Office for People With Developmental Disabilities

Compliance With Jonathan's Law

Report 2017-S-67 | November 2019

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller
Division of State Government Accountability

Audit Highlights

Objective

To determine whether the Office for People With Developmental Disabilities is complying with the requirements established under Jonathan's Law. This audit covers the period April 1, 2015 through April 25, 2019.

About the Program

In February 2007, Jonathan Carey, a 13-year-old non-verbal autistic and developmentally disabled boy, died while in the care of a State facility operated by the Office of Mental Retardation and Developmental Disabilities (subsequently renamed the Office for People With Developmental Disabilities, or OPWDD). Jonathan's parents attempted multiple times to obtain information concerning several unexplained injuries, unauthorized changes in treatment, and suspected abuse and neglect while at a privately run facility and then at a State-run facility. In May 2007, "Jonathan's Law" was enacted to expand parents', guardians', and other qualified persons' access to records relating to incidents involving family members residing in facilities operated, licensed, or certified by OPWDD, the Office of Mental Health, or the Office of Alcoholism and Substance Abuse Services. Under Jonathan's Law, facility directors are required to do the following in response to any incident involving a patient receiving care and treatment:

- Provide telephone notification to a qualified person within 24 hours of the initial reporting of an incident;
- Upon request by a qualified person, promptly provide a copy of the written incident report;
- Offer to hold a meeting with a qualified person to further discuss the incident;
- Within ten days, provide the qualified person with a written report on the actions taken to address the incident (Actions Taken Report).

In addition, upon written request to the provider, qualified persons may obtain records and documents related to reportable incidents within 21 days of either the conclusion of the investigation or the written request, whichever is later.

OPWDD operates 13 Developmental Disabilities State Operations Offices in six regions across the State to oversee over 1,100 certified programs. OPWDD also regulates, certifies, sponsors, and oversees approximately 650 community-based service providers subject to Jonathan's Law requirements. (The State- and community-operated programs are hereafter referred to collectively as "Facilities.")

Key Findings

- OPWDD has not implemented processes to effectively monitor whether Facilities are complying with Jonathan's Law. While Facilities have established practices for notifying qualified persons within the required time frame, 11 percent of the incidents we reviewed

lacked support that the required notification was made within the required time frames and 7 percent lacked support that an Actions Taken Report had been issued within the required time frames.

- Facilities do not always provide records to qualified persons when requested or are not providing them within 21 days of the request or the conclusion of the investigation (whichever is later), as required. In a sample of 63 record requests, 32 percent (20) were either not provided on time or not provided at all. In addition, Facilities provided inconsistent information – with some offering more detail than others – to qualified persons in response to record requests.

Key Recommendation

- Provide updated guidance to Facilities on their responsibilities related to Jonathan's Law requirements – including clear and consistent implementation procedures – and require Facilities to follow procedures.

Office of the New York State Comptroller
Division of State Government Accountability

November 18, 2019

Theodore Kastner, M.D.
Commissioner
Office for People With Developmental Disabilities
44 Holland Avenue
Albany, NY 12229

Dear Commissioner Kastner:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively. By so doing, it provides accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Office for People With Developmental Disabilities entitled *Compliance With Jonathan's Law*. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Abbreviation	Description	Identifier
DDSOO	Developmental Disabilities State Operations Office	*Office*
Facilities	Collectively refers to both State- and community-operated programs	*Programs*
Handbook	OPWDD's Part 624 and Part 625 Handbook	*Policy*
IRMA	Incident Reporting Management Application	*System*
Justice Center	Justice Center for the Protection of People With Special Needs	*Agency*
OASAS	Office of Alcoholism and Substance Abuse Services	*Agency*
OMH	Office of Mental Health	*Agency*
OPWDD	Office for People With Developmental Disabilities	*Auditee*
Substantiated	Reportable incidents that have been substantiated by the Justice Center	*Key Term*

Background

In February 2007, Jonathan Carey, a 13-year-old non-verbal autistic and developmentally disabled boy, died while under the care of a State facility operated by the Office of Mental Retardation and Developmental Disabilities (subsequently renamed the Office for People With Developmental Disabilities, or OPWDD). Before Jonathan's tragic death, his parents attempted multiple times to obtain information concerning several unexplained injuries, unauthorized changes in treatment, and suspected abuse and neglect while initially residing at a privately run facility and later at a State-run facility. Jonathan's passing and the lack of transparency in his care underscored the need for parents and guardians to receive timely information about incidents affecting the well-being of family members in such facilities.

In May 2007, legislation was enacted in New York State amending the Mental Hygiene Law. Known as "Jonathan's Law," these amendments were intended to expand access of parents, guardians, and other qualified persons to records relating to injuries and allegations of abuse or mistreatment (i.e., incidents) involving family members residing in facilities operated, licensed, or certified by OPWDD, the Office of Mental Health (OMH), or the Office of Alcoholism and Substance Abuse Services (OASAS). In August 2017, the Mental Hygiene Law was amended to include adult siblings as qualified persons.

Under Jonathan's Law, facility directors are required to do the following in response to any incident involving a patient receiving care and treatment at a facility:

- Provide telephone notification to a qualified person within 24 hours of the initial reporting of the incident;
- Upon a request from a qualified person, promptly provide a copy of the written incident report;
- Offer to hold a meeting with a qualified person to further discuss the incident;
- Within 10 days, provide the qualified person with a written report on the actions taken to address the incident (Actions Taken Report).

A qualified person is defined under Section 33.16 of the Mental Hygiene Law to include:

- Patient/client
- Legal guardian of a patient
- Parents
- Spouse
- Adult children
- Adult siblings

Upon written request to the provider, qualified persons may obtain records and documents related to reportable incidents within 21 days of the conclusion of the investigation or the request from the qualified person, whichever is later. For the purposes of Jonathan's Law, a reportable incident involves abuse (physical, sexual, or psychological) or neglect, but may also include incidents other than abuse or neglect that result in or have

the potential to result in harm to the health, safety, or welfare of a patient. Furthermore, qualified persons may have access to additional information pertaining to allegations and investigations of abuse and mistreatment, including complaints and reports made pursuant to Article 11 of the Social Services Law to the Justice Center for the Protection of People With Special Needs (Justice Center).

OPWDD is responsible for coordinating services for nearly 140,000 New Yorkers with developmental disabilities. While Jonathan's Law also applies to facilities operated and licensed by OMH and OASAS, this audit focused only on facilities operated and licensed by OPWDD.

OPWDD operates 13 Developmental Disabilities State Operations Offices (DDSOOs) in six regions across the State. These DDSOOs provide oversight and guidance to 1,121 State-operated programs. OPWDD also regulates, certifies, sponsors, and oversees approximately 650 community-based service providers. The State- and community-operated programs are hereafter referred to collectively as "Facilities."

OPWDD developed the Incident Reporting Management Application (IRMA), a web-based statewide database, for Facilities to record and report incidents to OPWDD's central office, including Jonathan's Law activity data (e.g., the date of telephone notice, the issuance of the Actions Taken Report, and whether a meeting took place). Information is either entered directly into IRMA by State-operated Facility employees, transferred into IRMA by community-based Facility employees via a web portal system, or uploaded into IRMA nightly through the Justice Center's Vulnerable Persons Central Registry. According to OPWDD's Part 624 and Part 625 Handbook (Handbook), any subsequent information concerning an incident (e.g., notifications) should be entered into IRMA by the end of the fifth working day after the action is taken, or when the information becomes available. Information related to investigations is not entered into IRMA until the report is completed. OPWDD officials may view incident data after it has been entered or transferred.

Pursuant to the Mental Hygiene Law, our access to individuals' clinical records is restricted. However, according to Section 496 of the Social Services Law, OPWDD is authorized to provide the State Comptroller records for incidents that were "substantiated" by the Justice Center. Although Jonathan's Law requirements are applicable to all reportable incidents, substantiated or not, this report focuses solely on substantiated incidents. According to IRMA data, from April 1, 2015 through July 19, 2018, Facilities reported 74,222 unique Jonathan's Law-applicable incidents, of which 7,699 (10 percent) involving 13,655 people were substantiated.

Audit Findings and Recommendations

OPWDD has not implemented processes to effectively monitor whether Facilities are complying with Jonathan's Law requirements. While Facilities have established procedures for notifying qualified persons within the required time frame, 11 percent (32) of the 295 incidents we reviewed lacked support that the notification was made within the required time frame. Furthermore, 7 percent (22) of the 295 incidents lacked support that the required Actions Taken Report was issued within the required time frame.

Facilities did not always provide records to qualified persons when requested or within 21 days of the request or the conclusion of the investigation, as required. In a sample of 63 record requests, 32 percent (20) were either not provided on time or not provided at all. In several instances, delays occurred because of the Facility's practice to wait until its Incident Review Committee verified the completeness of the Justice Center's investigation before fulfilling the request. This practice is not only contrary to OPWDD's regulations, but can significantly delay qualified persons' access to incident investigation information.

Two of the community-based Facilities in our sample were improperly denying access to records because they were unaware of their responsibilities under Jonathan's Law, including the updated requirement to treat adult siblings as qualified persons. Further, Facilities provided inconsistent information to qualified persons in response to record requests. Some Facilities included all records and documents, while others only released incident and investigative reports. At one State-operated Facility, officials were unaware of what records they should release.

Compliance With Jonathan's Law Requirements

Notifications and Actions Taken Reports

We visited six Facilities (three State-operated and three community-based) and reviewed records for 295 incidents involving 515 individuals to determine whether Facilities notified qualified persons and issued Actions Taken Reports within the required time frames. We found:

- 32 incidents (11 percent) involving 72 individuals (14 percent) lacked evidence to support that qualified persons were notified within the required time frame; and
- 22 incidents (7 percent) involving 42 clients (8 percent) lacked evidence to support that the Actions Taken Reports were provided within the required time frame.

OPWDD does not use IRMA or any other means to actively monitor whether Facilities are making telephone notifications within the required time frame, even though IRMA captures this information. As a result, OPWDD did not detect these instances of non-compliance, leading to delays in providing incident information to qualified persons.

Offer to Meet With Qualified Persons

At the six Facilities we visited, we also reviewed records for the 295 incidents involving 515 clients to determine whether evidence existed to support that qualified persons were offered an opportunity to meet regarding incidents involving their family members. While Facilities generally maintained adequate documentation to support that they made the offers, we found 48 incidents (16 percent) involving 73 individuals (14 percent) where there was no documentation to support that the Facilities offered to meet. A single State-operated Facility accounted for 45 of the 48 incidents (involving 70 of the 73 individuals). Subsequent to our site visit to this Facility, OPWDD officials informed us that, although there was no documentation in the hard copy files, this information was recorded in IRMA. However, Facility officials did not note this at the time of our site visit; therefore, we could not verify the information at that time. Additionally, we note that this Facility's policy is to offer to meet with qualified persons only after the close of an investigation. This does not align with OPWDD's regulations, which state an offer to meet should be made with the telephone notification. Facility officials only meet with qualified persons before the close of an investigation if the qualified person requests it, putting the burden of obtaining a meeting on the qualified person, who may not be aware of their rights to a meeting.

Release of Records

Facilities are not always providing all records to qualified persons when requested or are not providing them within 21 days of the request or the conclusion of the investigation (whichever is later), as required. At the six Facilities we visited, qualified persons made 63 record requests, with more than half (34) involving State-operated Facilities. Forty-three (68 percent) were provided within 21 days; 12 were provided within 45 days; 5 were provided after more than 45 days; and 3 were not provided to the qualified persons at all.

In several instances, delays occurred because of the Facility's practice to wait for its Incident Review Committee to verify the completeness of the Justice Center's investigation before fulfilling the record request. This practice is not only contrary to OPWDD's regulations, but can significantly delay qualified persons' access to incident investigation information. For example, as cited by

OPWDD, at one Facility, a qualified person made a record request on August 27, 2016, but did not receive the documents until December 14, 2016 – one day after the Incident Review Committee reviewed the investigation, but about 20 days after the required time frame.

Additionally, two of the community-based Facilities in our sample were improperly denying access to records because they were unaware of the change to Jonathan's Law to include adult siblings as qualified persons (two of the three unfilled record requests in our sample involved requests made by adult siblings). Moreover, OPWDD's guidance, policies, and procedures have not been updated to reflect this change. Consequently, a Facility denied an adult sibling access to investigative records for an incident involving the death of a loved one because, although the request was made after the addition of adult siblings as qualified persons, the incident occurred about a month before this change.

Another community-based Facility's practice was to restrict access to records and documents to only individuals identified as guardians. In September 2018, this Facility improperly denied an adult sibling's request for access to investigative records because the sibling was not the individual's identified guardian. According to OPWDD officials, upon becoming aware of its responsibilities under the Law, the Facility provided the information. Also, the Facility subsequently trained responsible officials on who can and cannot obtain information. Additionally, as a result of our audit, OPWDD conducted a review and found four other instances of adult siblings being denied access to records and documents. In three cases, the adult siblings ultimately received the requested information; in the remaining case, the adult sibling obtained the information from the Justice Center.

Furthermore, Facilities provided inconsistent information in response to record requests by qualified persons. Some Facilities included all records and documents; other Facilities only released incident and investigative reports. Officials at one State-operated Facility were unaware of what records they should release. OPWDD does not monitor Facilities to determine if they provide the correct information or if they comply with regulations. Additionally, IRMA does not capture this information. As a result, qualified persons may not be receiving all pertinent information on incidents affecting the well-being of their family members.

System Usefulness and Data Reliability

IRMA, OPWDD's primary system for recording incident information, is critical for incident management and for monitoring Facilities' compliance with Jonathan's Law. However, we found areas of improvement that could

enhance IRMA's usefulness as a compliance monitoring tool. For example, while IRMA captures some information on Jonathan's Law actions (e.g., date and time of telephone notifications; Actions Taken Report issue dates), it does not capture information about the request for or release of records and documents.

OPWDD reviews incident management processes while conducting surveys of Facilities to ensure that Facilities are accurately entering all required information into IRMA, including actions to comply with Jonathan's Law. During our site visits, we obtained and reviewed documentation supporting Facilities' actions to comply with Jonathan's Law. When comparing supporting documentation to data in IRMA, we found discrepancies between key information fields. OPWDD officials stated that there are cases when the information in IRMA may not always be accurate, such as when additional facts are discovered during the course of an incident investigation.

Even though the Handbook directs Facilities to enter additional information into IRMA within five days, OPWDD officials stated they do not require Facilities to enter all Jonathan's Law information into IRMA until just prior to the incident being closed, which can take significant time in some cases. As of July 2018, we identified over 3,000 incidents reported between 2015 and 2017, involving approximately 5,200 patients, with open or pending closure statuses that had incomplete Jonathan's Law information in IRMA. In some cases, the only support that certain Jonathan's Law actions had been completed is the information in IRMA. For example, OPWDD officials stated that one State-operated Facility only records meeting offers in IRMA but no other supporting documentation. If Facilities do not update IRMA timely, the information that officials rely on for incident management is compromised, diminishing IRMA's usefulness as a monitoring and management tool.

Recommendations

1. Provide updated guidance to Facilities on their responsibilities related to Jonathan's Law requirements – including clear and consistent implementation procedures – and require Facilities to follow procedures.

2. Take steps to improve the use and quality of data in IRMA, including:

   - Implementing procedures for quality assurance and timely input of incident data; and

   - Incorporating additional fields to capture information on the request for and release of records.

3. Implement procedures to perform periodic data analysis of IRMA data to identify patterns and/or areas of concern that may be indicative of non-compliance with Jonathan's Law.

Audit Scope, Objective, and Methodology

Our audit objective was to determine whether OPWDD is complying with the requirements established under Jonathan's Law. The audit covers the period April 1, 2015 through April 25, 2019.

To achieve our audit objective, we interviewed officials from Facilities and reviewed and gained an understanding of: Jonathan's Law; sections of the Mental Hygiene Law; OPWDD policies, procedures, and regulations; and selected Facilities' Jonathan's Law policies and procedures. We became familiar with and assessed the adequacy of OPWDD's internal controls as they related to our audit objective.

Of the 74,222 total incidents reported to OPWDD from April 1, 2015 through July 18, 2018, only 7,699 incidents (10.4 percent) were substantiated by the Justice Center. However, we were unable to review over 89 percent (about 66,500 of 74,200) of incidents reported to OPWDD due to limitations on our access to records according to Section 496 of the Social Services Law. Additionally, OPWDD does not require certain events (e.g., where the person suffers unintentional injuries requiring more than first aid) to be entered into IRMA even though they are subject to Jonathan's Law requirements. Consequently, these events are not included in the incident and client totals.

We interviewed officials at 12 DDSOOs to assess their Jonathan's Law policies and procedures. Furthermore, we obtained and analyzed substantiated incident and provider data from IRMA for the period April 1, 2015 to July 19, 2018 to determine the reliability and accuracy of the data. Overall, we determined the data to be reliable for the purposes of our audit objective, but limited our use of the data to the selection of our sample. We reviewed hard copy documentation for reported incidents at selected Facilities to support our audit findings.

We judgmentally selected six Facilities to determine compliance with Jonathan's Law. We based our selection on high frequency of serious substantiated incidents by incident type (e.g., abuse or neglect). We pulled attribute samples using a systematic selection process based on dividing the total sample size by the total population of incidents for each provider to determine a selection interval. We then applied that selection interval to the population of incidents. In total, we selected and reviewed 295 substantiated incidents involving 515 clients out of 7,699 substantiated incidents involving 13,655 clients. The results of our sample cannot be projected to the population of incidents as a whole.

Statutory Requirements

Authority

This audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our performance audit in accordance with generally accepted government auditing standards. Performance audits serve to provide findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria in an objective analysis that can assist management and those charged with governance and oversight to improve program performance. Generally accepted government auditing standards require that we plan and perform our audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence we obtained provides a reasonable basis for the limited findings and conclusions we made based on our audit objective. However, because our access to incident-related information was limited, we acknowledge the audit risk that our findings, conclusions, and recommendations are limited to only the substantiated incidents we reviewed and specifically exclude all unsubstantiated incidents.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Reporting Requirements

A draft copy of the report was provided to OPWDD officials for their review and comment. Their comments were considered in preparing this final report and are attached in their entirety at the end, along with our own State Comptroller's Comments, which are embedded within OPWDD's response to address some of OPWDD's specific statements. In general, OPWDD agreed with our recommendations, but took exception to our application of Jonathan's Law and characterized our findings and observations as overstated.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Office for People With Developmental Disabilities shall report to the Governor, the State Comptroller, and the leaders of the Legislature and its fiscal committees, advising what steps were taken to implement the recommendations contained herein, and if the recommendations were not implemented, the reasons why.

NEW YORK STATE OF OPPORTUNITY | Office for People With Developmental Disabilities

ANDREW M. CUOMO
Governor

THEODORE KASTNER, MD, MS
Commissioner

September 27, 2019

Mr. Stephen Goss, Director
Office of the New York State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

Re: Draft Audit Report 2017-S-67

Dear Mr. Goss:

The Office for People With Developmental Disabilities ("OPWDD") has reviewed the Office of the State Comptroller's draft report, 2017-S-67, titled "Compliance With Jonathan's Law."

Please find attached our response to this draft report. Thank you for the opportunity to comment. If you have any questions or concerns, please do not hesitate to contact me at 518-402-4368 or Anthony.J.Dolan@opwdd.ny.gov.

Sincerely,

Anthony J. Dolan, CPA
Director, Bureau of Internal Control

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Office for People With Developmental Disabilities' Response to the Office of the State Comptroller's Draft Audit Report (No: 2017-S-67): "Compliance with Jonathan's Law."

I. INTRODUCTION

The New York State Office for People With Developmental Disabilities ("OPWDD") appreciates the opportunity to respond to the Office of the State Comptroller's ("OSC") draft audit report (2017-S-67) entitled "Compliance with Jonathan's Law." OPWDD provides services and support to over 130,000 individuals with developmental disabilities throughout New York State. This OSC audit focused on adherence to notifications and disclosures required by Mental Hygiene Law Sections 33.23 and 33.25 (commonly referred to as "Jonathan's Law"), as carried out by both state and not-for-profit-operated programs.

Jonathan's Law was enacted in 2007 to allow certain qualified persons to receive notification and documentation after an incident involving a person who receives care at a facility licensed or certified by OPWDD, the Office of Mental Health or the Office of Alcoholism and Substance Abuse Services. Jonathan's Law was amended in August 2017 to expand the definition of qualified persons to include adult siblings.

OSC evaluated the compliance of three OPWDD state-operated and three not-for-profit-operated programs regarding providing notification and documentation to "qualified persons" (i.e., specified relatives or guardians of individuals receiving services) pursuant to Jonathan's Law. Specifically, OSC evaluated the programs' compliance regarding each of the following required elements:

1. Providing telephone notification within 24 hours of the initial report of an incident;
2. Providing a copy of the written incident report promptly upon request;
3. Offering to hold a meeting with the qualified persons to further discuss the incident;
4. Within 10 days of the initial incident report, providing a written report on the actions taken to address the incident; and
5. Providing records pertaining to allegations and investigations of abuse, neglect, or mistreatment, upon written request within 21 days of the conclusion of an investigation, provided that certain required redactions be made to the records prior to disclosure.[1]

OSC's audit covers April 1, 2015 through April 25, 2019.

II. DISCUSSION

At the onset, it is important to note that many of the findings articulated by OSC are based on faulty interpretation and inaccurate data. Each of the following inaccuracies are discussed in more detail below:

- OSC relied on flawed criteria when reviewing the timeliness of notifications, implying that programs are required to notify qualified persons of an incident even prior to that incident having been reported and properly categorized. This

[1] *See* Mental Hygiene Law §§ 33.23, 33.25.

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inappropriate timeline created inaccurate calculations which exaggerate the extent to which notifications and disclosures purportedly failed to meet the statutory deadline.

State Comptroller's Comment 1 - OPWDD's argument is incorrect because it is not in compliance with Jonathan's Law. Jonathan's Law requires facilities to provide telephone notification to qualified persons within 24 hours of the initial report of the incident. OPWDD interprets this 24-hour notification requirement as beginning to run when a facility reports an incident to OPWDD, and not when a facility becomes aware of the incident. Under OPWDD's regulations, a facility does not have to report an incident to the agency until the later of "24 hours of occurrence or discovery or by close of the next working day" [14 NYCRR § 624.5(f)(1)(ii)]. The facility would then have an additional 24 hours to provide telephone notification to a qualified person [14 NYCRR § 624.6(f)(3)]. Accordingly, OPWDD's regulations permit a facility that receives an initial report of an incident on a Friday to wait until the following Tuesday to provide the requisite notification. However, Section 33.23 of the Mental Hygiene Law requires facilities to provide notice within 24 hours of the initial report of the incident to the facility. Neither the plain language of Jonathan's Law, nor its legislative history, provides support for OPWDD's interpretation of the statutory 24-hour notification requirement.

- The report erroneously asserts that no supporting documentation existed to document telephonic communication regarding reports when such records did exist and were provided to OSC for review.

State Comptroller's Comment 2 - OPWDD provided information from IRMA, including a field indicating whether an offer to meet was accepted. However, our testing identified discrepancies between information in facility files and IRMA, as we report on page 11. In general, we found facility files were more complete than IRMA. Therefore, we relied on documentation from the Facility's files rather than IRMA to support our findings. As we report on page 9, with few exceptions, five of the six facilities we visited kept forms that documented all the necessary information required by OPWDD regulations. However, one facility did not maintain similar records and therefore accounted for 45 of the 48 exceptions. Subsequent to our preliminary findings, OPWDD officials, not Facility officials, indicated that IRMA data constituted their method of documenting whether an offer was made. Regardless, the field in IRMA does not include sufficient details of the telephone contact, including the offer to meet, per OPWDD's own regulations. OPWDD regulations [14 NYCRR § 624.6(f)(9)] stipulate that documentation must be maintained for the telephone notice and responses received, including the identity and position of the party providing the notice, the name of the party receiving the notice, the time of the original call or attempted call, the time of subsequent attempted calls if the initial call was not successful, and the time of follow-up calls if the notice occurred in more than one call. However, IRMA does not have fields to capture all these details. For this reason, we conclude that the 45 instances remain not in compliance.

- The report concludes that records were not provided when they were.

State Comptroller's Comment 3 - Subsequent to completion of our audit fieldwork, OPWDD officials provided us with additional documentation supporting the Facility's compliance with

providing requested records for three additional cases. Based on this additional information, we amended the final report.

When the percentages are recalculated based on the correct data, the findings illustrate near-perfect compliance for on-time notifications and disclosures made pursuant to Jonathan's Law requirements enumerated as items 1 to 4, above.

a. The Report Relies on Inaccurate Timelines

Jonathan's Law requires the director of a facility to provide telephone notice of an incident to a qualified person within 24 hours of the initial report of the incident and, upon request, to provide a written report of the actions taken to address the incident within 10 days. See Mental Hygiene Law § 33.23(a). The statute does not define the term "initial report." OSC's findings are based on an erroneous interpretation of the time at which an initial report is created. As a result, its report inflates the percentages used to describe missed timeframes for these two requirements.

OSC used the date an incident was discovered as the trigger date for these requirements, rather than the date that the incident was reported, as required by OPWDD's regulations at 14 NYCRR § 624.5(f)(1)(ii)(b). OSC's incorrect interpretation created unreasonable time limits for the program to provide telephone notification and a written report on the actions taken to address the incident.

The date of discovery occurs when the reporter first discovers or learns of the incident. Thereafter, the allegation is sent (by telephone or email) to the State's incident management system. It is not uncommon for an allegation to contain incomplete information when it is first reported to the incident management system. OPWDD's regulations, therefore, allow up to one working day after an allegation is received by the State's incident management system to gather necessary information and complete the initial report of the incident. See 14 NYCRR 624.5(f)(1)(ii)(*b*). This also allows time for the proper classification of the incident into different categories described by regulation. This assessment is critical to Jonathan's Law because not all allegations require disclosure under the law (e.g., some allegations end up being categorized as "non-reportable" due to their classification).[2]

State Comptroller's Comment 4 - Please see State Comptroller's Comment 1.

[2] For example, reporting is not required for certain injuries even in some circumstances that require first aid. OSC's report inaccurately described such reporting requirements. On page 13, the report states: "OPWDD has determined certain events (e.g., where the person suffers unintentional injuries requiring **less than first aid)** are excluded from Jonathan's Law requirements. These types of events are not entered into IRMA and are not reported to OPWDD" (emphasis supplied). However, the OPWDD regulations cite the criteria as being no **more than first aid**. *See* 14 NYCRR 624.4(c)(2)(ii)(*b*).

State Comptroller's Comment 5 - OPWDD incorrectly references Mental Hygiene regulations [14 NYCRR § 624.4(c)(2)(ii)(b)] by indicating that certain events are not subject to Jonathan's Law requirements. The regulations define minor notable occurrences as "any suspected or confirmed harm, hurt, or damage to an individual receiving services, caused by an act of that individual or another, whether or not by accident, and whether or not the cause can be identified, that results in an individual requiring medical or dental treatment by a physician, dentist, physician's assistant, or nurse practitioner, and such treatment is more than first aid." Although the incidents are not required to be entered into IRMA, they do fall under Jonathan's Law requirements pursuant to 14 NYCRR § 624.6(f)(3) and 14 NYCRR § 624.6(f)(8)(iii), which we confirmed with OPWDD's Director of Incident Management. However, we amended the definition of minor notable occurrences in the final report.

The OSC report found that, for the two timeframe requirements above (24-hour and 10-day), the task was completed timely in all but 11 and 7 percent of the incidents reviewed, respectively. In calculating these percentages, however, OSC erroneously relied on the discovery date as the date of the initial report, thereby starting the timeline too early to measure accurate compliance. OPWDD recalculated the percentages of compliance based on timelines that start with the initial report date (and allowing one working day to gather necessary information), as defined in OPWDD's regulation, and found the required timeframes were met in all but 3 percent of the 24-hour notifications and 5 percent of the 10-day notifications.[3] These figures do not account for situations where the program was unable to make the telephone contact within 24 hours due to extenuating circumstances such as outdated contact information or unanswered phone calls which required follow up at a later date. Factoring in these situations would result in even lower percentages for tardy notifications.

State Comptroller's Comment 6 - For our review of compliance with the 24-hour notification requirement under Jonathan's Law, we considered any attempt by Facilities to contact the qualified party to be in compliance regardless of whether or not the attempt was successful. Our findings do not include any instance where a qualified person did not answer the phone.

OPWDD acknowledges OSC's findings regarding certain deficiencies pertaining to the requirements in Jonathan's Law to provide records at the conclusion of an investigation of abuse, neglect or mistreatment. For many of these incidents, however, the facilities reviewed in the audit provided the records within 21 days of the date the incident review committee (IRC) concluded no further investigation was necessary. This was OPWDD's practice until 2014. At that time, OPWDD changed its regulations to require disclosure of records within 21 days of the receipt of the Justice Center's report, rather than the date of the IRC review.[4] Upon learning that some facilities were using the prior date for the conclusion of the investigation, OPWDD reminded these facilities of its regulations.

OSC improperly calculated the 21-day period for compliance in at least 2 incidents. On one occasion, OSC calculated the 21-day period from the date the Justice Center sent a letter indicating that the charges were substantiated, rather than the date the Justice Center sent its redacted report and notice that the investigation was concluded, which occurred 12 days later. Jonathan's Law requires the facility to provide this report to the person who made the request and the date the Justice Center sends the report is the appropriate date from which the 21-day period should be calculated. The facility sent the report within 21 days of this date. On another occasion, OSC calculated the 21-day period from the date the person making the report signed the return receipt postcard acknowledging receipt of the documents. The tracking number on that postcard shows that the documents were sent 6 days earlier and within the 21 days.

State Comptroller's Comment 7 - We amended the final report based on additional documentation provided by OPWDD officials.

b. The Report Incorrectly Concludes That No Supporting Documentation Existed Regarding Meeting with Qualified Persons

[3] As the basis for the starting point, OPWDD used the most reliable piece of data, the date the allegation was received, which is computer generated as the incident is being typed in by the hotline call representative (or it is time stamped when the allegation was received electronically). An allotment of one working day was added to allow for the completion of the initial report. On August 16, 2018, OPWDD provided OSC a detailed accounting supporting the lowering of its statistics, but OSC did not adjust its draft report for the issues identified.
[4] *See* 14 NYCRR § 624.5 (o).

Jonathan's Law requires that the director of a facility offer to meet with a qualified person to discuss a reported incident. On page 9 of the OSC draft report, under the section titled *"Offer to Meet With Qualified Persons,"* OSC makes the following statement:

While Facilities generally maintained adequate documentation to support that they made the offers, we found 48 incidents (16 percent) involving 73 individuals (14 percent) where there was no documentation to support that the Facilities offered to meet. A single State operated Facility accounted for 45 of the 48 incidents (involving 70 of the 73 individuals). Subsequent to our site visit to this Facility, OPWDD officials informed us that, although there was no documentation in the hard copy files, this information was recorded in IRMA. However, the Facility officials did not note this at the time of our site visit; therefore, we could not verify the information at that time.

Prior to its site visit at the facility mentioned in this paragraph, OSC was provided a download of IRMA data and had the ability to verify this information during its site visit. Rather, OSC erroneously concludes that "there was no documentation to support that the Facilities offered to meet." A review of the information noted in IRMA, and provided to OSC, related to these reports illustrates there was only a one-percent exception rate for the offers to meet not being adequately documented.

State Comptroller's Comment 8 - Please see State Comptroller's Comment 2.

The same section of the draft report also contains the assertion that: "this Facility's policy is to offer to meet with qualified persons only after the close of the investigation." This is untrue and, like the discussion above, the documentation to corroborate compliance is available in the electronic data provided to OSC.

State Comptroller's Comment 9 - We amended the final report.

c. The Report Incorrectly Concludes Records Were Not Provided Pursuant to Jonathan's Law

Jonathan's Law requires the provision of information or records to qualified persons at multiple times following the report of certain incidents. On page 9 of the draft report, under the section titled *"Release of Records,"* OSC concludes that certain document requests were not fulfilled at all. Specifically regarding five incidents at community-operated programs, the report stated:

- "For two record requests, at one community-operated Facility, officials could not provide information about when the record requests were made *or if they were fulfilled'* (emphasis added).

- "3 were not provided to the qualified persons at all."

In response to this audit report, OPWDD contacted the community-operated facility and found that the two incidents cited by OSC were unrelated to Jonathan's Law requests. Rather, the requests for records came from an advocacy agency with authority under federal law to access certain records. This was not a Jonathan's Law request and the scope of the request extended beyond that allowed under Jonathan's Law. Although this was not a request under Jonathan's Law, and should therefore not have been considered by OSC, the program nonetheless fulfilled the request, as was supported by a signed receipt from the advocacy agency.

State Comptroller's Comment 10 - Please see State Comptroller's Comment 3.

OPWDD also contacted the three community-based programs regarding the record requests where OSC inferred that the programs did not provide any records and found that, in one instance, the records were provided. OPWDD worked with the programs to ensure the requests from adult siblings were fulfilled for the two remaining incidents.

III. RESPONSE TO OSC'S RECOMMENDATIONS

Setting aside the misapplication of requirements and miscalculation of timelines described above, OPWDD acknowledges and responds to OSC's recommendations as follows:

Recommendation #1: Provide updated guidance to Facilities on their responsibilities related to Jonathan's Law requirements – including clear and consistent implementation procedures– and require Facilities to follow procedures.

OPWDD Response: In May 2018, OPWDD posted on its website a clear and concise updated summary of Jonathan's Law Requirements. This document defines who is a qualified person under the statute (including adult siblings) and includes guidance for the records that must be disclosed and the criteria for when an incident is considered closed. More recently, in response to the audit finding that some programs were using the wrong criteria for the incident closure date, the managers of those programs were informed of the finding and were given refresher guidance for the proper procedures.

Recommendation# 2: Take steps to improve the use and quality of data in IRMA, including:

a) Implementing procedures for quality assurance and timely input of incident data; and

b) Incorporating additional fields to capture information on the request for and release of records.

OPWDD Response: Beginning April 1, 2019, OPWDD instituted a quality improvement program, as part of its onsite facility surveys, whereby reviews are conducted for compliance with Jonathan's Law notifications and disclosures, including a review of 100 percent of written requests for records. If findings arise from such inspections, the program experiencing such non-compliance will be notified and corrective actions sought.

OPWDD does not believe that additional data fields are necessary in IRMA to improve its present monitoring of compliance with Jonathan's Law. IRMA is a large and complex database system utilized for multiple purposes that extend well beyond compliance with Jonathan's Law, and modifications to it would pose an unnecessary and expensive undertaking.

Recommendation #3: Implement procedures to perform periodic data analysis of IRMA data to identify patterns and/or areas of concern that may be indicative of non-compliance with Jonathan's Law.

OPWDD Response: As noted above, OPWDD has instituted a quality improvement program that will routinely test for and provide assurance of compliance with Jonathan's Law. These procedural alternatives, in lieu of evaluating IRMA data, will provide significantly improved assurances.

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