**Poor Oversight Left Group Home Residents At Risk**

The Office for People With Developmental Disabilities’ (OPWDD) inadequate emergency management coordination left people living in group homes at risk during the onset of the COVID-19 pandemic, according to a new audit released recently by New York State Comptroller Thomas DiNapoli.

OPWDD reported 657 people died from COVID-19, and more than 13,000 contracted the virus in its residential programs from March 2020 to April 2022.

“Group homes are supposed to offer people with developmental disabilities safe places to live as independently as possible,” DiNapoli said. “Our audit found the Office for People With Developmental Disabilities did not issue timely, consistent guidance to the vast majority of their certified group homes. Inconsistent emergency management coordination and oversight put residents, families and staff in harm’s way. I urge OPWDD to implement our recommendations before the next public health emergency.”

DiNapoli’s audit found OPWDD did not provide consistent guidance to some 6,929 group homes across the state during the first wave of the deadly pandemic, though the audit did not establish a causal relationship between OPWDD’s actions and COVID cases. As explained by the department, certified facilities run by nonprofits (6,921), as opposed to those that are state-run (eight), are required to have their own emergency policies and procedures in place, even though they are home to 99 percent of the state’s 34,117 group home residents.

In September 2020 and November 2021, OPWDD developed additional guidance, which covered COVID-19 emergency planning and response, but restricted their distribution to the eight state-run facilities, excluding the others.

While OPWDD’s emergency management and overarching emergency planning documents considered pandemics as a risk even before the COVID-19 pandemic, OPWDD did not take steps to ensure all group homes followed suit. The audit found that while many group homes had emergency response plans, they did not account for pandemics or emerging infectious diseases, while others referred staff to follow OPWDD’s guidance.

This lack of effective emergency response plans at the onset of the pandemic led to difficulties in securing personal protective equipment (PPE), dealing with staff shortages and confusion and delays over how to isolate or quarantine individuals during the worst waves of COVID-19.

The audit noted OPWDD’s stockpile of PPE was exhausted early in the pandemic, and group homes had trouble getting masks and gowns on their own due to overwhelming demand. Masks were crucial to stopping the spread of COVID-19 and especially important in group homes settings, where clients often have multiple medical issues and staff typically cannot socially distance when helping individuals with bathing, dressing or eating. The pandemic further led to staffing shortages at many group homes. To maintain minimum staffing levels, some frontline employees had to work across multiple group homes or work longer than normal shifts, risking increased physical and emotional fatigue, mental distress, and contracting COVID-19. Between March 2020 and November 2021, 81 group homes were closed or temporarily closed due to staffing shortages.

OPWDD recertifies group homes every three years, but according to the audit, their oversight needs improvement. While review of emergency response plans are part of the recertification process, OPWDD inspectors did not review plans for infection control practices or public health emergency response.

In May of 2020, OPWDD began COVID-19 surveys of group sponse to the pandemic, but the audit found investigators only visited 22 percent of homes. Further, surveys often lacked meaningful observations, and staff at certified group homes were not required to take refresher trainings on infection controls.

DiNapoli’s audit recommended OPWDD review and update the Emergency Management Operations Protocol and supplemental documents to ensure all group homes implement current policies and procedures in the event of another public health emergency. They also encouraged them to develop procedures to ensure that group homes’ emergency plans encompass planning for and responding to public health emergencies.

OPWDD should ensure group homes monitor and review protocols of well-developed infection control practices and are consistently applied when conducting reviews at homes and establish effective communication with staff responsible for infection control policies and procedures when deficiencies are identified.

While OPWDD expressed concern with the audit’s methodology, it agreed with many of the recommendations.