DISABILITY RIGHTS NEW YORK

New York's Protection & Advocacy System and Client Assistance Program

ABUSE AND NEGLECT OF NEW YORK STATE RESIDENTS AT WOODS SERVICES IN PENNSYLVANIA

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EXECUTIVE SUMMARY

Disability Rights New York ("DRNY") is the designated federal Protection and Advocacy System ("P&A") for individuals with disabilities in New York State.[1] DRNY has broad authority under federal and state law to monitor conditions and investigate allegations of abuse or neglect occurring in any public or private facility that provides care, services, treatment or habilitation to New Yorkers with disabilities. See 42 U.S.C. § 15043(a)(2)(B); 45 C.F.R. § 1386.22; N.Y. Exec. Law § 558(b)(ii)-(iii).

DRNY initiated an investigation in June 2016, in response to allegations of abuse and neglect at Woods Services ("Woods") in Langhorne, Pennsylvania. Woods operates a private facility on three hundred and fifty (350) acres which houses over six hundred and fifty (650) individuals with developmental and intellectual disabilities. Residents, ranging in age from five (5) to eighty (80), and come from thirty-one (31) States and the District of Columbia. Many people at Woods have spent most of their lives institutionalized. Its residential settings range from ranch style homes that accommodate seven (7) people to large institutional buildings housing up to forty-eight (48) people. Nearly all of Woods' services and supports are provided directly on its campus.

As of October 2016, one hundred and eleven (111) New Yorkers with disabilities resided at Woods. Most New Yorkers are placed at Woods by their local school districts or through the foster care system. Twenty-eight (28) New Yorker's have aged out of school services and are awaiting discharge back to New York State. There are nine (9) New Yorkers who have been living at Woods since the 1950's.

DRNY conducted an unannounced visit to Woods in October 2016. DRNY was accompanied by seven (7) investigators from Disability Rights Pennsylvania (DRP), and Disability Rights New Jersey (DRNJ), the P&A Systems for Pennsylvania and New Jersey. A second visit occurred in December 2016 where West Virginia Advocates (P&A System for West Virginia), joined DRNY, DRNJ, and DRP to monitor Woods' facilities. DRNY, DRP, DRNJ, and West Virginia Advocates were given full access to the grounds, facilities, residents, and staff at Woods on both visits.

DRNY conducted in-person interviews with New York residents, phone interviews with thirty-seven (37) parents and involved family members, and met with the staff and administrators. DRNY reviewed all Woods and State oversight records for allegations of abuse and neglect of New York residents between 2014 and October 2016.

[1] DRNY is supported by the U.S. Department of Health & Human Services, Administration on Intellectual and Developmental Disabilities; Center for Mental Health Services, Substance Abuse & Mental Health Services Administration; U.S. Department of Education, Rehabilitation Services Administration; and the Social Security Administration. This report does not represent the views, positions, or policies of, or the endorsement of, any of these federal agencies.

DRNY finds that abuse and neglect of residents at Woods is a longstanding, pervasive, and systemic issue. Woods failed to diligently investigate and report allegations of abuse and neglect. Despite repeated corrective action plans to address these concerns by New York regulators, Woods has been unable to implement these recommendations.

DRNY finds that Woods:

- Repeatedly used physical restraints in violation of federal and state laws;
- Failed to develop and implement appropriate behavioral intervention;
- Retaliated against residents and family members who complained about treatment and conditions;
- Failed to properly investigate and report serious incidents of abuse, neglect, and injury;
- Operated unsanitary facilities;
- Failed to give residents basic privacy;
- Failed to provide adequate assistive technology;
- Imposed treatment and restrictions without the informed consent of the individual or the legal guardian;
- Neglected to provide training for adult residents; and
- Operated a sheltered workshop which violates federal laws.

> *"As far as how the individuals are treated, it can be awful. Some staff have absolutely no idea what they're doing …they increase the restraints . . . result[ing] in less progress for the individuals . . . and more problems than the 'warm body' was worth."*
>
> *Former Woods Staff Member*

HISTORY OF ABUSE & NEGLECT

Woods has a well-documented history of abuse and neglect of New Yorkers. In October 2009, a student, was killed after staff neglected to supervise him and he was run over by multiple cars. Less than a year later, in July 2010, another student, suffocated in a hot car when the staff responsible for his safety failed to notice he had not exited the vehicle and he suffocated to death.

In 2013, the New York State Education Department (NYSED) and the Office for People With Developmental Disabilities (OPWDD) substantiated complaints of non-consensual sexual activities between adult resident and student which were not properly reported by Woods. While these New York agencies continued to find violations, both NYSED and Administration for Children's Services (ACS) continued to allow placement of New York students, and OPWDD made minimal effort to repatriate adults to community settings in New York.[2]

NYSED and OPWDD's 2013 joint investigation also uncovered several violations of abuse and neglect including: failure to notify parents when children were injured, failure to obtain consent before administering psychotropic medications, inappropriate restraints lasting longer than 20 minutes, and failure to investigate and report incidents of abuse and neglect. Despite uncovering these significant issues, neither OPWDD nor NYSED returned to Woods to confirm corrective action or monitor the treatment of New Yorkers since 2013.

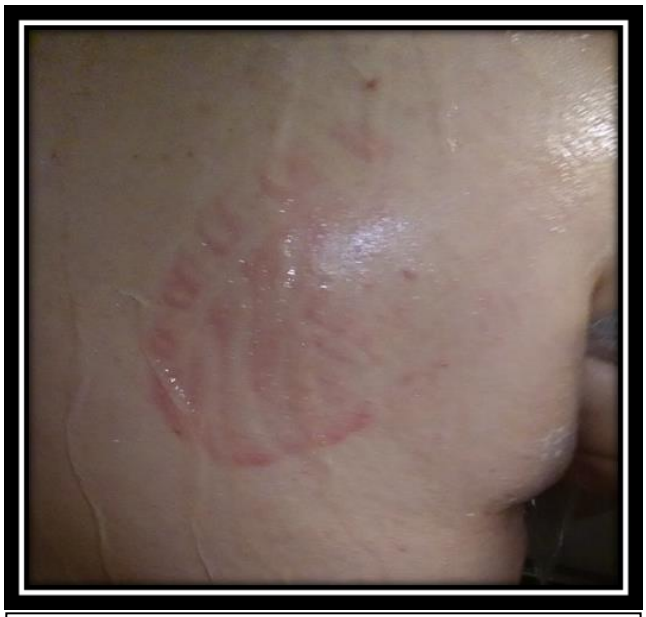
A culture of abuse and neglect, which goes unreported and unaddressed, exists because Woods has failed to address system-wide problems. This failure places all residents at significant and on-going risk of abuse, neglect, and injury.

In fact, DRNY's findings confirm the same violations continue today. Only when DRNY brought these issues to the attention of OPWDD and NYSED did those agencies schedule site visits to Wood in 2017. NYSED's site visit substantiated thirty four (34) separate violations of New York State's Special Education regulations. Likewise, in 2017 OPWDD again found significant deficiencies at Woods.

Despite this monitoring, residents were still not protected from further abuse. In May 2017, a resident with autism was beaten with a shoe. In February 27, 2017, a staff member was

[2] ACS renewed its contract with Woods in 2011, after the death of Bryan Nevins at a rate of $385 dollars a day which was far higher than their rate for in-State residential programs. *See* The New York World, Despite Recent Deaths, Youth Care Contract on Track For Renewal, (September 22, 2011) accessible at: http://www.thenewyorkworld.com/2011/09/22/despite-recent-deaths-youth-care-contract-on-track-for/

arrested for punching a thirteen year-old in the face which fractured his nose.[3] Unless and until Woods is held firmly and permanently accountable, New York's most vulnerable citizens remain at high risk of abuse, neglect, and abandonment.



PHOTOGRAPH OF A SHOE PRINT INFLICTED BY WOODS STAFF FOUND ON THE BACK OF A YOUNG FEMALE STUDENT IN MAY 2017

COMPLAINTS TO DRNY

From June 2016 through August 2016, DRNY received multiple complaints of abuse and neglect of students and adults with intellectual and developmental disabilities. These complaints include:

- Students and adults were being subjected to excessive and inappropriate physical restraints;
- Improper use of restraints caused multiple bruising to a child;
- Failure to notify parents of the use of physical restraints;
- Neglecting to monitor a health condition resulted in a resident being placed in the intensive care unit for a week and almost dying;
- Physical assault by staff causing a child to suffer a fractured jaw and the loss of two (2) teeth;
- Staff assault of another young adult necessitated emergency medical attention and a black eye; and
- Physical assault by staff on a third young adult.

[3] *See* Levitttownnow, Woods Services Caretaker Charged with Assaulting 13 Year Old, (February 27, 2017), accessible at: http://levittownnow.com/2017/02/27/woods-services-caretaker-charged-with-assaulting-13-year-old.

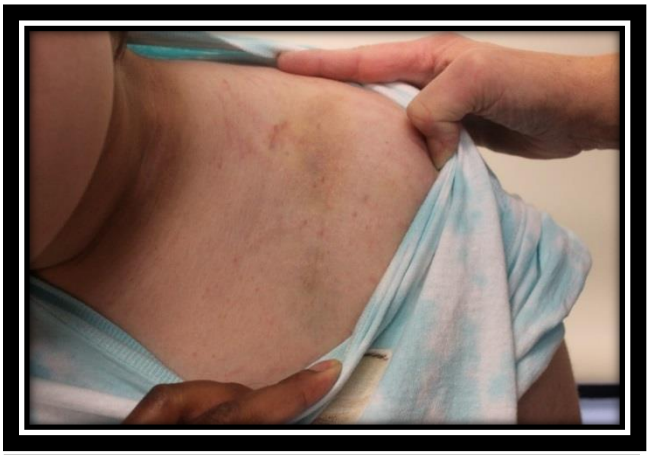
INVESTIGATIVE FINDINGS

I. Use of Physical Restraints in Violation of Federal and State Laws

Finding: Woods uses excessive amounts of physical restraints.

Woods illegally uses physical restraint as a substitute for less restrictive behavior interventions in violation of New York State law.[4] Woods is required to follow New York law and regulations, which set out clear rules limiting physical restraints to emergency situations, i.e. where an individual poses a danger to themselves or others.[5] While Woods' restraint policy states "restraints should not be used in a punitive manner, for the convenience of staff, or as a program substitution," DRNY's investigation reveals this is not its practice.

In fact, Woods accounts for eighty-five percent (85%) of all restraints on adults with intellectual or developmental disabilities residing in State-operated and certified residences in the Southeast region of Pennsylvania (the most populous region of the State), despite the fact that Woods only serves about three hundred (300) adults with disabilities.



PHOTOGRAPH OF BRUISE ON STUDENT'S SHOULDER AFTER A RESTRAINT IN SEPTEMBER 2016

In January 2016, the Justice Center for the Protection of People with Special Needs (Justice Center) found that a student with intellectual disabilities was abused by a staff's use of a physical restraint. Woods was directed by the Justice Center and NYSED to implement a corrective action plan to retrain staff on de-escalation strategies and recognizing legitimate signs of dangerousness to self and others. Yet, in February 2016, the Justice Center substantiated that Woods abused the same student by using inappropriate restraints. In August 2016, the Justice Center substantiated that Woods abused another student with the use of restraints. Woods again was directed to retrain their staff. Instead, Woods responded that the restraint was justified, and disputed whether any corrective action was needed.

The very next month, the Justice Center substantiated that staff had abused another student with autism through an inappropriate use of restraint. Woods was again directed to retrain its staff on legitimate signs of dangerousness. However, in November 2016, a second allegation of abuse for inappropriate restraints on the same student with autism was substantiated.

[4] NYCRR 200.22(d); 14 NYCRR 624.3(b)(4); 14 NYCRR 624.4(c)(1); 18 NYCRR 441.17

[5] *See* 8 NYCRR 200.15(a); NY Ment. Hyg. § 16.13; 18 NYCRR 441.1.

Despite repeated admonishment by New York State oversight agencies, Woods has not implemented any corrective actions to address these findings of repeated abuse.

Finding: Serious injuries have resulted from Woods' staff use of physical restraints on New York adults and students.

The use of physical restraints have caused serious injury to New York residents.

In May 2016, staff restrained a child with intellectual disabilities. During the restraint, staff reported that he "was banging [his] head on the ground and fighting staff. [He] was observed having difficulty breathing and we stopped the restraint immediately. Supervisor contacted the nurse . . ."[6] When Woods' nurse arrived she found the child lying unconscious on the floor and gasping for air. The nurse administered 2 liters of oxygen after which he became conscious and was taken to a hospital. DRNY interviewed the child who stated staff had intentionally placed their elbows around his throat choking him unconscious.

When Woods' nurse arrived she found the individual lying unconscious on the floor and gasping for air. The nurse administered 2 liters of oxygen.

Woods did not properly report this incident to New York State. The report to Pennsylvania did not include that the child required oxygen following the restraint and instead only stated that the restraint was due to "on-going behavioral episodes…"[7] Finally, Woods did not tell the parent that their child needed treatment at a hospital emergency room because of a restraint. When the parent learned of the incident, Woods claimed that their child became unconscious due to self-injurious behavior.

In January, June, and December of 2016, three other individuals were injured as a result of inappropriate restraints. The first incident involved an adult with Prader Willi Syndrome (PWS), who was restrained by four (4) staff resulting in a fractured finger.

A second incident occurred in June 2016, when a student with autism refused to leave the pool area. Staff members forcibly picked her up and removed her resulting in injury. This incident was not reported to New York State's oversight agencies, nor was it reported to the child's parent. Instead, when the parent later found out about the injury, the parent reported it to the Justice Center which concluded that a staff member intentionally misrepresented the incident by creating a false incident report months later in October 2016.

A third incident involved a child with an intellectual disability who was put into a chokehold during a restraint. Woods' staff admitted that their arm was up against this individual's throat during the restraint.

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[6] Woods Incident Report, (May, 3, 2016).
[7] Id.

Finding: Woods' physical restraint curriculum does not comply with New York State's OPWDD regulations.

Woods' training curriculum for restraints and restraint prevention fails to comply with New York State regulations. Woods uses its own physical restraint curriculum known as Self-Awareness, Milieu, Active Engagement, Relationship Building, and Tools ("SMART"), instead of OPWDD's physical restraint curriculum for adults known as Strategies for Crisis Intervention and Prevention Revised ("SCIP-R").[8] The SMART curriculum is not approved by any regulatory agency in Pennsylvania or New York, and differs substantially from SCIP-R. OPWDD has determined that failure to train staff in the SCIP-R curriculum substantially increases the risk of harm and injury.[9]

On November 14, 2016, an individual with PWS was restrained on the floor by six staff members. This is a clear violation of SCIP-R which allows only a maximum of three staff to restrain an individual on the floor absent clinical justification, for a maximum of four (4) staff.[10] This was not an isolated incident.

In December 2016, DRNY observed five staff members restraining an individual in a wheelchair who was visibly upset. Another individual with PWS was restrained for 30 minutes on two separate occasions. SCIP-R does not permit a restraint to last longer than 20 minutes "without evidence that an attempt to release the person receiving services has been made, [if not, it] should be reported as an allegation of physical abuse."[11]

Woods failed to report any of these restraints to New York State's oversight agencies.

Finding: Woods failed to report emergency interventions on students to their parents as required by New York State regulations.

Prior to DRNY's investigation, Woods consistently failed to report the use of physical restraints, (called "emergency interventions" in New York's Education Law), to parents as required by New York State regulations.[12] DRNY first received complaints in June 2016 when Woods failed to

[8] 14 NYCRR 624.4(c)(1); *see* OPWDD, The Part 624 Handbook A Handbook for all OPWDD Providers, 50 (2011) "'[u]ntrained staff' refers to those staff members who have never been trained in the OPWDD training curriculum that includes physical/personal intervention techniques."
[9] OPWDD, The Part 624 Handbook a Handbook for all OPWDD Providers, 51 (2011), accessible at: https://opwdd.ny.gov/sites/default/files/documents/maual_part624_handbook.pdf
[10] OPWDD allows for four person restraints, but there must be a clinical justification to do so.
[11] Id., at 50.
[12] 8 NYCRR 200.22(d)(4).

notify the parents of a DRNY client with autism of an emergency intervention that resulted in injury.[13] This incident was later substantiated by the Justice Center as an abusive restraint.

Similarly in 2015, Woods engaged in at least three separate emergency interventions on a student with an intellectual disability. Woods' records reflect that they did not notify the parents of this child.

Finding: Woods' staff used unnecessary physical restraints on adults and students.

Woods' staff inappropriately restrained individuals that do not pose a danger to themselves or others in violation of federal and state laws and regulations.

In August 2016, a student with an intellectual disability was restrained after she refused to remain in her bedroom during an inappropriate mandatory seclusion time from 3:00 pm to 4:00 pm. Nothing in the incident report stated that the student posed a danger to herself or others prior to a physical restraint being implemented. The incident report stated that the student stood in the living room and argued with staff about whether it was necessary for her to go back to her bedroom. When staff tried to redirect her back to her bedroom, she left the residence, was restrained by three staff members, and brought her back to the residence.

Then again, in October 2016, the same student was restrained after she complained to her residential supervisor about the way staff treated her and refused to leave the supervisor's office. Staff resorted to an unnecessary and inappropriate restraint of this student instead of briefly leaving the office to allow the student to calm down.

II. Absence of Appropriate Positive Behavioral Interventions and Behavior Plans

Finding: Woods' positive behavioral intervention and support system for both students and adults is punitive and inappropriate.

Woods' positive behavioral intervention and supports ("PBIS"), system is often punitive and inappropriate. Residential schools are required to develop and implement Behavioral Intervention Plans (BIP), to address students' dangerous or disruptive behavior.[14] New York State also requires residential facilities to develop and implement behavior support plans for adult service recipients.[15] Both federal law and state regulations require schools to conduct a

[13] In addition, Pennsylvania's Special Education Regulations require Woods to convene an IEP meeting within 10 school days following an emergency restraint unless the parents or guardians, after written notice, agree to waiver the meeting. Woods neglected to notify the parent of the right to an IEP meeting following the June 2016, emergency restraint and consequently an IEP meeting was not convened.

[14] 20 U.S.C. § 1414(d)(3)(B)(1); 8 NYCRR § 200.22(b)(1)(i); *Id.* § 200.1(d).

[15] 14 NYCRR 633.16(e).

Functional Behavioral Assessment (FBA) for students to determine the root cause of the targeted behavior, and then how to best address it.[16] In addition, programs must periodically review each student's BIP to evaluate how effective the interventions are in meeting the student's needs.[17] The intention behind these plans is to reduce the use of highly restrictive and often dangerous interventions, such as restraint and seclusion, as a substitute for safer and more effective forms of behavior support.[18]

Woods failed to meet residents' behavioral support needs, and instead utilized reactive and restrictive physical restraints and seclusion. Consequently, New York residents were subjected to excessive restraints.

One individual was restrained fifty eight (58) times in 2014, fifty nine (59) times in 2015, and thirty eight (38) times through November 22, 2016. Similarly, another individual was restrained twenty one (21) times from January to November 2016. It is not apparent that Woods explored less restrictive alternatives for these individuals. Rather, Woods utilized restraints as a substitute for appropriate programming and less restrictive alternatives.

In March 2017, NYSED cited Woods thirteen (13) times for failure to follow behavioral plans.

- Woods had not conducted an FBA or the FBA was out of date for six (6) students;
- No BIP identified baseline data for behaviors;
- Five (5) student's BIPS lacked antecedent strategies to alter problematic behaviors;
- Seven (7) student's BIPs did not include any strategies to teach alternative adaptive behaviors; and
- Woods lacked any polices on why a student would be placed in time out.

WOODS' BEHAVIORAL INTERVENTION SYSTEM DESCRIBING THE LOSS OF RECREATIONAL AND OUTSIDE CAMPUS TRIPS

Some interventions specified in residents' plans caused them to become more aggressive or self-injurious. For example, one resident's plan stated he has emotional outbursts and leaves his program if he is not allowed to go on off-campus outings. Instead of allowing him to take a walk on

[16] 14 NYCRR 633.16(d).
[17] 8 NYCRR 200.22(b)(5); 14 NYCRR 633.16(e)(2)(ix).
[18] *See* 8 NYCRR §200.22(d)(2); 14 NYCRR § 633.16(c)(3)-(5).

campus to decompress, his plan directs staff to "physically redirect" him back to the workshop and restrain him if he becomes aggressive.

Another resident's plan establishes unreasonably high and vague behavioral expectations. This resident becomes angry when staff prevent him from leaving his residence without permission. Nonetheless, his plan requires him to be "appropriate" for twenty one (21) hours to go on an off-campus outing. This unrealistic expectation needlessly creates a cycle of reactive interventions. The resident becomes upset because he is forced to remain on his residential unit, thus resulting in behavior prompting repeated restraints.

Even when Woods attempts to adopt non punitive measures within a behavioral plan, these plans are not followed. For example, one student's plan prescribes a reward-based system and verbal redirection, yet staff repeatedly respond by restraining her.

Another student's records reveals numerous incidents of repetitive self-injurious behavior without any evidence that Woods used a mat to protect her from injury as prescribed in her plan. On a single day, this person hit her elbow twenty three (23) times, hit her ankle six (6) times and hit her head thirty eight (38) times.[19]

Another resident's plan clearly states that she becomes upset when not provided fresh hot food and directs staff to provide a different snack if she yells about the cold food. In July 2016, she was restrained twice after becoming upset when staff failed to provide a snack. Woods's staff refused to modify its practice of transporting food from across the campus where it is neither hot nor fresh. Consequently, she engaged in behavior that resulted in the use of repeated physical restraints.

III. Illegal Retaliation Against Residents and Family Members Who Complain

Finding: Residents feared retaliation for making complaints.

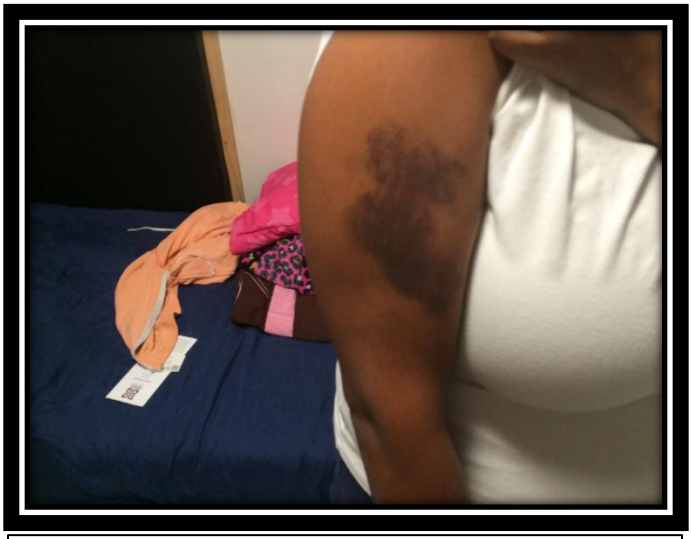
Several students reported a disturbing pattern of intimidation and physical assaults when making complaints about staff. Residents are fearful of staff members, especially in the residences, with some students referring to staff as "the mafia". They consistently reported that any sign of perceived disrespect, even to the most basic infraction, is met with physical and emotional retribution. Pennsylvania's Bureau of Human Services Licensing has found Woods staff retaliated against students when they do not follow their orders.

In December 2014, a student was pushed to the ground and punched in the back of the head by staff after he refused to follow staff's order to not call the maintenance department to replace a broken lightbulb in his bedroom.

[19] Prior to DRNY's investigation, Woods did not utilize a body check form to document injuries. When asked to do so by DRNY they were initially reluctant, but finally agreed at DRNY's insistence.

Another staff member pushed a student with a traumatic brain injury (TBI) when he reported the staff member for threatening him.[20]

An adult with an intellectual disability complained to management about the rate of pay at Woods' on-campus Common Grounds café; in response he was fired and placed at the sheltered workshop where he now receives significantly less wages.



DRNY DISCOVERED A BRUISE ON THE ARM OF A RESIDENT WHO SAID SHE WAS AFRAID TO REPORT IT TO STAFF.

Woods' professional evaluators may also be complicit in retaliatory practices by designing behavioral programs that punish allegedly false accusations. For instance, one student's behavioral assessment states that she has a tendency to lie and manipulate, and staff should take the punitive response of refusing to let her go on off-campus outings, participate in on-campus activities, or receive her allowance. Consequently, this student is punished for reporting allegations of abuse. This practice legitimizes retaliation, and has a chilling effect on reporting complaints.

Staff has also retaliated and intimidated residents who have spoken with DRNY investigators about their concerns. For example, staff created an incident report for a student after she called DRNY, suggesting that staff treated it as misbehavior. Likewise, a program administrator interrogated two students about what they had discussed with DRNY investigators and whether they had signed consents to release their records. The administrator's conduct was sufficiently intimidating to temporarily dissuade the student from seeking further assistance from DRNY.

IV. Reporting and Investigation of Abuse, Neglect, and Other Serious Incidents is Grossly Improper

Finding: Woods did not consistently report incidents of abuse to New York State's oversight agencies.

Woods inadequately investigated and failed to report allegations of abuse to New York State. In March 2016, Woods' Clinical Director neglected to notify New York State's oversight agency, the Justice Center, of an allegation of abuse. The Justice Center concluded that the Clinical Director needed to be retrained, but the next month, the Clinical Director failed to report another

[20] Woods Incident Report, (Jun. 20, 2016).

allegation of abuse. The Justice Center demanded "corrective actions that … should include systemic change and should not mirror previously reported corrective actions that have proven ineffective."[21]

In response, Woods agreed to no longer have its Clinical Director complete investigations into abuse of New Yorkers, fired another one of its investigators, and reassigned a third investigator as a job coach. Nevertheless, in May 2016, Woods again failed to report an allegation of abuse. Once again, the Justice Center recommended that Woods identify systemic corrective action to address the repeated failure of its investigators to interview all potential witnesses as a means of gathering evidence, noting that previous corrective actions have been ineffective. In addition, the Justice Center found that Woods delayed the reporting of physical abuse of a student with an intellectual disability which hindered safety measures for the student. Woods once again agreed to retrain their staff on how to report allegations of abuse. However, DRNY's investigation identified additional unreported instances of reportable abuse since that assurance.

> *"The amount of unreported abuse is over the top but that is not to even be compared to the amount of abuse that gets reported and management makes it go away to avoid dealing with it. Those clients are going to be leaving [Woods] with more issues than they had when the[y] entered."*
>
> *Current Woods Staff Member*

In June 2016, a staff wrote "I attacked [the student, he] threatened to attack me when [he] returned to [the residential] unit."[22] The staff person's supervisor did not follow-up on this admission of abuse, and merely signed the incident report without comment. There is no evidence that this admission of abuse was reported to the Justice Center as required.[23]

Another staff member corroborated that the student had been abused. This staff member documented on an incident report that the student was asked to get off the phone while talking with his family, or potentially lose his off-campus privileges. When the student complained, he was pushed by staff. It was reported that the assault occurred in the presence of this manager. The student complained to the manager, who responded by saying he had not seen anything. The report further states that the staff who assaulted the student later struck him in the face. This student was not seen by a nurse, and the supervisor's only follow-up was to write "unit

[21] Letter from Director of Quality Improvement at Woods, to Principal Professional Conduct Investigator Office New York State Education Department's Special Education Quality Assurance Incident Management Unit, (Apr. 28, 2016).
[22] Woods Incident Report, (Jun. 20, 2016).
[23] Similarly in March of 2016, an individual placed at Woods by ACS complained to their house manager that staff choked them during a restraint without evidence that this allegation was reported to the Justice Center.

manager notified of incident that allegedly occurred during the 3-11 shift @ unit over weekend."[24]

In August 2016, a parent reported to staff that she saw a cigarette burn on her daughter's hand. Woods' incident report described the injury as a "circular abrasion", and not an allegation of possible abuse. The burn was not reported to the Justice Center.

In April 2017, a student was punched by a staff member. This incident was not reported to the Justice Center until two months later and only after two staff who witnessed the incident were overhead discussing it by other staff, who then reported it. Shortly thereafter, the three staff members were terminated, and the Bucks County District Attorney issued an arrest warrant for one of the staff accused of hitting the New York student.

Finding: Investigations into allegations of abuse are inadequate.

In January 2015, a resident was punched in the eye by staff. Woods' records contain contemporaneous pictures clearly showing he had a black eye. In addition, emergency room records state the individual "reports [he was] struck by staff [Woods'] Aide with him agrees, states incident was reported to Nursing supervisor, doctor and administration."[25] Despite the staff agreeing that abuse had occurred, the Woods' investigator did not substantiate the allegation. Instead, Woods claimed that this individual recanted their allegation and the injury was caused by a fall.

On two separate occasions, DRNY investigators interviewed this individual about this incident. Both times he stated he was hit in his bedroom and refused to follow staff's order, used a racial slur, and spit at staff. He said he recanted his allegations after the Woods' investigator pressured him to do so. DRNY discovered, and OPWDD has substantiated, that Woods' investigator questioned this individual while the supervisor was present and allowed the supervisor to state that the alleged victim was lying about being abused during the interview. After this incident, the individual's mother demanded the installation of video cameras in his room. Video footage from October of 2016, revealed staff physically pushing him six (6) times for failing to comply with their orders.

Similarly, an adult with autism alleged that in March 2015, he was punched in the face by a staff member. The individual wrote a detailed statement about the alleged abuse asserting that a staff member bullied him by repeatedly requesting that he punch him. When he finally complied by timidly striking the staff member, the staff member immediately responded by punching him in the face. The Nurse documented that the resident had a swollen lip. According to this individual, the Woods' investigator pressured him to recant his allegation, but he insisted that he had been abused. Despite his detailed statement and evidence of an injury consistent with

[24] Woods Incident Report, (Jun. 20, 2016).
[25] St. Mary Medical Center, Medical Records for Service Recipient, (Jan. 27, 2015).

being punched, Woods' investigator was "unable to determine whether staff hit [him and] was unsure how [he] obtained the cut on [his] lip . . ."

Finding: Woods characterized allegations of neglect as accidents to avoid investigation.

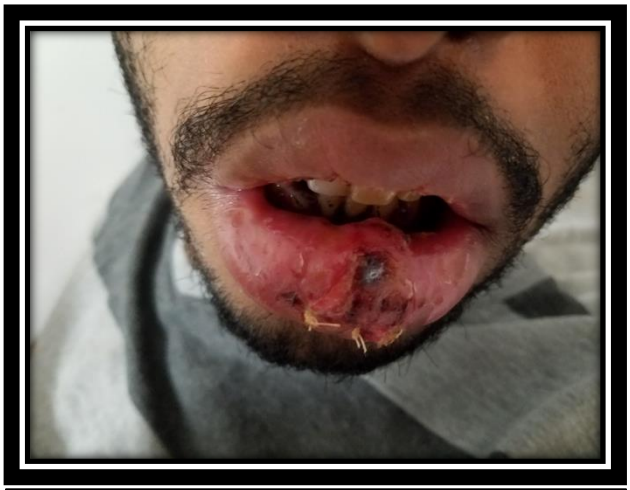
Woods does not investigate all allegations of neglect because it reports some incidents as accidental injuries. DRNY discovered numerous other incidents attributable to neglect, but characterized by Woods as injuries.

In December 2014 "while preparing [a seventy eight (78) year old resident] for shower, staff left to check on a noise in next room. Staff came b[ac]k to find [her] on floor next 2 toilet & vanity. [The] ER treated ¼ inch lac[eration to right] occipital w/2 staples." Woods did not investigate this injury for potential staff neglect. Woods did not report this injury to Pennsylvania's oversight agency, the Administration on Aging as required. And, because this individual is privately funded to be at Woods, no report to the Justice Center was required.

In March 2015, an adult with autism was treated at the emergency room for repeated vomiting. He was diagnosed with "acute Depakote toxicity," even though his Depakote levels should have been minimal after his physician discontinued the medication in February. Even though toxicity means that the medical order was likely ignored, no investigation was conducted. Woods likewise failed to report this incident to New York State and instead documented that a report to "NY not needed."

In April, 2015, the same adult with autism ended up in the emergency room with a fractured wrist due to repetitive self-injurious behavior at Woods' day program. Woods stated that he jumped off a desk onto the floor three (3) times in the span of five (5) minutes. A half hour later he attempted to jump over a desk and injured his lip. When Woods' nurse examined him, she noted a fat lip and a swollen hand. Woods did not investigate possible neglect by their staff for failing to intervene and prevent this individual from hurting himself.

In June 2016, less than two weeks before the same individual was to be repatriated to New York State, he ended up in the emergency room with serious injuries including a lacerated lower lip requiring stitches, two lost teeth, and a fractured jaw. Woods' staff mischaracterized these injuries as "a cut on [his] bottom lip." Two (2) Woods staff members claimed that this injury was the result of him hitting the corner of a wall while falling. However, pictures of the wall and investigatory records are inconsistent with the staff members' explanation of the



PHOTOGRAPH OF RESIDENT SWOLLEN LIP WITH STITCHES AFTER HE LOST TWO TEETH AND FRACTURED HIS JAW.

incident. The injury was not reported to New York State. Instead, his mother reported the injury to the Justice Center who found that the "account of the incident was completely different than what [staff] reported and documented [and] did not contain the broad impact or velocity required to cause [the individual's] injuries."

V. Facilities Were Unsanitary & Residents Lacked Privacy

Finding: Woods' facilities were unsanitary, unsafe, and unhygienic.

Woods puts residents in danger by operating unsanitary, unhygienic and unsafe facilities. In October 2016, DRNY visited Brown Hall, a residence which houses thirty six (36) adults. The stench of urine permeated the building. The building's common area was very dim and music was blaring loudly; the television casted flickering shadows. Residents in the facility were not engaging in any meaningful activity, with some individuals hitting themselves without any redirection from staff.

PHOTOGRAPH OF BATHROOM WITH DIRTY TOILET BRUSH ON THE FLOOR AND STAINS ON THE WALL.

Other facilities at Woods raised additional concerns. At Woods' Garner Education Center (GEC), debris was scattered throughout the building including coins, rubber bands, toy pieces, and dirt in the "counseling rooms" where students go or are taken to deescalate. These conditions posed a particular hazard to the students at Woods who have PICA, a condition involving the persistent ingestion of inedible objects.

At another residence, the freezer had a jagged, broken handle with extremely sharp edges, posing a safety hazard. Cockroaches were observed at the short term autism residential treatment facility. In October 2016, an infestation of bed bugs was reported to Pennsylvania's Child Protective Service. Two (2) New York students were covered in bug bites. Two (2) separate reports of neglect were made by parents of the New York students to Pennsylvania's Child Protective Service that administrators instructed staff to not to tell parents about the bed bug infestation.[26]

Immediately following this visit, DRNY, DRP, and DRNJ wrote to Woods' administration about the unsanitary, unhygienic, unsafe conditions within its facilities. Woods agreed to clean up the debris at the GEC and have pest control address the infestation of insects on its campus. Woods

[26] Bureau of Human Service Licensing, Childline Report of Suspected Child Abuse and Neglect, (Oct. 10, 2016); Bureau of Human Service Licensing, Childline Report of Suspected Child Abuse and Neglect, (Oct. 10, 2016).

also agreed to have its housekeepers mitigate the smell of urine in Brown Hall. Finally, Woods replaced the broken freezer handle.

When DRNY visited Brown Hall in December of 2016, the facility smelled significantly better and the lighting had been improved. However, when OPWDD visited in January of 2017, it found that two residences smelled of urine.

Finding: Residents did not have privacy while using the bathroom or in their bedrooms.

Residents lacked basic human privacy at Woods. A manager brought DRNY to one resident's bedroom, stating the resident was ready to meet us. Without knocking, the manager opened the door. The resident was naked having just gotten out of the shower. The manager then stated another resident was ready to meet with us but, again, when staff brought the individual to the door of his bedroom, he was naked but for a towel which did not protect his modesty.

DRNY, DRP, and DRNJ observed privacy concerns throughout the facility. Students in the school setting toileted in a classroom bathroom with the door wide open. An adult resident toileted in a hall bathroom with the door open. Finally, several residents reported to DRNY that they were not allowed to use bathrooms in private. In fact, DRNY found that all bathrooms and bedrooms lacked locks.

In November 2016, DRNY, DRP, and DRNJ demanded that Woods address these concerns. In response, Woods agreed to install bathroom door locks by the end of 2016, and to reemphasize to their staff the need to protect the privacy of its adult and student residents.

VI. Inadequate Assistive Technology

Finding: Woods failed to provide adults and students with appropriate assistive technology or augmentative communication systems.

Woods failed to provide residents with necessary and appropriate assistive technology ("AT") including safety equipment and communication devices. Such devices are critical for safety, effective communication, and skill building.

One (1) residence did not have a Hoyer lift, a device that allows the safe transfer of individuals with mobility impairments, even though two (2) New York residents require this device due to significant mobility impairments. Instead, a staff person stated he physically lifts and carries individuals, putting individuals at risk of falling during this process.

Likewise, the school program failed to provide students with communication disabilities with augmentative communication systems. A student was only given a toy to say "hello" instead of an adequate communication device. Another student was not provided access to a picture

exchange communication system required by her educational plan. The system that the parent provided remained untouched in the speech therapist's office for almost a year.

In addition, there was no evidence augmentative communication systems were utilized by Woods' adult resident population. DRNY, DRP, and DRNJ demanded that Woods address these failures. In response, Woods asserted that there are forty three (43) children in its school utilizing electronic communication devices and that there "are substantial number of adult clients using these technologies as well." Nonetheless, DRNY did not observe any adult or student resident with an electronic communication device during our monitoring visits.

At a subsequent visit in January of 2017, Disability Rights Maryland found nothing to support the assertions of Woods and observed residents with AT needs without communication devices. Depriving individuals of the means of effective communication is a well-established cause of behavioral challenges.

VII. Woods' Segregated Employment Program Violates Federal Labor Laws

Finding: Woods' segregated employment program inappropriately paid substandard minimum wage and discriminated against workers on the basis of their disabilities.

Woods takes illegal financial advantage of residents working in its sheltered workshop and failed to prepare others for competitive employment. Woods' policies and practices represent an outdated approach to employment for people with disabilities. Many New Yorkers at Woods continue to work in segregated settings, often for subminimum wage, with little to no assistance in building the skills necessary for employment in other workplaces. In the sheltered workshop, the residents engage in repetitive tasks such as putting together umbrellas or flags.

Section 14(c) of the Fair Labor Standards Act establishes an exception to its minimum wage requirement for people "whose earning or productive capacity is impaired by" a disability.[27] However, a sheltered workshop can only pay a worker with a disability a subminimum wage if the worker's disability interferes with the worker's ability to perform the assigned tasks.[28]

Woods, however, pays subminimum wage even when the individual's disability does not affect productivity. For example, one resident with autism worked two days a week for minimum wage doing data entry at Woods, but spent the rest of his week working for a subminimum wage at Woods' sheltered workshop. His disability had no impact on his ability to perform his assigned tasks.

[27] 29 U.S.C. § 214(c)(1)(A).
[28] 29 C.F.R. § 525(5)(a).

Another resident was transferred to the workshop after he made complaints about his job at Woods' café where he was working for minimum wage. He was paid $5.74 for the work performed in the sheltered workshop even though his performance was not impeded by his disability. Woods paid another worker subminimum wage even though the worker's only disability is listed as Tourette's syndrome – a condition which would have no impact on his productivity in the sheltered workshop.

Finally, when DRNY observed Woods' workshop in October and December 2016, almost half of the individuals were sleeping or looking at magazines because there was not enough work to do. During downtimes such as these, Woods is supposed to pay its workers minimum wage; however it did not do so.

PHOTOGRAPH OF A RESIDENT SLEEPING AT THE SHELTERED WORKSHOP

VIII. Woods' Day Program Neglected Individuals With Disabilities

Finding: Woods' day program deprived New Yorkers of appropriate and effective training and skill building.

Day programming for adults at Woods failed to provide appropriate and effective skill building and training. Woods offers a day habilitation program at the Holland Enrichment Center (HEC). DRNY found participants were not engaged in any activities, instructors were not present, no community outings were scheduled, and programming included watching television. The day program director was unfamiliar with the term "community integration."

In addition, Woods failed to offer alternative day programming for residents who do not want to go to the HEC. DRNY observed an individual with an intellectual disability refusing to get off the van and enter the day program. Program administrators reported that this individual had refused to attend for six months. Staff would simply bring him back to his residence each day. At the residence, he received no programming at all, remaining indoors throughout the day. DRNY asked whether Woods had considered alternative options for him including taking him on outings into the community. The administrators responded that they would have to hold a meeting to discuss this possibility, and had no plans to do so at the time. When OPWDD visited Woods in January of 2017, they also noted that this resident was still not attending day program and merely spending his day at his residence.

Rather than preparing residents to transition to more integrated settings, the HEC caused some residents to decompensate. Woods is warehousing people with disabilities and does not

provide opportunities for residents to learn skills and participate in community-based activities while they await repatriation to New York.

X. Woods' Failed to Obtain Informed Consent and Lacked a Human Rights Committee

Finding: Woods failed to obtain informed consent from adult residents or their guardians for medical treatment, behavioral modification, and human rights restrictions.

Woods neglected to obtain informed consent for medical treatment, behavioral modifications, and human rights restrictions on New York residents. According to New York State law, when an individual turns 18, they are presumed to be competent and have the ability to make their own decisions regardless of disability.[29] Consequently, such individuals must provide informed consent for medical decisions,[30] the use of physical restraints, and human rights restrictions.

In situations where a person is not able to provide consent due to the severity of his or her disability and does not have a guardian, the provider should seek approval and consent from a Human Rights Committee.[31] Woods does not have a Human Rights Committee. Indeed, on Woods' behavioral management review committee forms (which authorizes the use of physical restraints), there is a section to be completed by a Human Rights Committee to approve the use of restraint. However, in every resident file that DRNY reviewed, this section was blank, even though individuals were repeatedly subjected to physical restraints.

Similarly, in 2013, OPWDD found that Woods neglected to obtain the necessary consent to prescribe psychotropic medications and authorize physical restraints on residents. However, in the four years since that finding, Woods continues to neglect its duty to obtain consent from individuals who are able to provide informed consent for medical treatment, physical restraints, and human rights restrictions; or to utilize a Human Rights Committee. Woods did not obtain informed consent before subjecting a resident to psychotropic medications, physical restraints, and restricting access to food. Woods did not obtain informed consent for several students over the age of 18 before administering psychotropic medications, using physical restraints, and confining them to their residences.

In January 2017, OPWDD again found that Woods failed to obtain informed consent from adult residents for psychotropic medications and physical restraints. Woods' consistent failure to seek required consent is both abusive and illegal.

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[29] Domestic Relations Law § 2.

[30] Pennsylvania's regulations also stipulate that for medical treatment Woods is obligated to make "reasonable efforts . . . to obtain consent from the individual or substitute consent in accordance with applicable law." 55 Pa. Code § 6400.143

[31] 14 NYCRR 633.16

CONCLUSION

Woods has been a troubled agency that provides inadequate custodial care to the individuals with disabilities that are placed there. Woods' negligence has already lead to the deaths of two New York residents in less than a decade, and to date Woods has failed to take the steps necessary to correct its numerous and systemic deficiencies. In almost every respect, all of its facilities and programs have serious and troubling deficiencies. Accordingly, individuals with disabilities at Woods are at risk of serious injury, death, psychological harm, and trauma.[32]

Despite Woods' glaring long standing deficiencies, neither New York State nor Pennsylvania's regulatory agencies have adequately monitored Woods nor held it accountable for endangering the welfare of residents and violating their civil and human rights. New York's most vulnerable citizens are without meaningful protection from any regulatory agency that would otherwise be responsible for their welfare.

PROPOSED IMMEDIATE ACTIONS

Use of Physical Restraints:

1. Establish meaningful processes to ensure that physical restraints are not to be used "in a punitive manner, for the convenience of staff persons or as a program substitution," and retrain staff from utilizing restraints in non-emergency situations.

2. Take immediate steps to comply with OPWDD's *Strategies for Crisis Intervention and Prevention-Revised* for all OPWDD-funded adults at Woods.

3. Obtain informed consent from service recipients or their legal guardians for physical restraints, and human rights restrictions.

4. Hire an independent consultant to assist with developing meaningful processes to reduce and eliminate the use of physical restraints.

Development and Implementation of BIPs, FBAs, and PBIS:

5. Hire an independent consultant to assist with developing an appropriate positive behavioral intervention system.

6. Implement IEPs, BIPs, and Behavior Support Plans as written before imposing restraints. If restraints are consistently needed, the FBA and BIP must be reviewed and revised.

[32] In May of 2017, a parent of a former Woods student who has been repatriated back to New York State discussed with DRNY that her son is experiencing symptoms of PTSD after returning to New York State. He will oftentimes state "No Woods" and "bad Woods."

7. Designate one or more staff (administrator, school psychologist or behaviorist) in each school building to periodically review all Emergency Intervention Forms to identify developing patterns of behavior and ensure that FBAs and BIPs are current, accurate and consistently followed.

8. Require a timely team meeting which includes the school psychologist, teacher, parent and CSE administrator to review and modify, as needed, the most recent FBA, BIP and IEP whenever an emergency intervention is used on a student more than three (3) times in a three (3) week period.

Documentation and Reporting:

9. Complete and submit an OPWDD 147: Reportable Incidents and Notable Occurrences, for all OPWDD funded individuals, as they are required to do so, when necessary.

10. Whenever an emergency intervention is utilized on a New York student, report this intervention in accordance 8 NYCRR 200.22(d).

11. Maintain records regarding the use of emergency interventions in accordance with 8 NYCRR 200.15(f)(1)(b).

12. Comply and enforce reporting polices for staff regarding allegations of abuse and neglect.

13. Create an incident review committee and send annual incident trend reports to OPWDD which it is required to do pursuant to 14 NYCRR § 624.7(a).

Abuse and Neglect:

14. Implement the Justice Center's corrective action plans, as instructed.

15. Investigate all allegations of abuse and neglect. This includes interviewing all witnesses, interviewing the service recipient, and gathering all evidence in a timely manner.

16. Incorporate reporting obligations, including reporting to the Justice Center, for all allegations of abuse and neglect.

17. Any time an injury occurs to a resident, investigate the injury as a possible instance of abuse and/or neglect.

18. Create an anonymous ethics hotline which will allow service recipients, family members, and staff to report concerns, without fear of retaliation.

Day Services:

19. Assist individuals whom are interested in pursuing competitive integrated employment by referring them to the federally funded Pennsylvania Office of Vocational Rehabilitation.

20. Conduct accurate time studies for its sheltered workshop with a nexus between an individual's disability and why they are being paid a substandard minimum wage.

21. Compensate the individuals with a disability at minimum wage during down time in the workshop when there is not enough work for them to do.

22. Reimburse all sheltered workshop employees who were illegally paid a substandard minimum wage.

23. Woods must provide meaningful treatment and community based opportunities for individuals attending its day program.

24. Woods should create a "without walls" day program which would allow individuals to have a personalized, community based day habilitation experience.

25. For individuals who do not want to attend Woods' day program, explore one-on-one community based opportunities for these individuals, rather than having these individuals spending their day at their residence without programming.

Quality of Life:

26. Immediately discontinue its mandatory seclusion time from 3pm to 4pm for students.

27. Hire an independent consultant to assist with person center planning, developing community integration opportunities, independent living programming and campus accessibility for service recipients and visitors. Service recipients, at a minimum, should have one meaningful outing into the community every week and have input in selecting this outing. Van rides do not count as an outing.

28. Develop an independent Human Rights Committee in accordance with OPWDD regulations.

29. Provide all eligible service recipients with assistive technology and augmentative communication devices.

30. Develop appropriate protocols to monitor that facilities are sanitary and safe.

31. Ensure residents are afforded privacy in their bedrooms, and while using the restroom. All bathrooms and bedrooms should have locks on them.

32. Educate staff that all residents must have access to their attorneys.

33. Discontinue any searches of an individual's belongings without their consent, or in accordance with their behavioral plan.

34. Never deny food to residents for non-compliance.

END