



STATE OF NEW YORK  
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES  
44 HOLLAND AVENUE  
ALBANY, NEW YORK 12229-0001  
(518) 473-1997 • TDD (518) 474-3694

M E M O R A N D U M

TO: Executive Directors Voluntary Agencies  
DDSO Directors

FROM: Jan Abelseth   
Deputy Commissioner  
Division of Quality Assurance

DATE: January 13, 2003

SUBJECT: Willowbrook Residential Expansion

The following is intended to clarify the matter of expansion of certified capacity of homes serving Willowbrook class members.

Per Paragraph 6 of the Willowbrook Permanent Injunction, OMRDD agencies are obligated to "maintain class members in the community residential facility in which they live at the time of entry of this permanent injunction, or in such community residential facilities with equal or smaller residential capacities as are appropriate for the class member." In order to comply with this stipulation, the Willowbrook attorneys must approve the expansion of existing facilities serving class members. Therefore, DDSOs and licensed providers seeking to increase the certified capacity of any OMRDD certified program that serves class members must submit the Request for Expansion of Community and Qualifying Facilities. This includes requests to change the status of a temporary use bed (TUBS) to a regularly certified bed. In addition to Willowbrook approval, it is still necessary to meet all other OMRDD applicable requirements related to an increase in residential capacity in certified residences serving class members.

The expansion request, which is attached for your reference and use, should be submitted to Denise Pensky, Director Litigation Support Services, at 44 Holland Avenue, Albany, NY 12229 or via fax at (518) 473-1121. Ms. Pensky will facilitate the OMRDD review prior to submission to the Willowbrook parties for their consideration.

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Please ensure that your staff are aware of this Willowbrook compliance issue and adhere strictly when processing a request for an increase in residential certified capacity. Your staff should contact Ms. Pensky immediately should an expansion request be considered for a certified residence serving class members. She can be reached by telephone at (518) 473-6026.

Thank you for your assistance in ensuring compliance with Willowbrook residential expansion requirements.

Attachment  
cc:  
H. DeSanto  
K. Broderick  
P. Pezzolla  
R. Wolfe  
J. Trent  
R. Jung  
D. Pensky

Request for Expansion of Community and Qualifying Facilities

**FACILITY INFORMATION**

Name of facility:

Address of facility:

Certification Information

Date of initial certification:

Certified capacity upon opening:

Current certified capacity:

Proposed certified capacity:

Describe any licensure and/or standards waivers currently in effect or required as a result of the expansion:

Describe any change in facility classification regarding funding and/or licensure as a result of the proposed expansion:

Attach copy of the most recent facility survey results along with any plan of correction which is in effect or is proposed for approval.

Description of facility location

Is this facility freestanding?

Is this facility on the grounds of a developmental center, hospital, or other institution? (If so, specify.)

Are there any other freestanding or attached structures used for mental health or mental retardation or correctional services adjacent to this facility? (If so, specify configuration and names of facilities.)

Is this facility included on ATTACHMENT C of the *Willowbrook Settlement* (2/25/87)?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

Is this an EMERGENCY Request? (i.e.: Has the operating certificate of another facility has been revoked, suspended, or surrendered? Has another facility been rendered unsafe for habitation?) If so, complete section immediately below.

\_\_\_\_\_ Yes

\_\_\_\_\_ No (If no, skip next section.)

Emergency Status

Name of facility closing:

Operating certificate number:

Address of facility closing:

Emergency Status (continued)

Names of *Willowbrook* class members in closure facility:

Reason for closure: (If certificate was revoked, who made decision?)

Actions taken to prevent loss of facility:

Alternative placement sites explored:

**PURPOSE OF PROPOSED EXPANSION**

Target Date for proposed expansion:

Brief summary of the rationale for the proposed facility expansion:

**IMPACT ON CLASS MEMBERS**

Population: Current and Proposed Class Members

Complete "Client Characteristics Chart for Consent Judgment Staffing Audit Data". (Form is attached.) Instructions for completing the form are:

- Enter names of all class members currently residing in the facility and enter NYS ID numbers (instead of names) for nonclass clients currently residing in facility.
- Draw a double line following the names of the current clients and add the names or ID numbers of clients proposed to be placed in the facility as a result of this expansion.
- Place a checkmark in any of the categories of description which apply to any client as follows:

Nonambulatory

Blind

Deaf

Other disability: other physical impairments

Intensive Behavior Modification Program: needs or receives intensive behavior modification services

Psychotropic Drugs for behavioral reasons: receives psychotropic drugs for behavioral reasons

Enriched staffing: client is receiving 1:1; 1:2; or 1:3 staffing ratio

Recommended for enriched staffing: client is recommended for 1:1; 1:2; or 1:3 staffing ratio

Attach a summary of the most recent ITT recommendations for each class member listed above, including recommendations for community placement.

**IMPACT ON STAFFING**Clinical/Professional Staff (include all staff other than direct care staff)

Attach list of current positions and full-time equivalency of each position which is designated for services to this facility.

Attach list of positions to be added and full-time equivalency of each position which would be designated for services to this facility.

Direct Care Staff

Number of direct care staff positions currently:

Number of direct care staff positions to be added as a result of the expansion:

Proposed direct care staffing pattern

Minimum # direct care staff on duty  
(Presently) (After expansion)

Weekday morning shift:

Weekday afternoon/evening shift:

Weekday night shift:

Weekend morning shift:

Weekend afternoon/evening shift:

Weekend night shift:

Identify any other scheduling, organizational, or activity changes which will occur as a result of the proposed expansion.

**IMPACT ON PHYSICAL PLANT**

Attach a copy of the physical layout of the facility and identify any structural or physical changes which will alter the interior and the exterior as a result of the proposed expansion.

**IMPACT ON TRANSPORTATION RESOURCES**

Attach a description of current transportation resources, including vehicles, the number of passengers which any vehicles hold, etc. Describe changes to occur in transportation resources after expansion.

**CONSENT OF AGENCY**

Attach a copy of written consent of agency and other supportive comments from any of the parties involved.

**PERSONS/AGENCY RESPONSIBLE FOR INFORMATION**

\_\_\_\_\_  
Signature of Facility/Agency Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Signature of OMRDD Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone



FACILITY CLOSURE QUERY FORM

**LOSS OF OPERATING CERTIFICATE/LICENSURE**

1. Provide a copy of the following to the Office of the Special Master:
  - a. The last annual survey by the certifying/licensing agency.
  - b. The most recent Plan of Correction in response to the last annual survey.
  - c. The latest verification survey (if any) of completion of the Plan of Correction or corrections of deficiencies.
  - d. The decertification/licensure revocation notice (if any).
  
2. Were there any rate appeals pending or filed since the last annual survey or within ninety (90) days prior to the last annual survey?  
 Yes       No

If Yes, indicate what the provider expects to gain from an increased rate (check all that apply):

- More staff for:
  - Direct Care
  - Clinical
  - Administrative
  - Other (state) \_\_\_\_\_
  
- Purchase of vendor/professional services:  
State the services: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
- Facility Capital Improvement  
Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
- Facility maintenance/repair  
Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
- Other  
State \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FACILITY CLOSURE QUERY FORM

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LOSS OF LEASE

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1. Names of parties:

Lessor:

Company Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_

Lessee:

Agency Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_

2. Lease Term (current or most recent lease):

Beginning Date \_\_\_\_\_ Ending Date \_\_\_\_\_

3. Has the Lessor requested a rate increase as a condition of renewal?

Yes Current Rate \$ \_\_\_\_\_ Proposed Rate \$ \_\_\_\_\_  
 No

4. State the Lessor's or Lessee's reason(s) for non-renewal:

Lessor  Lessee

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Date of Notice of non-renewal \_\_\_\_\_

(Provide a copy of any written notice of non-renewal)

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CLOSURE FOR OTHER REASONS

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*If the closure is for reasons other than loss of a lease or loss of an operating certificate, then provide a detailed written explanation explaining the circumstances and actions taken or to be taken to continue operation.*

**FACILITY CLOSURE QUERY FORM**

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**FACILITY INFORMATION:**

Operating Agency Name \_\_\_\_\_  
Facility Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Operating Certificate Number \_\_\_\_\_ Type (VOICF, VOICR, etc.) \_\_\_\_\_  
Certified Bed Capacity \_\_\_\_\_ Date Facility Opened \_\_\_\_\_  
Contact Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

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**FACILITY RELOCATION**

Is this a relocation of an existing program into a newly created residential site?  Yes (complete information below)  No

**ADDRESS OF NEW SITE:**

Operating Agency Name \_\_\_\_\_  
Facility Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Operating Certificate Number \_\_\_\_\_ Type (VOICF, VOICR, etc.) \_\_\_\_\_  
Certified Bed Capacity \_\_\_\_\_ Date Facility Will Open/Opened \_\_\_\_\_

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**Plaintiffs have reviewed and agreed to this closure:**

- Yes (Provide documentation of approval and complete only this page of this form)  
 No (Complete all applicable sections of this form)

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**PERSON COMPLETING FORM:**

Name \_\_\_\_\_  
Title \_\_\_\_\_  
Affiliation \_\_\_\_\_  
Date \_\_\_\_\_

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**COMPLETE ALL APPLICABLE SECTIONS OF THE FORM FOR THE CLOSURE OR RELOCATIONS:**

- Loss of Operating Certificate/Licensure
- Loss of Lease
- Closure For Other Reasons