

Your browser does not support iFrames

Home » Services & Supports » About Service Providers » Early Alert

Share:   [Tweet](#)

[Print](#)

Early Alert

Early Alert is a process to proactively identify providers that may show signs of decreased quality, enabling OPWDD to take timely and definitive action. The committee is chaired by the Deputy Commissioner of Quality Improvement, and comprised of agency leadership.


At each meeting there is a focus on specific agencies who have repeated certification deficiencies impacting the quality of care or have significant fiscal concerns that threatens its fiscal viability.

Remedial actions may be required by the Early Alert committee based on a variety of factors, including the size of the agency, the extent of the problems identified and the agency's past history as an OPWDD provider.

Remedial actions would include meeting with the agency Executive staff and/or the BOD to discuss the circumstances in which the agency finds itself. At this juncture OPWDD may require the agency to develop and implement a management plan that has been reviewed and approved by OPWDD staff, to address governance, fiscal or programmatic.

An agency that has been placed on the Early Alert list can be removed from the list if it complies in full, with OPWDD's recommendations and provides evidence to show that issues that were of concern, have been corrected and a system has been put in place to prevent recurrence. The other occasion when an agency will be removed from the list is when OPWDD takes action to transition service(s) to another agency.

Early Alert Process

OPWDD | 44 Holland Avenue | Albany, NY 12229-0001 | (866) 946-9733  | Hearing impaired: NY Relay System 7-1-1

[Accessibility](#) | [Privacy Policy](#) | [Disclaimer](#) | [Contact](#)

Select Language | ▼

[TRANSLATION DISCLAIMER](#)

Last updated on Thursday, 6 Nov 2014 at 9:45 am.

Your browser does not support iFrames

Your browser does not support iFrames

Home » Services & Supports » About Service Providers » Early Alert

Share:   [Tweet](#)


[Print](#)

Early Alert Committee

The following are permanent members of the committee:

- Deputy Commissioner for Quality Improvement (Chair)
- Deputy Commissioner for Service Delivery
- Regional Associate Commissioners for Service Delivery
- Counsel's representative
- Regional Directors from the Bureau of Program Certification (BPC)
- Director of Compliance Management
- Director of Incident Management
- Director of Rate Setting
- Director of Central Operations
- Directors of the respective DDSOs whose agencies will be discussed at the meeting.

In addition, a staff member from the Technical Assistance Unit will also be in attendance. Area Directors from the Bureau of Program Certification and Audit Managers from Compliance Management (BCM) will be asked to participate on an as needed basis.

OPWDD | 44 Holland Avenue | Albany, NY 12229-0001 | (866) 946-9733  | Hearing Impaired: NY Relay System 7-1-1

[Accessibility](#) | [Privacy Policy](#) | [Disclaimer](#) | [Contact](#)

Select Language | ▼

TRANSLATION DISCLAIMER

Last updated on Thursday, 6 Nov 2014 at 9:46 am.

Your browser does not support iFrames



Executive Office

44 Holland Avenue
Albany, NY 12229-0001

TEL: 518-473-1997

FAX: 518-473-1271

TTY: 866-933-4889

www.opwdd.ny.gov

To: Executive Directors of Voluntary Provider Agencies
DDSO Directors

From: James F. Moran, Acting Executive Deputy Commissioner

Date: 6/1/11

Re: OPWDD Accountability Initiative

The New York State Mental Hygiene Law allows for the imposition of fines to address failures to comply with the terms of an operating certificate or with the provisions of any applicable statute, rule or regulation. Mental Hygiene Law specifies that the commissioner may impose a fine of up to \$1,000.00 a day or \$15,000.00 for each violation.

OPWDD is aware that occasionally, adverse events occur. OPWDD requires all providers to remain committed to their obligation to protect individuals they serve. In situations where providers act promptly and appropriately, OPWDD is committed to working with providers to improve areas of concern and to help agencies improve their services. However, for any agency identified as having failed to adhere to critical requirements for reporting incidents/allegations or for the protection of individuals, fines will be imposed to make clear that noncompliance with these requirements is unacceptable. In addition to monetary fines, additional adverse actions may be taken.

This memo shall serve as notice that OPWDD, through a centralized committee, may choose to impose a fine or take other adverse actions when an agency's action or inaction poses a significant risk to one or more individuals. Examples of situations that may result in fines include **but are not limited** to the following:

Incident management:

- Failure of an agency to report significant incidents/allegations of abuse to OPWDD when an agency discovers them (i.e., dismissing an individual as an unreliable reporter, repeated failure of a provider to notify OPWDD timely in the required form and format of an allegation of abuse or a serious reportable incident).
- Failure of agency to take immediate actions to protect individuals who are at risk when an allegation or serious reportable incident is reported (i.e., an alleged perpetrator of sexual or intentional physical abuse is not effectively removed from contact with an individual who is the alleged victim as well as other potentially vulnerable individuals; an individual does not receive timely medical treatment for an injury).
- Failure of an agency to ensure a thorough, timely and objective investigation is completed (i.e., failure to interview witnesses, a clear conflict of interest on the part of the agency or the investigator).
- Failure to identify and implement adequate corrective measures to prevent similar abuse from recurring (i.e., failure to identify or implement changes in procedures for training, supervision or monitoring of staff and/or services needed to prevent a similar event from occurring).
- Failure of an agency to recognize trends in incidents and injuries of unknown origin and to take appropriate action to minimize recurrence (i.e., repeated reports of bruises found on an individual without evidence that this has been investigated to rule out a medical condition, possible physical abuse **or other relevant circumstances**).

Failure to Protect; Health and Safety:

Significant delay in obtaining medical treatment for an individual who has displayed prolonged symptoms of significant illness (i.e., a physician is not notified and care is not obtained for an individual who is consistently refusing food or drink, has a high grade fever or evidences a low grade fever for several days, or repeatedly complains of a symptom of illness such as stomach ache, sore throat, persistent cough or head ache).

- Failure to obtain prompt medical care when an injury is suspected.

- Failure to obtain medical evaluation or treatment when an individual complains of significant pain after a fall.
- An egregious failure to follow a doctor's or nurse's orders for treatment of a significant illness or injury.
- Significant or repeated deficient practices in the safe administration of medications (i.e., needed medications are not administered due to a lack of availability at the residence, failure to write them onto the Medication Administration Record, inadequate communication with staff, discontinued medications continue to be administered, staff who are not currently Approved Medication Administration Personnel (AMAP) administer medications, staff administer medications without appropriate oversight by a Registered Nurse because the provider does not have adequate nursing staff).
- Failure to provide modified diets ordered by a physician or dietician to prevent choking or to address a disease or food allergy.
- Frequent medication administration errors with no assessment of possible causes or remediation by the provider.
- Inadequate training and/or monitoring of staff performing delegated nursing tasks that could result in significant consequences if done incorrectly such as tube feedings, glucose monitoring, catheterizations, etc.

Fire Safety:

- The fire alarm system has been inoperable for a period of time. Agency staff are aware of this, but no action or inadequate action has been taken to either; make needed repairs or establish compensatory safety protocols such as a fire watch.
- The sprinkler system has been inoperable for a period of time. Agency staff are aware of this, but no action or inadequate action has been taken to make needed repairs or establish compensatory safety protocols such as a fire watch.
- Removing required fire safety protection equipment such as smoke or heat detectors, fire doors on vertical openings or in smoke barriers.

Physical plant:

- Means of egress are blocked; staff put furniture in front of exit doors at night, day program door is chained closed.
- Construction requiring a building permit is under way; consumers are exposed to areas under construction, there is no safety plan in place that has been approved in advance by DQM/BPC.
- Hot water that poses a significant risk (due to temperature) in areas that are accessible by individuals served who do not have the ability to adjust the water temperature independently.
- Bedrail systems do not meet safety standards.

Facility operations:

- The facility has not conducted adequate or appropriate fire drills.
- There is evidence that fire drills have been falsified.
- The facility has failed to maintain operational minimum staffing as required by the facility evacuation plan.
- Individuals in a home repeatedly take longer to evacuate than is allowed based on its rating.
- There is a pattern of falls by individuals which have resulted in injury with no action from facility.

Limitations of Individual Rights:

- A person's mobility is limited for the convenience of staff.
- Food or drink are withheld or modified as a consequence of behavior.

- A person does not have access to or a voice in the use of his/her personal allowance moneys.
- Food, clothing, or other personal items are locked without a written justification or a plan to allow access.
- Failure to provide behavior support services or adequate supervision to an individual who repeatedly elopes from the facility.
- Failure to comply with the requirements of notice and process under Part 633.12 regulations when seeking to discharge an individual from his or her residence or to terminate or suspend an individual's services.

Providers will be notified of the procedures for contesting a fine when they receive notice that a fine is to be imposed.

Please direct any questions to your Regional Director in the Division of Quality Management. The 3 Regional Directors' are Ken O'Connor (ken.oconnor@opwdd.ny.gov), Deborah Burkhardt (deborah.burkhardt@opwdd.ny.gov) and Mohan Iyer (mohan.iyer@opwdd.ny.gov).

cc: OPWDD Leadership Team
Provider Associations
DQM staff

