serina Williams[1] - a resident of New Queen Esther Home for Adults in Queens, New York who was an outpatient of Creedmoor Psychiatric Center which offers on-site mental health services in the residence - assaulted and critically injured Marianne Burns, a fellow resident of the home who received on-site mental health services from the New Hope Guild Centers. Ms. Burns sustained numerous injuries - including multiple fractures, partially collapsed lungs and intra-cerebral bleeding. She was rushed to a hospital where she died on January 20, 1993 of a myocardial infarction; her death was classified a homicide.

On October 12, 1992, Serina Williams - a resident of New Queen Esther Home for Adults - assaulted and critically injured Marianne Burns, a fellow resident of the home.

The incident, and the subsequent death of Ms. Burns, were reported to the Commission as was an allegation by Kevin Smythe, Ms. Burns' therapist with New Hope Guild Centers, concerning staffing at the time of the incident. According to Mr. Smythe, no residence staff were available when he entered the facility just moments after the October 12, 1992 assault occurred.

Pursuant to Article 45 of Mental Hygiene Law, the Commission commenced an investigation into the events of October 12.

During the investigation, Commission staff conducted more than 25 interviews with New Queen Esther staff and residents; staff of the on-site mental health teams, Creedmoor Psychiatric Center and New Hope Guild Centers, including the therapist who raised the allegation concerning staffing; Department of Social Services staff who investigated the incident; and police officers who responded to the scene of the assault.

Ms. Burns was rushed to a hospital where she died on January 20, 1993; her death was classified a homicide.

Commission staff also reviewed the mental health treatment histories of Ms. Burns and Ms. Williams; various residence records, including medication administration records, the home's communication logbook, staffing schedules and payroll records; police and ambulance reports; and the Department of Social Services' inspection and investigation reports.

Finally, in March 1993, Commission staff toured the New Queen Esther Home for Adults. Commission staff also briefly visited the New Seville Home for Adults in Queens, New York, which is operated by the same individual who operates New Queen Esther, as certain records relevant to the investigation were housed at that facility.

[1] The names of all individuals in this report are pseudonyms.

Findings

Background

Marianne Burns was an 83-year-old, high functioning, but thin and frail, mentally ill woman who had lived in New Queen Esther for approximately 14 years after she was hospitalized for depression following the death of her husband. She carried a diagnosis of Dysthymic Disorder and received mental health services from the New Hope Guild Centers. According to staff and residents, Ms. Burns was very independent, well-liked and often volunteered to assist staff in their chores.

Marianne Burns was an 83-year-old, thin and frail, mentally ill woman who had lived in New Queen Esther for approximately 14 years.

Serina Williams was a 60-year-old woman who was discharged to New Queen Esther from Manhattan Psychiatric Center in October 1991 after having lived in mental hygiene institutions for more than 40 years. Ms. Williams carried a diagnosis of Chronic Undifferentiated Schizophrenia. During her decades of continuous hospitalization, Ms. Williams was described as mute and withdrawn, having a poor attention span and requiring assistance in daily living activities. She was also described as unable to sustain 20 hours a week of active programming and, when she did attend programs, was passive and not fully aware of what was going on around her most of the time.

Serina Williams was discharged to New Queen Esther in October 1991 after having lived in mental hygiene institutions for more than 40 years.

In September 1991, Ms. Williams' inpatient team determined that in order to meet discharge criteria, she would have to become "verbal enough to make her needs known by using words and not gestures." Yet, the next month, she was discharged to New Queen Esther where she was linked with Creedmoor Psychiatric Center's on-site mental health team for outpatient services.

According to outpatient staff and records, while at New Queen Esther, Ms. Williams remained mute, never spoke and was very regressed. Staff reported that she was cared for largely by her roommate, who would wake her in the mornings and - using verbal and physical prompts - instruct her to wash, dress and go downstairs for the day. Ms. Williams would spend her days sitting in the lobby or pacing the halls. She was not allowed to go outside alone, lest she get lost, and, reportedly, a resident sitting near the front door would alert staff, who would intervene, if Ms. Williams wandered out. On occasion, however, Ms. Williams did leave the premises and became lost.

While at New Queen Esther, Ms. Williams remained mute, never spoke and was very regressed.

As Ms. Williams had difficulty negotiating stairs, and did not know how to use the elevator, her roommate or a staff person would take her to her room at night-time. Staff reported that unless Ms. Williams received this level of assistance, usually provided by her roommate, she could not have survived in the home - if not prompted to get up in the morning, she would have stayed in bed all day; if not escorted to her bedroom, she would have stayed all night in the lobby or the elevator, not knowing which button to push; and, staff surmised, if someone yelled "fire," she would either not respond or not know what to do, and would require assistance to vacate the residence.

As extremely regressed as Ms. Williams was, there was no evidence that she was violent in the residence; and during the nearly one year that Ms. Burns and Ms. Williams resided together in New Queen Esther, neither was involved in any incident which would have presaged the events of October 12, 1992 - until the afternoon of October 11.

Neither was involved in any incident which would have presaged the events of October 12, 1992 - until the afternoon of October 11.

Significant Events, October 11 - 12, 1992

On the afternoon of October 11, the normally docile Ms. Williams was observed by staff hurting other residents. She pulled one resident's ear, then hit another with a coffee cup. According to a staff witness, Ms. Jones, these incidents seemed unprovoked and Ms. Williams stopped when requested to do so.

Ms. Jones called the home's operator who was working at the New Seville at the time, and reported the incidents. The operator gave no specific instructions other than to check whether Ms. Williams had received her medication, which she had. According to all interviewed, it is standard operating procedure to call 911 - to trigger police intervention and possible hospitalization - when residents act out dangerously. Ms. Jones stated that she did not call 911 because she did not believe Ms. Williams' actions were all that serious and there were no further incidents during the shift. Ms. Jones, however, noted the incidents in the logbook with a request: "please do something about her (Ms. Williams) before she hurts someone seriously."

On the afternoon of October 11, Ms. Williams was observed by staff hurting other residents.

During the next shift, residents reported to staff that Ms. Williams punched Ms. Burns in the eye, which staff noticed was discolored. As the operator had left the New Seville by this time and could not be contacted, due to his observance of a religious holiday, a staff member, Ms. Keegan, called Ms. Jones, who had worked the previous shift and was now working at the New Seville.

Upon interview, Ms. Jones reported telling Ms. Keegan to have Ms. Williams taken to the hospital. However, Ms. Keegan, in her interview, reported considering calling 911, but for Ms. Burns, not for Ms. Williams as Ms. Jones had advised. She reported that she encouraged Ms. Burns to keep a cold compress on the eye (which was a little red) and asked her several times if she wanted to go to the hospital for treatment of her injury, but Ms. Burns declined. Ms. Keegan stated that she refrained from calling 911 as it would have been fruitless to call on behalf of Ms. Burns who had only a minor injury and was refusing medical attention/hospitalization. Apparently, Ms. Keegan misunderstood Ms. Jones' instruction.

Ms. Jones noted the incidents in the logbook with a request: "please do something about her (Ms. Williams) before she hurts someone seriously."

According to Ms. Keegan, she escorted Ms. Williams to bed, and the night passed without further incident, as did the next morning, according to Ms. Brewer, who worked the 7 - 11 am shift.

Interviewees, staff schedules and payroll records confirmed that at approximately 11:00 am on October 12, Ms. King reported to work and relieved Ms. Brewer. According to Ms. King, this was her first day working as a direct care staff person at New Queen Esther; she had worked for a number of years at a different adult home as a cook, but lost

that job when the home closed. Also on duty at the time were four other staff assigned to support service tasks: housekeeping, maintenance, food service, etc. The primary language of these support staff was Polish and none spoke fluent English, thus compromising their ability to effectively communicate with residents or assist Ms. King.

During her interview, Ms. King expressed concern that she alone was responsible for the supervision of the more than 40 residents of the home. (New Queen Esther is a 47-bed facility; Department of Social Services regulations require a minimum of two staff, 24 hours a day, for the supervision of residents in facilities with between 41 and 80 residents.)

About one and a half hours into Ms. King's first day of direct care work, resident screams alerted her to a crisis. Ms. King turned and saw Ms. Burns lying on the lobby floor - bleeding from the head.

Upon arrival at the facility, Ms. King did not read the logbook depicting the prior day's events. She reported that her more immediate tasks were supervising the mid-day meal and dispensing residents' medications. This she did from a desk located in the dining room.

The dining room is adjacent to the lobby/sitting room and the position of the desk allows for visualization of both rooms, if one stands and turns around. However, paper notes posted on a plexiglass window mounted on the desk blocked a complete view of the lobby area for anyone sitting at the desk; from certain vantage points in the lobby, a person would not readily see someone sitting at the desk because of the papers affixed to the plexiglass.

At approximately 12:20 pm, about one and a half hours into Ms. King's first day of direct care work, resident screams alerted her to a crisis. Stationed at the desk dispensing medications, Ms. King turned and saw Ms. Burns lying on the lobby floor - just paces away from the desk - bleeding from the head. Ms. Williams was seen walking away from where Ms. Burns lay. Ms. King did not witness what had happened to Ms. Burns but reported she had seen Ms. Burns just moments earlier when Ms. Burns took a drink from the water fountain and began walking into the lobby. The water fountain is located in the dining area, one pace from the desk, near the entrance to the lobby.

Ms. King expressed concern that she alone was responsible for the supervision of the more than 40 residents of the home.

Several residents confirmed Ms. King's position/location at the time and two residents reported witnessing what happened to Ms. Burns. According to these residents, as Ms. Burns was walking from the desk area she bumped into Ms. Williams who, with no warning, "threw" or "shoved" Ms. Burns to the lobby floor.

Ms. King reported that upon seeing Ms. Burns she called 911, tended to Ms. Burns who was vomiting by turning her on her side, and stayed with her until EMS arrived. When EMS responded, at 12:25 pm according to their records, Ms. King returned to the desk to gather information needed by the paramedics. This was confirmed by residents. Police, who arrived several minutes later, also reported finding Ms. King at the desk, but couldn't recall whether she was standing or sitting.

Although Ms. King indicated that she was in control of the situation, statements of other witnesses suggest otherwise. One resident, Ms. Andrews, indicated that she told Ms. King to call 911. Ms. Andrews also stated that she had to get another resident, Ms. Owens, to help Ms. King locate the paperwork needed to send Ms. Burns to the hospital.

A police officer, who arrived after EMS, described the lobby scene as a state of confusion with clients milling about and no responsible person appearing to be in charge. The officer stated that "it didn't look like anyone was in charge...there was a lot of chaos...everyone was walking around...no one wanted to say they were in charge." Eventually, the officer was introduced to Ms. King who, he said, was at the desk in the dining room. According to the officer, "it didn't look like she was in charge, it looked like she couldn't handle something like this."

A police officer, who arrived after EMS, described the scene as a state of confusion, "it didn't look like anyone was in charge...there was a lot of chaos... everyone was walking around...no one wanted to say they were in charge."

At some point, one of the residents, Ms. Owens, called an off-duty staff person, Ms. Brewer, who lives across the street. Ms. Brewer responded to the scene, arriving after the police. Ms. Brewer called Ms. Jones, who was working at the New Seville, five blocks away. Ms. Jones reported that she ran to New Queen Esther, entered and had to push Ms. King, who appeared nervous, away from the desk in order to gain access to the phone to call the facility's operator and complete the paperwork needed by EMS. Ms. Jones also recorded the incident in the home's logbook.

Concerning the whereabouts of the four support staff, it appears, based on interviews conducted by the Department of Social Services with the aid of an interpreter, that two were on other floors of the residence and did not witness any part of the incident. The other two - the maintenance man and a dishwasher/waitress - became aware of the incident after it occurred and EMS and police were on the scene; they reported seeing Ms. Burns on the floor. By all accounts, it does not appear that either of these staff played a role in attempting to manage the crisis.

At approximately 1:00 pm, Ms. Burns was taken to a hospital, where she died three months later. Ms. Williams was taken by police, in handcuffs, for a psychiatric evaluation and was readmitted to the unit at Manhattan Psychiatric Center where she had lived for 20 years. According to the police, while they were at the scene Ms. Williams sat calmly in a chair and appeared "to have no idea what was going on...she couldn't give you a name...you couldn't even talk with her."

Ms. Williams was taken by police, in handcuffs, for a psychiatric evaluation and was readmitted to the unit at Manhattan Psychiatric Center where she had lived for 20 years.

Kevin Smythe's Observations/Actions

Upon interview, Mr. Smythe, Ms. Burns' therapist with New Hope Guild Centers, indicated that he arrived at New Queen Esther on the day of the incident shortly after EMS personnel, whom he had seen enter the facility as he was parking his car, and before the police arrived. Upon entering the facility lobby, Mr. Smythe saw Ms. Burns in a pool of blood on the floor being assisted by EMS. He saw no adult home staff whom he recognized and when he asked what occurred, two residents, Ms. Owens and Ms. Andrews, told him that Ms. Burns had been assaulted by Ms. Williams. Police arrived shortly after Mr. Smythe, and the two residents spoke with them, recounting what they had told Mr. Smythe. It was Mr. Smythe's impression that these two residents were in charge. During the Commission interview, Mr. Smythe stated that he did not ask about the whereabouts of staff; nor did he go into in the dining area or look to see if anyone was at the desk.

After being assured by EMS and police officials that Ms. Burns would be brought to the hospital and that Ms. Williams would be removed from the home, Mr. Smythe went to his office on the third floor, as he had an appointment to keep. Later that afternoon, Mr. Smythe met privately with Ms. Owens and Ms. Andrews to allow them to "process their feelings" over the incident. He left the facility after 2:00 pm without making any further inquiries about whether staff were present.

Other Observations

Conditions in the Home

Many of the areas, including resident rooms, the lobby and laundry area, were either dirty or malodorous. Some common areas, as well as bedrooms, smelled of urine, indicating the presence of incontinent residents and at least one resident was observed in urine-soaked pants.

During the Commission staff's March 1993 tour of New Queen Esther, it was noted that many of the areas, including resident rooms, the lobby and laundry area, were either dirty or malodorous. Some common areas, as well as bedrooms, smelled of urine, indicating the presence of incontinent residents and at least one resident was observed in urine-soaked pants. A number of the residents had very strong body odors and appeared in need of bathing. The clothing of many was either dirty, mismatched, ill-fitting or torn. Some residents were not wearing shoes and walked around in their socks. The laundry room had piles of dirty clothes nearly three feet high on the floor, and the clothing supply room, which the operator showed off with pride, was stocked with piles of shoes in no particular order and rows of clothes which appeared to be old "hand-me-downs"; most appeared dirty and had an odor.

It was also noted that less than half of the facility's more than 40 residents attend outside day programs, leaving the remaining residents behind. It appeared that these residents have little to do during the day to hold their interest. Many residents were observed in their rooms, some in bed, or sitting idly in the lobby. Two residents in particular stood out, Ms. Lions and Mr. Lucas. Both were physically disabled, by stroke or blindness, and spent most of their days in their rooms or in bed; it was questionable whether they could safely evacuate the residence in the event of an emergency.

A review of the facility's logbook revealed numerous incidents of residents' acting out, engaging in inappropriate and at times dangerous behaviors, calls to police for assistance and staff pleading, to the effect of: "please do something about this resident." A reading of the logbook leaves one with the impression of a facility out-of-control, an impression echoed by one police officer interviewed.

During the nearly two full days on-site, Commission staff observed only three structured activity programs being offered. One was a religious program offered the second morning of the visit by a volunteer from a local church; it attracted three to four residents. The other sessions were offered each afternoon of the visit by the home's activity staff person and involved table-top activities such as bingo, coloring in children's coloring books, making decorations for St. Patrick's Day and a game of pick up sticks; no more than 10 residents attended each day's session.

While Commission staff observed no untoward incidents during their visit, a review of the facility's logbook revealed numerous incidents of residents' acting out, engaging in inappropriate and at times dangerous behaviors, calls to police for assistance and staff pleading, to the effect of: "please do something about this resident." A reading of the logbook

leaves one with the impression of a facility out-of-control, an impression echoed by one police officer interviewed, who indicated that he has received numerous calls to respond to the residence for client fights, disputes, elopements, etc. The police officer reported his belief that the residents are not appropriately supervised and that all staff do is "sit behind the desk" and call 911 when the situation gets out of hand.

The conditions in the home mirrored those found by the Commission during its 1989 study of adult homes serving a preponderance of residents with mental illness. During that study, the Commission made unannounced site visits to 47 adult homes across the State. New Queen Esther was one of the homes visited and was found to have serious problems in all areas reviewed; the facility was rated as one of the poorest homes in the Commission's sample.[2]

The facility's substandard conditions have long been known to the Department of Social Services which, in 14 complete inspections since 1980, gave the home noncompliance ratings.

In an inspection of the home, following the assault of Ms. Burns, Department of Social Services staff found 135 violations of State regulatory standards. Inspectors also found that the placement or continued stay of approximately one-third of the facility's residents was inappropriate or questionable given their clinical conditions. In their report, Department of Social Services staff concluded that the violations are "extensive, serious and indicate a total lack of regard for the regulatory process, and more importantly, resident well-being and rights." These staff strongly recommended denial of the operating certificate, which had expired on December 31, 1992. As of May 1993, however, the home was still in operation and Department of Social Services officials reported that they plan to give New Queen Esther Home for Adults a one-year operating certificate contingent on the home immediately addressing key deficiencies.[3]

Certain conditions observed, and information learned during the Commission's visit, raise serious concern about the roles of the on-site mental health teams which seem poorly defined and not aligned with resident needs.

Concerns Regarding Mental Health Services

Certain conditions observed, and information learned during the Commission's visit, raise serious concern about the roles of the on-site mental health teams which seem poorly defined and not aligned with resident needs.

For example, although most clients observed were idle all day and many appeared regressed in their self-care abilities, Commission staff observed no programs offered by the on-site teams to address these

2 *Adult Homes Serving Residents with Mental Illness: A Study of Conditions, Services and Regulations* (Commission on Quality of Care, October 1990.)

3 On June 9, 1993, as the Commission was finalizing this report, the Department of Social Services informed the operator of New Queen Esther Home for Adults that as a result of his inability to correct a majority of the violations found, his request for a renewal of the operating certificate was being denied and that a fair hearing would be scheduled concerning the denial, a process which takes months to conclude. Meanwhile, the residents continue to endure substandard conditions.

issues. Although the Creedmoor team's schedule indicated that programs would be offered, none was observed during the visit; and the New Hope therapist reported that he offered only half-hour individual therapy sessions totaling eight hours weekly.

It was also reported by the New Hope therapist that he rarely reads the home's logbook, although residence staff view this as their primary means of communicating residents' needs with mental health staff.

And, although both teams profess to having means of responding to crises in the home during "off-hours," as a matter of practice the residence does not avail itself of these avenues; instead police are called.

One would expect that staff of the on-site mental health teams would be familiar with their patients' conditions and needs. Interviews conducted during the Commission's March 1993 visit, however, suggested that this was not the case.

Finally, one would expect that staff of the on-site mental health teams would be familiar with their patients' conditions and needs and have an understanding of how well other providers involved in their patients' lives are meeting their needs. Interviews conducted during the Commission's March 1993 visit, however, suggested that this was not the case.

Although the Department of Social Services issued an inspection report in January 1993 citing scores of deficiencies in New Queen Esther's operations and indicating that the placement or continued stay of one-third of its residents was inappropriate or questionable for clinical reasons, neither mental health team was aware of the Department's findings, which have a direct bearing on the well-being and treatment of the teams' patients.

The staff of the mental health teams also reported having little or no knowledge of the regulatory requirements of adult homes (e.g., basic expectations concerning environmental and safety features, mandated services, staffing patterns and qualifications, residents' rights, etc.) - a finding which suggests they are ill equipped to advocate for their patients' rights and interests.

New Seville Observations

In order to review certain records relevant to the investigation, Commission staff visited the New Seville Home for Adults twice. During each visit at least 15 - 20 residents were found sitting idly in the lobby area and front porch/smoking area. Some were sitting on the floor in the middle of the room, some were sitting on stairs leading to the second floor. The dress of the residents mirrored that of the New Queen Esther clientele--dirty, mismatched, ill fitting, etc. And many of the residents appeared to require a shower or a bath. Although Commission staff did not review New Seville residents' records, it was their impression that a number of the home's residents appeared more regressed psychiatrically, than the New Queen Esther residents. Considering that the two homes share the same management, a number of staff and the same mental health teams, Commission staff's observations raised concern that the New Seville's residents' needs may be as poorly met as those of New Queen Esther, as found during the Department of Social Services' recent comprehensive assessment of the New Queen Esther facility.

At least 15 - 20 residents were found sitting idly in the lobby area and front porch/ smoking area. Some were sitting on the floor in the middle of the room, some were sitting on stairs leading to the second floor. The dress of the residents mirrored that of the New Queen Esther clientele--dirty, mismatched, ill fitting, etc.

Conclusions and Recommendations

The Commission's investigation into the events of October 12, 1992 confirmed that New Queen Esther staff were present at the time of, and following, the incident involving Ms. Williams and Ms. Burns. It appears that the New Hope therapist who alleged that no staff were present, entered the scene of the lobby incident at a time when the facility's lone direct care worker was stationed at the desk in the dining room, just paces away, attempting to retrieve information needed by EMS who were also on the scene. The therapist, sensing that residents were in charge, made no attempt to look for staff and erroneously concluded no staff were present.

Although residence staff were present, they were unable to effectively manage the crisis of October 12, which began unfolding on the evening of October 11. It appears that chaos reigned.

The investigation, however, revealed other more pervasive and interrelated problems, as serious as the therapist's mistaken report. These include: the facility operator's inability to provide a safe environment and appropriate services for residents; the inappropriate placement and continued stay of certain residents in the home; and the inadequacy of services provided by on-site mental health teams.

Although residence staff were present, they were unable to effectively manage the crisis of October 12, which began unfolding on the evening of October 11. When Ms. Williams' behaviors started escalating on the evening of October 11 and direct care staff were advised to seek her hospitalization, they failed to do so, probably as a result of a miscommunication. When Ms. Williams critically injured Ms. Burns on October 12, five staff were on duty; but four of these were assigned support service tasks and spoke little or no English, and the one direct care staff member, reportedly working her first day in this capacity, apparently panicked. Based on various reports, it appears that chaos reigned. It was into this chaos that the New Hope therapist wandered, and then left without making any effort to ensure responsible persons were supervising the residents.

The facility's logbook and police reports indicate that this state of chaos is not an unusual event. To a great extent, it appears that many of these events involve residents whose placement in the home is inappropriate. This raises serious concerns about the discharge practices of mental hygiene facilities.

The facility's logbook and police reports indicate that this state of chaos is not an unusual event. The book is replete with entries reporting resident altercations, elopements, inappropriate behaviors and staff's frustrations with attempting to manage these situations.

To a great extent, it appears that many of these events involve residents whose placement in the home, as determined by the Department of Social Services in its recent inspection, is inappropriate. This in turn raises serious concerns about the discharge practices of mental hygiene facilities.

Ms. William's placement in the home is a case in point. Mute, withdrawn and unable to care for many of her basic needs, she was discharged to the residence after more than 40 years of continuous hospitalization. According to outpatient staff, she survived in the home not because it had the qualified staff her condition would require for adequate supervision, but because she had the good fortune of having a roommate who cared for her basic needs. The conditions of many

residents observed by the Commission suggest that either their discharges to the home were inappropriate and they do not have the good fortune of having a roommate as caring as Ms. Williams' was, or they are not receiving the attention and care they require from residence and on-site mental health staff, or both.

Recent, and most thorough, Department of Social Services inspections of the New Queen Esther residence uncovered numerous violations of regulations governing adult home operations. On the basis of these inspections, the Department of Social Services has decided not to renew the facility's operating certificate, a decision which will be subject to a fair hearing. Although the Department has commenced enforcement action - which will trigger protracted due process procedures lasting months - and the Office of Mental Health has ceased referrals to the home, the Commission believes additional steps are required to ensure the well-being of the facility's residents.

The Commission believes additional steps are required to ensure the well-being of the facility's residents.

Specifically, the Commission recommends that:

- The Department of Social Services should exercise its enforcement powers under Section 460-d Social Service Law and issue a Department Order, or secure a Court Order, directing the operator of the New Queen Esther Home for Adults to remedy deficient conditions.
- On-site mental health teams should be apprised of the Department of Social Services' findings concerning inappropriate placements in the home and be required to move expeditiously in assessing these individuals' needs and facilitating their transfer to an appropriate level of care;
- The on-site mental health teams should receive training in the Department of Social Services' standards for adult homes to better enable them to serve, and advocate on the behalf of, their clients;
- The Office of Mental Health should conduct a thorough assessment of the adequacy of services provided by the on-site mental health teams, as such appears woefully inadequate, based on the conditions observed and the fact that the Department of Social Services, and not the on-site clinical teams, determined that one-third of the residents were not appropriately placed given their clinical conditions.

Finally, the Department of Social Services and the Office of Mental Health should conduct a thorough inspection of the New Seville Home for Adults and assessments of its residents. This facility's management and mental health teams are the same as New Queen Esther's and brief visits to the facility suggest it has many of the same problems as New Queen Esther.

Appendix

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Commission on Quality of Care
99 Washington Avenue - Suite 1002
Albany, NY 12210

Dear Mr. Sundram:

The Department has received and reviewed the Commission's confidential report of April 1993 entitled "Life and Death At New Queen Esther Home for Adults." The Department is pleased to have been able to coordinate our mutual investigative efforts with regard to the incidents at this facility.

The Department concurs with the findings and conclusions indicated in the report and would like to make the following comments regarding the Commission's recommendations:

As a result of our most recent inspections, Department staff have apprised several of the staff of the on-site mental health teams of our findings regarding the inappropriate placements in the home and have explained Department standards for adult homes. Unfortunately, despite invitations extended to them, New Hope Guild did not attend meetings arranged by the Department to clarify the role of the mental health provider and adult home operator in addressing the needs of residents with chronic mental illness. The Department will continue its efforts to obtain the participation of the respective provider agencies at our inter-agency council meetings. In collaboration with the Office of Mental Health, the Department will ensure that resident's needs for mental health services are assessed and will assist with transfers to appropriate levels of care, if necessary.

With regard to our actions against the operator of New Queen Esther, the Department met with the operator in late February in order to identify our serious concerns with the care and services in this facility and identify conditions for the recertification of this facility. As a result of this meeting, the Department demanded that the operator hire a new, Department-approved, administrator and a separate, Department-approved, case manager in order to address the deficiencies that the Commission has identified and we have confirmed in our inspection report. The Department has met with and recently approved the qualifications of a newly appointed administrator, Ms. Angela Scott.

However, as a result of a recently completed reinspection of the facility, we found that the operator failed to correct the majority of violations found in the previous inspection and, therefore, failed to bring the facility into compliance with the Department's regulations. As a result, the Department denied the renewal of the operating certificate for New Queen Esther on June 9, 1993 and is preparing a statement of charges in preparation for an assessment of civil penalties.

In keeping with our joint inspection agreement, the Department will collaborate with the Office of Mental Health in the thorough inspection of the New Seville Home for Adults in order to clearly ascertain the extent of any problems in the operations and develop the appropriate corrective actions. As you may know, the Department is transferring the homes in Queens County under the jurisdiction of the Metropolitan Regional Office in order to improve the coordination between the Department and other state and local agencies regarding care and services to adult home residents. The Department will also work with the Office of Mental Health to ensure that the discharge practices of mental hygiene facilities and the admission and retention practices of adult home operators more adequately address the residential care needs of the chronically mentally ill. Additionally, the Department recognizes the importance of appropriate services for residents and is working with the Office of Mental Health to identify and address systemic issues related to the provision of mental health services for residents of adult homes.

We appreciate the opportunity to have provided you with our comments to the Commission's report and look forward to your continued cooperation.

Sincerely,

Gregory M. Kaladjian
Acting Commissioner

cc: Richard Surles,
Commissioner OMH

NEW YORK STATE
OFFICE OF MENTAL HEALTH
44 Holland Avenue, Albany, New York 12229

RICHARD C. SURLES, Ph.D., Commissioner

May 7, 1993

Clarence J. Sundram, Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, NY 12210-2895

Dear Mr. Sundram:

I am writing in response to your letter of April 2, 1993, which accompanied the Commission's report on the New Queen Esther Home for Adults.

As you know from our earlier correspondence, on March 1, 1993, the Office of Mental Health suspended referrals from state psychiatric centers to New Queen Esther after a review by the New York City Regional Office. Subsequent to that action, Dr. Ronald Melzer met with the home's owner, Mr. Emanual Guttman, to advise him of the specific steps that would be required before the Office of Mental Health would consider restoring referrals. These included implementation of a verifiable mechanism to document timely and consistent communication between the home and mental health providers, modifications to the medication system to ensure that residents always have a supply of their prescribed drugs, and improved safeguards to prevent alterations to the facility shift log.

On April 14, 1993, Mr. Guttman confirmed in writing his understanding of our requirements and requested that we visit again as rapidly as possible to determine whether conditions were now satisfactory. However, as has been our policy in the past, we will not schedule a review until sufficient time has passed to permit an assessment of whether meaningful changes have actually taken place.

With regard to the question of residents who may be in need of an alternate level of care, we have reviewed the findings of the Department of Social Services inspection to which you referred, and have discussed their implications with staff of the DSS Metropolitan Regional Office. Nancy Ray, of your staff, has also been involved in discussions with OMH and DSS in identifying alternate strategies for improvement in delivery of services in adult homes.

According to the DSS report, a total of 12 individuals were determined to be inappropriate for the home due to the severity of their mental illness, their behavior and/or their interference with the operation of the facility. The Department of Social Services

confirms that these determinations do not attempt to differentiate between the appropriateness of placement at the time it was made and current conditions in a home which may adversely impact residents' ability to function in that setting. Consequently, we would not necessarily agree with the Commission's conclusion that the DSS report "... raises serious concerns about the discharge practices of mental hygiene facilities."

Furthermore, we are advised by DSS that placement into an alternate level of care is not the only option for correcting the cited deficiencies, particularly if conditions and services are improved to appropriately address the needs of individuals where they now reside. If, however, it is determined that even with such improvements, the home is not capable of providing adequate care to some residents, the Office of Mental Health will actively seek to identify appropriate alternatives. With that in mind, we will be simultaneously focusing on the home's responsibility to maintain and transmit accurate information about residents, and on mental health programs to provide interventions which directly target problem behaviors. We will assist the operator in identifying other resources for carrying out such evaluations.

As to the issue of assessing the adequacy of on-site mental health services, we are now in the process of developing modifications for review of certified programs in adult homes. These will include specific examination of the mechanisms by which the home and providers share information about residents' behavior, compliance with medication regimens, and significant events which suggest the need for changes in the frequency, intensity or type of mental health services.

Finally, the New York City Regional Office will collaborate with the DSS Metropolitan Office to determine the best approach for evaluating whether the problems at New Queen Esther are of concern at the New Seville home as well. We will continue to advise the Commission of our findings and progress.

Sincerely,

Richard C. Surles, Ph.D.
Commissioner

cc: R. Hettenbach
R. Melzer, Ph.D.
S. Forquer, Ph.D.