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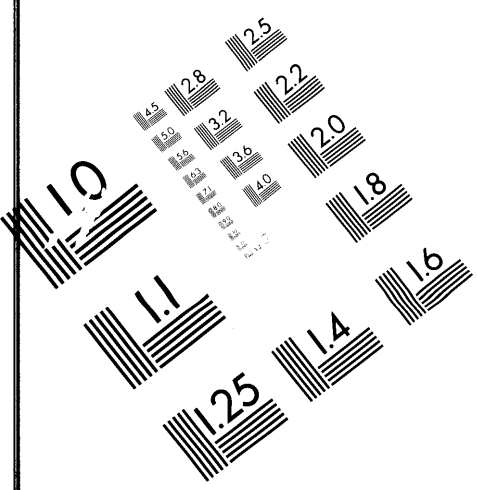
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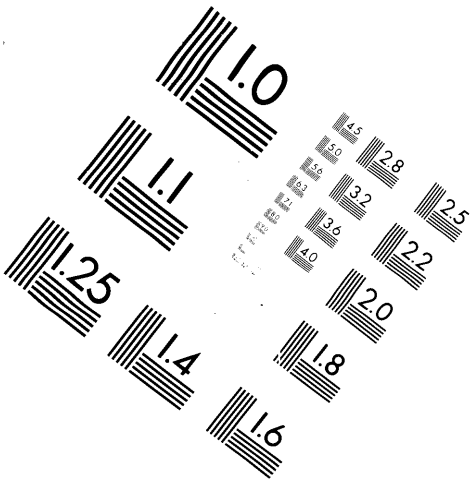
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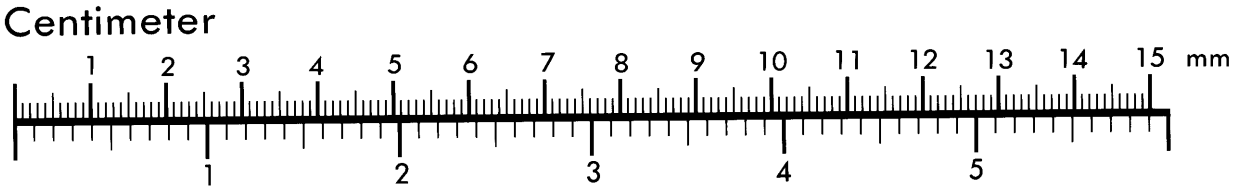
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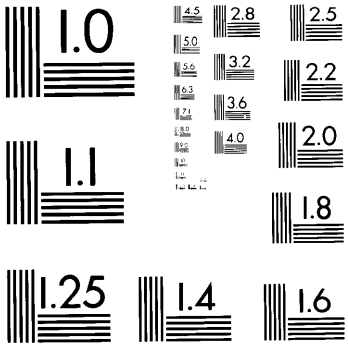
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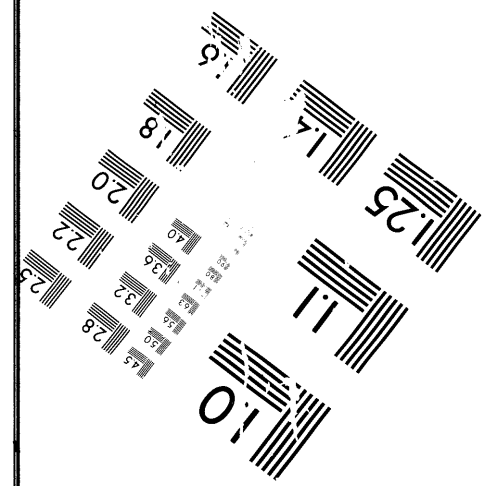
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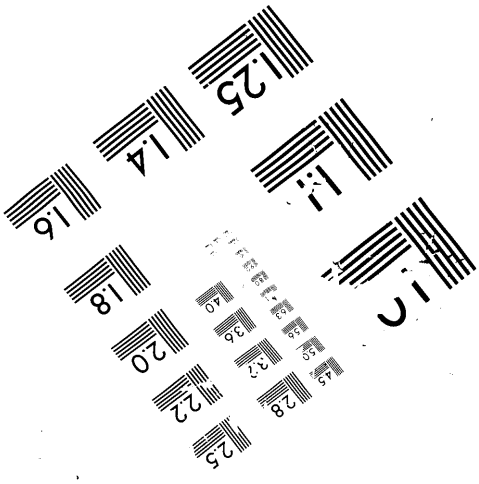
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ABANDONING ITS NOT-FOR-PROFIT PURPOSE:

THE CASE OF PROJECT INDEPENDENCE OF QUEENS NY, INC.

NEW YORK STATE COMMISSION ON QUALITY OF CARE
FOR THE MENTALLY DISABLED

JUNE 1999

ABANDONING ITS NOT-FOR-PROFIT PURPOSE:

THE CASE OF PROJECT INDEPENDENCE OF QUEENS NY, INC.

Gary O'Brien
CHAIR

Elizabeth W. Stack
Louis J. Billittier
COMMISSIONERS

JUNE 1999

NYS COMMISSION
ON QUALITY OF CARE
FOR THE MENTALLY DISABLED

PREFACE

In delivering community-based services to individuals with mental disabilities, the State of New York has committed itself to a network of not-for-profit agencies with the goal of becoming less reliant on institutional care. These agencies operate residential and non-residential programs to meet the needs of persons with disabilities and to allow them to live successfully in the community and with their families with appropriate support services. In doing so, the state relies on the mission and commitment of these agencies to provide quality care and treatment to persons with mental disabilities; upon their boards of directors to set policy and maintain vigilance in carrying out their mission; upon the competence and integrity of executive and direct care staff; and upon the professionalism of independent accountants who perform annual audits and express opinions on the financial statements of these agencies, which are largely funded with public monies.

The sheer number of agencies licensed to deliver these services by the Office of Mental Retardation and Developmental Disabilities (OMRDD) makes the state heavily dependent upon the reliability of each link in this chain of accountability. The majority of not-for-profit agencies have proven to be reliable, dependable and cost-effective partners with the state in making certain that persons with mental disabilities receive quality treatment and habilitation to live independently in the community. However, as periodic investigations by the Commission on Quality of Care for the Mentally Disabled have revealed, there are some unscrupulous individuals whose actions undermine the good work of their fellow providers.

Such errant providers fail to realize that not-for-profit corporations by their nature are not a family business which can be run in any manner the operators choose. They are subject to extensive state regulation and are accountable to the appropriate state agency charged with ensuring that disabled individuals receive the highest quality care with the greatest economy. When public monies are channeled through these corporations to finance residential and support services, they must keep and maintain records to document that these funds are used honestly and efficiently in the promotion of their public purpose. In no event should the compassionate purpose of the programs be subverted by the improper diversion of public funds for private benefit, nor through the inability of government to oversee and control the use of such funds.

Findings

As this report documents, the Commission has found evidence of wrongful diversion of large amounts of public funds at Project Independence of Queens NY, Inc. (PIQ), an OMRDD-licensed not-for-profit corporation in Jamaica, New York, for purposes unrelated to the care and treatment of residents of this program. The available information shows that Marie Chantal Joseph, the executive director, and 15 employees and several non-employees related to her diverted tens of thousands of dollars of public monies away from providing care and treatment to persons with developmental disabilities in order to enrich themselves. Furthermore, due to the poor state of PIQ's records, financial documentation was neither available during the course of the Commission's investigation to explain significant transactions, nor was it produced in response to the Commission's draft report despite PIQ's disagreements with the Commission's findings and conclusions.

The quality of care rendered to the mentally disabled residents of the program was unacceptably poor, as found during the Commission's first inspection in late 1997 and, subsequently confirmed by OMRDD through its own extensive monitoring efforts (Appendix A). The Commission's inspectors found seriously deficient conditions that, in large part, can be attributed to the conversion of the facility's funds for the benefit of Ms. Joseph and other employed family members, many of whom provided services at the residence. For example, the supply of food in the residence consisted mostly of free U.S. government surplus (i.e., canned meats, pasta, and beans), apparently obtained from PIQ's food pantry program. Aside from their inferior quality, these foods failed to conform to the required special dietary needs of six of the eight residents. Indeed, the Commission questions the business necessity and appropriateness of this practice, since PIQ's reimbursement rate of $65,587[1] annually for each resident includes ample funds for such a basic necessity of life.

The facility had a severe roach infestation and multiple other habilitation deficiencies, including inadequate hot water, missing resident personal hygiene supplies, and an unsafe fire alarm system. The smell of urine in the facility was so overpowering that it caused Commission inspectors during their initial visits to open windows and to leave periodically.

In addition to the poor conditions and conversion of funds, there is also reason to seriously question the vigilance of this agency's board of directors in overseeing the operations of PIQ. Its board of directors apparently operates uncritically with respect to activities of the executive director, particularly regarding certain large financial withdrawals that were converted to her personal use. For example, a $15,000 salary increase, used for closing or other costs related to purchase of a personal home by the executive director, was approved "retroactively" by the board after Ms. Joseph had already withdrawn the funds and deposited them into her personal checking account. By not requiring a second authorizing signature on agency checks, the board also enabled Ms. Joseph to write checks to cover other personal expenses for herself and her family, such as a $20,000 withdrawal for a down payment on a personal home, supposedly for starting businesses in Florida and Haiti, and for personal trips of both employed and non-employed relatives.

Conclusions and Referrals

The case of PIQ involves an executive director who abused the public trust placed in her and neglected and financially exploited the eight adults residing in its facility by depriving them of adequate food, services, and shelter. The Commission believes that a root cause of these problems was the board's failure to monitor the executive director's activities and hold her accountable for the management of the agency. This abdication of board responsibility freed the executive director to place her family's interests above those of the vulnerable consumers she had pledged to serve. She demonstrated a disregard for the residents' welfare by placing relatives of doubtful competence in charge of their care, and forcing the residents to live in a rundown and roach-infested facility. She also misappropriated money to help buy a new home, took trips out of the country and bought jewelry with public funds, while residents were fed an inappropriate diet of free surplus food and provided limited opportunities to participate in community activities.

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[1] July 1, 1997 rate includes $55,867 from Medicaid for residential habilitation services and $9,720 from Supplemental Security Income (SSI) for room and board. These sums do not include funds for the residents' day programs and transportation, case management, medical and other services. Additionally, the residents received a $109 monthly personal needs allowance from SSI.

In this and other cases, the Commission has found that the misuse of funds almost invariably results in unacceptable levels of care. Clearly the diversion of funds at PIQ, as well as gross mismanagement by the operator, put the facility in constant jeopardy with care suffering dramatically as a result. OMRDD's response was quick in protecting the residents from "imminent danger." Although the completion of the Commission's financial audit was substantially delayed because PIQ did not keep and make available records relating to its spending, some of the questions about the operator's poor performance have been answered.

On January 19, 1999, a draft of this report was sent to OMRDD and a response from the Commissioner is appended to this report. (Appendix A) The response which supports the Commission's findings notes that, although the agency has been brought into general regulatory compliance as a result of OMRDD's continued monitoring efforts, OMRDD finds that "unless significant and specific corrective action" can be initiated by the agency it will be unable to renew PIQ's operating certificates.

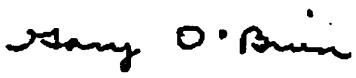
On January 19, 1999, the Commission similarly sent its draft to the PIQ board president and executive director noting that given the seriousness of the Commission's findings it was important that any disagreement with them be supported by substantial and relevant evidence.

Subsequently, on February 5, 1999, OMRDD forwarded copies of the Commission's draft report to the three board members directing the board to conduct its own internal review given the seriousness of the Commission's program and fiscal findings. (Appendix B) OMRDD also requested detailed explanations or necessary documentation to support any rebuttal of the correctness of these findings, specific time frames to remedy the issues identified, and required that each board member attend a mid-March meeting with OMRDD senior staff.

After a March 17, 1999 meeting between OMRDD and the board and a review of the agency's written replies, both OMRDD and the Commission conclude that the board's response is inadequate and that it has not fulfilled its duty of care and diligence in overseeing the activities of the corporation. Specific responses or comments from the board's reply to the Commission, along with Commission rebuttal statements, are included in pertinent sections of this report.

Pursuant to its statute requiring that the Commission "give notice to the appropriate law enforcement official" when there is cause to believe that a crime may have been committed, in late 1998 the Commission gave notice to the U.S. Attorney for the Eastern District of New York, who along with the Federal Bureau of Investigation have worked cooperatively with the Commission. The U.S. Attorney and OMRDD are coordinating possible follow-up enforcement actions within the scope of their respective jurisdictions. As a result of the Commission's findings and subsequent direction from OMRDD, the PIQ board reorganized its senior administrative staff. The Commission also intends to refer its findings to the Department of Law for possible violations under state statutes and the State Education Department for apparent violations of regulations relating to the practice of public accountancy.

This report represents the unanimous opinions of the members of the Commission.



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Chair

Elizabeth W. Stack
Commissioner

Louis J. Billittier
Commissioner

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A special acknowledgment is also due Lisa M. Fleischman, Esq., U.S. Department of Justice, Eastern District of New York, and Paul D. Bernreuther, U.S. Department of Justice, Federal Bureau of Investigation. Their considerable efforts were invaluable in conducting certain aspects of this investigation.

INTRODUCTION

Background

The Commission's investigation was prompted by an anonymous written complaint about deficient care, poor living conditions, and significant diversions and misapplications of public assistance funds at Project Independence of Queens NY, Inc. (PIQ), a not-for-profit corporation located at 169-18 Hillside Avenue, Jamaica, New York. PIQ was incorporated on January 10, 1990 to provide family support services, residential habilitation and case management services to persons with developmental disabilities and their families. PIQ began operations in 1994 and currently operates several OMRDD programs, including: two four-bed individualized residential alternatives (IRAs),[2] home-and-community-based services case management for 25 individuals, comprehensive Medicaid case management for 25 individuals, and a small family support services program.[3] PIQ receives approximately $750,000 annually in Medicaid/Supplemental Security Income (SSI) funds to operate its OMRDD-licensed programs.

Commission Involvement with PIQ

In late 1997, the Commission received anonymous allegations that the care at PIQ was grossly deficient in the areas of consumer diets, medication, and clinical supervision. In addition, "personal needs allowance" monies of the residents were allegedly being misappropriated. Furthermore, it was reported that PIQ employed as many as 15 family members of the executive director and corporate funds were being inappropriately spent by them for leisure trips to Florida, Haiti and the Dominican Republic.

On December 4, and December 15-16, 1997, Commission program staff visited PIQ's IRAs and found the living conditions to be egregious and the care deficient. Also, on December 16, 1997, Commission fiscal staff reviewed the agency's financial records to assess the complainant's allegation that PIQ staff were inappropriately reaping personal financial gain from the funds meant for client care.

Although PIQ's corporate charter provides that "no part of the net earnings of the corporation shall enure to the benefit of any member, trustee, director, officer of the corporation or any private individual," it soon became apparent that PIQ's executive director was systematically diverting substantial public funds to enrich both herself and her relatives, often without the knowledge or prior approval of the board of directors. PIQ also diverted its corporate funds in supposed attempts to establish a foster care program in Miami, Florida and a series of food canteens in Port-Au-Prince, Haiti.

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[2] The two IRAs are located on the first and second floor of a single building in a residential area of Springfield Gardens, Queens.

[3] Although the Commission did not review them, PIQ purports to operate a food pantry for low income residents of Queens and an after-school program for 20 children with disabilities.

FINDINGS

I. Program Care and Treatment

The Commission's review of services and programs at PIQ was undertaken on an expedited basis because of allegedly seriously deficient environmental conditions and inadequate care which jeopardized the physical health of some residents of the two IRAs run by the agency. This was quickly confirmed by the Commission's quality assurance staff and soon thereafter by OMRDD. Overall, these reviews found that medication management was problematic; special diets for residents with diabetes, hypertension and high cholesterol were not provided; program plans and behavior plans were very poorly crafted and often not implemented. Meetings between the case manager and her clients were not held as frequently as required, with several months elapsing with no documentation of a meeting. Residents' personal funds were mismanaged. Not surprisingly, quality assurance measures to identify and correct problems were not in place.

During the Commission's unannounced visits in December 1997 to the two IRAs, staff found:

- Roach traps filled with live roaches were hanging on the wall above the food preparation area.[4]
- Staff on duty acknowledged that menus were not being followed, and that the food supply was largely government surplus. For dinner on the night of the review, rice and beans were substituted for fish which was supposed to be served.
- The external appearance of the residence was poorly maintained, e.g., the front entrance of the building was littered with trash and there was a junk car with two old car batteries in the back yard.
- The insides of the two IRAs were found to be dirty and poorly maintained. Walls, doors and carpets were soiled and stained. There was inadequate hot water; broken bathroom wall fixtures were found; and bathroom floor tiles were missing. Other findings included: a dirty stained bathtub, an exposed radiator, soiled dresser drawers, and a broken dresser and closet door.
- There was evidence of marked inattention to the personal needs of residents. For example, clothing and underwear of different residents were intermingled in dresser drawers; no resident had a complete supply of personal hygiene items and no soap or hand towels were available in the bathrooms.

On December 15 and 16, 1997, Commission staff returned to the residences for a two-day review of the quality of life of the eight men living there. Environmental conditions had improved marginally, but this more intensive review revealed substantial problems in program oversight, staff training, case management,

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[4] On March 14, 1999, PIQ's attorney submitted a nine-page response letter and numerous exhibits to address the issues raised in a draft copy of this report. On March 23, 1999, the board president confirmed that the PIQ board endorsed the response of its attorney at a board meeting, stating that both the board and its attorney investigated issues raised in the Commission's draft report and assembled documentation to rebut the allegations. Excerpts from the agency's letter are included in this public report as footnotes to the appropriate sections along with comments by the Commission where the correctness of its findings have been unfairly challenged.

The response letter addressing these findings asserts that the agency should be excused because of the unreasonable hour of the Commission's visit at "approximately 5 a.m." In fact, the Commission staff arrived at the home at 10:30 a.m., after the residents had left for their day program.

and psychological services provided by Global Communications Services, Inc.[5] Numerous unattended problems in the physical environment of the IRAs, inattention to the personal care and health needs of the residents, the faulty implementation of program and behavior plans, and insufficient community activities for its clients indicated the program was not meeting its obligations.

The initial Commission visits were the beginning of a sustained plan for inspecting and monitoring efforts by the Commission and OMRDD after the agencies met and agreed that action must be taken. These measures included the bi-weekly presence of OMRDD staff at the residence, several formal inspections and requests for plans of correction, and requests for revisions to the plans. A presentation to the agency's board of directors by the OMRDD Deputy Commissioner for Quality Assurance and other senior staff described the serious problems at the IRAs and the types of systemic corrective actions necessary to bring the residences into compliance with OMRDD standards.

Serious Deficiencies in the Physical Environment and Attention to Personal Care Needs

Commission quality assurance staff found serious deficiencies in the physical/environmental conditions at PIQ as well as major problems in attending to the personal care needs of PIQ residents. These deficiencies existed despite the responsibility of the house manager to check the environment each day.

- Each IRA had a separately hard-wired fire alarm system which would not necessarily respond to a fire on another floor.
- Bathrooms and bedrooms were in complete disarray, dirty and unsanitary and had a urine odor which was so strong that CQC reviewers could not remain in the room.
- One resident's already-made bed was urine-soaked.
- Two of the four beds (in the lower level IRA) had only one sheet, and the blankets on three of the four beds were ripped.
- No soap or towels were available in the bathroom for hand washing, and the towel rack and soap dish were broken. Two used bars of soap stored in the linen closet were the only soap available and presumably used communally for showering.
- Much of the food supply consisted of bulk quantities of government surplus food; several apples were the only fresh fruits found, and there were no fresh vegetables.
- Those residents with personal care supplies had them unhygienically stored in dirty plastic kits or in their dresser drawers. Many residents had an incomplete supply, lacking such essentials as toothbrushes, toothpaste, combs and brushes.

Medical and Nursing Care

The Commission's review of the medical records of the residents and conversations with the nurse revealed that she was uninformed about a number of important issues, had failed to detect errors on the part of direct care staff in the execution of the physician's and nutritionist's orders, and to ensure that medical records were accurate and complete.

For example, one resident with diabetes had orders for blood sugar level testing every other day. This was not being done. Additionally, staff acknowledged that they were not serving the man a diabetic diet as prescribed—a practice also not addressed by the nurse.

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[5] Global Communications is a firm that provides psychology and recreational services to the residents of PIQ's two IRAs to improve their social interaction skills.

A review of medication administration sheets revealed several different kinds of errors that could have very serious consequences. There were several instances of missed administrations, duplicate records of administrations for several days which were inconsistent and inaccurately written orders for medication. In another case, the Commission found the instructions for a dressing on a leg wound were written so that the bandaging was done in the early morning and then in the evening at 9:00 p.m., but the application of the ointment was ordered for 5:00 p.m. When confronted with the impossibility of fulfilling such an order, the nurse responded that the ointment was apparently put on the wound at night when the bandage was changed, despite staff signatures for only the 5:00 p.m. application. The instructions, which were reportedly checked by the nurse (as were all of the medication and treatment orders), had been incorrectly written each week from October until the Commission's mid-December review. This "assumption" that the ointment was applied at night was an inadequate response that did not fit the seriousness of the leg infection being treated.

Staff Training

The inattention to the needs of the residents for guidance in the development of basic self-care and interpersonal skills and the lack of community integration developed, at least in part, from a failure to provide staff with sufficient training. A review of the training records for staff revealed that only the residence manager and two other staff had received training in CPR, SCIP, behavior management, sign/symptoms of illness, client rights and incident reporting. The only training which had been given to the vast majority of the staff was medication administration.[6] This may, in part, explain the environmental and programmatic deficiencies observed by Commission and OMRDD reviewers.

Case Management Services

Case management services are provided to the eight IRA residents by PIQ staff, and each record contained a signed statement that the resident's family agreed with this choice. Based on the documentation available in the records, these services were inadequate in both quantity and quality. Case management notes were not written monthly as required,[7] contained little useful information, and showed a lack of initiative and strategies for handling problems. One resident's record illustrates these problems.

> A case management note for mid-February 1995 indicates that one resident had an invalid Medicaid card. No subsequent notes mention the card until a December 1995 note which states that, because the man is not covered by Medicaid, he has lost his day program and transportation services. The case manager took action at this point and applied for Medicaid. In February, the application was denied because the man received too much money from the Social Security Administration. The agency appealed, and a hearing was

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[6] In its response, PIQ acknowledged ongoing training needs. It notes that "the state has commendably committed itself to fostering sufficient diversity to ensure that providers are culturally competent to deliver community-based services." When providers recruit staff from underserved communities, PIQ asserted, "it is inevitable that providers will need to perform extensive staff development themselves." The PIQ response concludes that "the situation described in the draft...identifies training needs, but does not describe an organization that lacks commitment to training."

[7] "A Guide to the Individualized Service Environment, The HCBS Waiver, A Road Map to Community Services, Office of Mental Retardation and Developmental Disabilities," May 1993, Chapter 5, p.6. *See also,* HCFA Approval of State Plan Amendment 89-16 under Title 19 of Social Security Act, April 1, 1989.

> held in May. In June, the agency was advised that the denial had been reversed and this would be confirmed within 30 days. July and August passed and there was no official confirmation of the reversal and no action on the part of the case manager. In September, the case manager called the Queens DDSO for assistance. No case management notes address the Medicaid problem or the lack of day program for this man in October, November, and December. In fact, there are no case management notes at all for October and November. A January 30, 1997 note indicates that the notice of entitlement had been received, and the man is back in his day program.[8]

Individual Habilitation Plans and Behavior Plans

A snapshot of the afternoon and early evening of the Commission's December 15, 1997 visit provides examples of the inability of PIQ to effectively implement habilitation and behavior plans for its residents.

> According to their Individual Habilitation Plans, several residents were supposed to help with meal preparation or clean-up, and several were supposed to be learning to cut their food and eat more slowly. One person was supposed to be encouraged to interact more with his peers, and another asked by staff to talk about his day.
>
> In actuality, the individuals who were supposed to clear the table did not do so; the men who were supposed to be cutting their food were not assisted; and, those who were supposed to be cautioned to eat slowly, were not. Consequently these men ate overloaded mouthfuls of uncut spaghetti. Upstairs, despite the presence of two and sometimes three staff members to assist the four residents, one resident was able to steal the salad and the dessert from a house mate without detection.
>
> The man who was supposed to interact more, came home and immediately went to bed where he stayed until dinner. He ate and went back to bed. No staff member attempted to intervene or ask if anything was wrong. The man who was supposed to be encouraged to talk was not engaged in conversation by staff and spoke exactly one word from the time he walked into the house from day program until reviewers left, approximately two and one-half hours later.

Similar problems were noted in the design and implementation of behavior plans by Global Communications. In some instances, behavior plans were developed but simply ignored. In others, too many behaviors were targeted to be effective and rarely occurring behaviors were targeted with observation methods that did not match their infrequency.

Aside from the poor planning and implementation of behavior plans, Global Communications staff also failed to properly evaluate the effectiveness of these plans in dealing with challenging behaviors. Indeed, the Commission was unable to locate any notes from the consultant describing the efficacy of the plans. For

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[8] PIQ states, in its response, that it provided transportation for the resident which allowed him to stay in day program during part of the time he was without Medicaid funding.

example, one man had a behavior plan to reduce his habit of rectal digging. However, the narrative portion of the plan called for him to be rewarded for not spitting, instead of for not putting his hands in his pants. This error had gone undetected, although the plan was designed in October 1996 and reviewed in August 1997, and again sometime between the Commission's first and second visits in December 1997.

For behavior plans to be effective, there is a need to provide ongoing monitoring and reinforcement of positive behaviors. However, in the case of PIQ, staff at the residence did not keep a record of the frequency of the behavior or whether the plan was effective. Instead, the consultant came to the home several times a week and watched the individual for 20 minute sessions and recorded the occurrence of the behavior. He made no notes about the effectiveness of the plan on the rare occasions when he had an opportunity to implement it.[9]

Community Integration

A review of the logs and money expenditures for the most active residents in the first-floor IRA indicated that, with the exception of trips to the laundromat and the hair salon, these residents went into the community only six times from October 27-December 15, 1997, with several of these trips being sponsored and supervised by their day program. The notations for the other excursions merely document the purchase of a snack, but no expenditure for an activity, e.g., bowling, swimming, a movie. This suggests that PIQ was taking inadequate measures and provided insufficient funds to support the men in enjoying community activities.[10]

PIQ Response and Commission Follow-up

PIQ responded with a plan of corrective action dated February 14, 1998. In response to the environmental problems, the agency said the bathroom flooring, toilet and vanity in the first floor IRA were replaced; paper towels and liquid soap were now available in each bathroom; new bath towels, sheets, bath mats and pillows had been purchased; each resident had been supplied with a full compliment of personal hygiene supplies; and, menus were being developed which reflected the personal preferences of the residents and the need for special diets.

The quality assurance section of the plan of correction described a new system of staff accountability which requires the residence manager to conduct weekly physical plant checks. Direct care staff are assigned hourly or shift assignments and must sign when their job duties have been completed. These sheets are to be reviewed daily by the manager and weekly by the director. The plan promises the revision of all residents' habilitation plans during their semi-annual reviews and the retraining of all staff on the documentation and implementation of program goals. Staff must write daily notes to guide the goal development and revision process. All behavior goals are to be rewritten by the consulting psychologist, and the direct care staff are to be trained on the implementation of the revised plans and responsible for data collection.

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[9] PIQ responds to these criticisms by characterizing them "as disagreements among professionals" regarding what behaviors would be prioritized and what methods should be used. Nonetheless, the response included new behavior plans for four residents by a different Global Communications Services, Inc. staff member dated May 1998.

[10] PIQ contends, in its response, that this level of community involvement was adequate, although, as noted, the agency hired a recreation worker to increase recreational opportunities.

An increase in community activities is promised and a recreation counselor was hired to determine the recreational preferences of the men. This new staff person was to develop an activities schedule and make a monthly note for each resident about his participation.

In answering the concerns raised by the Commissions's review regarding the ability of the agency to safeguard the health of the individuals in its care, PIQ responded that it did not have the financial resources to hire a nurse to supervise the current one. PIQ thought that keeping the same nurse but giving her a list of duties to perform and evaluating her performance bi-monthly by the agency director would suffice. In addition, the agency would ensure that all staff who gave out medications were trained in how to perform a finger-stick for blood glucose testing for the individual with diabetes.

The Commission informed PIQ of its intention to review the implementation of the plan at a later date and was assured by OMRDD that its regional staff would monitor the health and safety of the residents.

Commission Return Visit

The Commission's return visit occurred on April 2-3, 1998. During the second day of the visit, Commission staff and the executive director and case manager met to discuss the positive findings of the review, the problems which remained, and the portions of the corrective action plan which had not been implemented. The positive findings noted by the Commission on its return visit included the following changes at PIQ:

- The physical environment of the homes had been substantially improved. The common areas were clean and neat, the bathrooms had been refurbished and supplied with paper towels (but no soap), the double bedroom downstairs no longer smelled strongly of urine, and all the beds had a complete set of clean linens.
- A new nutritionist had been hired, and she had supplied the homes with menus which included modifications for special diets. Blood glucose monitoring for the resident with diabetes had been completed every other day, according to the physician's instructions.
- The habilitation plans for each resident had been revised, and the recreation therapist had completed initial assessments of each man's likes and dislikes in recreational activities.

With the exception of the substantial improvements to the environment, each of these corrective measures represented only a small step in improving performance, and substantial work in all areas still needed to be done. Significantly, this visit clarified that the quality assurance portions of the corrective action plan had not been effectively implemented, as substantial problems had gone uncorrected:

- Although new menus had been supplied, nutritionally inadequate substitutions were still being made. Fruit punch made of 2 percent juice was substituted for milk at the afternoon snack and flavored sugar water was packed in lunches instead of juice.[11]
- Food supplies, while adequate, were comprised substantially of government surplus and other food pantry items.
- Three of the four men on the first floor had no toothpaste and the fourth had toothpaste in his hairbrush.
- Although the residential habilitation plans of residents had been revised, staff were not working on current goals and had not kept any notes/data related to goal performance since the February 1998 revisions.

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[11] PIQ replies that these substitutions were made to respect consumer preferences.

- Global Communications was still providing poor service. Verbal therapy was provided to one resident three times a week in an effort to curtail the man's inappropriate verbalizations, with no stated rationale or documentation that it was useful. In another instance, seriously misleading information was present in the evaluation of a resident whose "dressing up" in costume was described as psychotic and stemming from "command hallucinations," without proper documentation or validation by a psychiatrist.
- Daily notes designed to hold staff accountable for housekeeping, recreation and other activities were not completed for five days in February in the first floor IRA, and did not mention recreational activities in the upstairs IRA.
- Recreational outings were infrequent. Even though the recreation therapist worked weekends, activities were scheduled for only three of the nine weekend days in March. Additionally, on twelve days in March, residents were supposed to pick an activity of choice in the evening, but few options were available. One of these options, watching television, was difficult because of poor reception after PIQ discontinued cable service because the agency could not afford it. The cable service had previously been paid for by the residents.
- Training records were materially incomplete. PIQ provided no evidence that the residence manager was monitoring training needs or that the training sessions which were supposed to occur in February were in fact held. Commission staff were later faxed documentation purporting to show that a substantial number of staff had been trained in Fire Safety, Nutrition and Recreation and a smaller number in Incident Reporting. Single sign-in sheets covered more than one training and indicate that some staff took the same training twice within three days, raising questions regarding their legitimacy. Commission staff informed the executive director that the use of training videos with no knowledgeable person available to answer questions and evaluate whether staff adequately understood the content was not an effective means to upgrade the skills of PIQ's workforce and to ensure that staff understood their responsibilities.

At the same time that CQC was periodically reviewing conditions at the two IRAs, OMRDD maintained a frequent presence at the program. In an effort to ensure that all those responsible were aware of the seriousness of the deficiencies in this program, the OMRDD Deputy Commissioner for Quality Assurance and other senior OMRDD staff also met with the PIQ Board of Directors.

Minutes dated April 30, 1998, following the meeting with the board, indicated that the board now had a better understanding of its duties and responsibilities and acknowledged that each member had read the statement of deficiencies prepared by OMRDD. The minutes note that several staff had been terminated and a new date for the completion of staff training had been established—the end of June. The minutes promised that a more experienced psychologist from Global Communications would be hired to work with consumers, write behavior plans and train staff. In addition, a qualified mental retardation professional had been hired to oversee programming.

Continuing visits by OMRDD to monitor the program revealed progress by the agency in providing appropriate services for the residents, but also pointed out the limited ability of the agency to sustain its corrective actions and monitor its operations.

II. PIQ Fiscal Practices

Seriously Deficient Agency Recordkeeping

Although PIQ's comptroller and fiscal officer were cooperative, the Commission's completion of its fiscal review was severely hampered by the poor state of the agency's accounting and business records, which were disorganized, incomplete, and contained numerous errors.[12] The inability to produce clinical (see pp. 3-4 above) and ordinary business records literally blinds the state in fulfilling its obligation of oversight since the essence of oversight is access to all documents of a facility. This is the only way the state can verify the welfare of its citizens with developmental disabilities and the financial status that supports that care. The problems uncovered included:

- expenditures posted to the wrong account;
- excess volume of voided checks;
- unorthodox use of a single checking account to pay both payroll and vendor bills;
- two sets of checks with overlapping sequence numbers;
- bank reconciliations months behind;
- wage and tax statements not reconciled at year end (for 1997, PIQ under-reported $7,327 in W-2 wages involving 21 employees); and
- books not closed at year end.

More importantly, these errors often effectively severed the link between specific expenditures and client care and, more broadly, made it impossible to accurately ascertain the agency's fiscal viability, which is a condition for licensure.

Failure to Protect Agency Funds

In terms of failing to safeguard against the thefts of facility funds, the Commission also discovered serious deficiencies in PIQ's internal controls over the cash disbursements process. The most important of these weaknesses involved the executive director's ability to issue agency checks in any amount without a second authorizing signature.[13] As discussed below, the executive director exploited this weakness in the internal control system to misappropriate $35,000 by issuing herself salary and "bonus" checks which did not have

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[12] For instance, it took PIQ over six months to retrieve supporting invoices for 59 expenditures which the Commission had selected for examination to determine their validity and propriety. Additionally, although the Commission requested copies of all of PIQ's American Express bills in March 1998, several were not submitted until November 1998. In part, these problems stemmed from PIQ's failure to properly refile these documents after the completion of previous PIQ audits by OMRDD and the agency's certified public accountant (CPA). PIQ's part-time comptroller attributed many of the delays experienced by the Commission to PIQ's full-time fiscal officer's lack of a fundamental understanding of the agency's computerized accounting system, E-Z Fund, and how its records were organized. In fact, the fiscal officer was fired by the agency during the course of the Commission's review. Moreover, the part-time comptroller who operates an extensive private tax practice and provides accounting services to other not-for-profit clients, did not devote sufficient time to both managing the agency's fiscal affairs and fulfilling the Commission's reasonable data requests.

[13] At the behest of the Commission, PIQ's board passed a resolution on February 10, 1998 requiring the board president to countersign certain checks issued by the executive director.

the prior approval of the board of directors.[14] Concerning the unfettered use of PIQ's American Express account, the agency had no policy on controlling the issuance of cards, restricting their use to legitimate business purposes, and setting expenditure documentation standards. Despite the poor conditions at PIQ, funds were diverted by PIQ employees for their personal benefit at the expense of ensuring appropriate care and treatment for residents of their programs.

Benefits to the Executive Director

Marie Chantal Joseph, the PIQ executive director, was responsible for and the largest beneficiary of the diversion of funds from client care. She accomplished this largely without knowledge of the board of directors. Yet, in those instances where the board did know of suspect fund transactions, it failed not only to scrutinize the expenditures but actually ratified them retroactively. The executive director used several methods to divert funds to herself and her family members, including an unauthorized salary increase and "bonus" to help purchase a new home. In addition, the executive director along with other family members appeared to have unfettered use of agency American Express cards which the Commission found to have been used for their private benefit. Each scheme is described below.

(1) Executive Director's Salary

Despite PIQ's small size and apparent cash flow problems, the executive director has steadily received an increase in salary. Over the last three years, it has increased by $67,217 (142 percent), from $47,398[15] in 1995 to $114,615 in 1997 (Figure 1). As outlined below, $35,000 of these salary increases were taken in 1997 by the executive director without seeking prior board authorization. In contrast, the Consumer Price Index had increased by only 7.8 percent over this same time period. Furthermore, when the Commission compared the PIQ executive director's $114,615 salary to 40 executive directors of similar size OMRDD licensed programs, her salary was more than double (235 percent) the $48,775 average (Figure 1). Of the 43 employees of PIQ, the executive director's 1997 salary of $114,615 represented 23 percent of PIQ's $503,744 in total wages paid.

Since 1996, the executive director has followed a recurrent pattern of having pay increases applied retroactively to furnish herself with additional compensation, despite their negative impact on the agency's cash flow. For example, the executive director used this mechanism twice in 1997 to increase her pay by $35,000—$15,000 which was approved "retroactively" by the board and $20,000 recorded on the books as

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[14] The PIQ response letter states that the board approved the executive director's salary when the agency budgets were adopted by the board each year. Yet, the Commission could neither find budgets in PIQ's files, nor evidence of their approval in board minutes. Despite the importance of this factual disagreement, PIQ does not explain why the records in question did not exist at the time of the Commission's review or why the agency continues to fail to produce this proof. Therefore, the Commission is forced to conclude that the requested information has not been provided because there is no substantiation for the assertions, or that the available information would not support the claim made.

[15] Includes $5,949 paid under an OMRDD minority outreach contract.

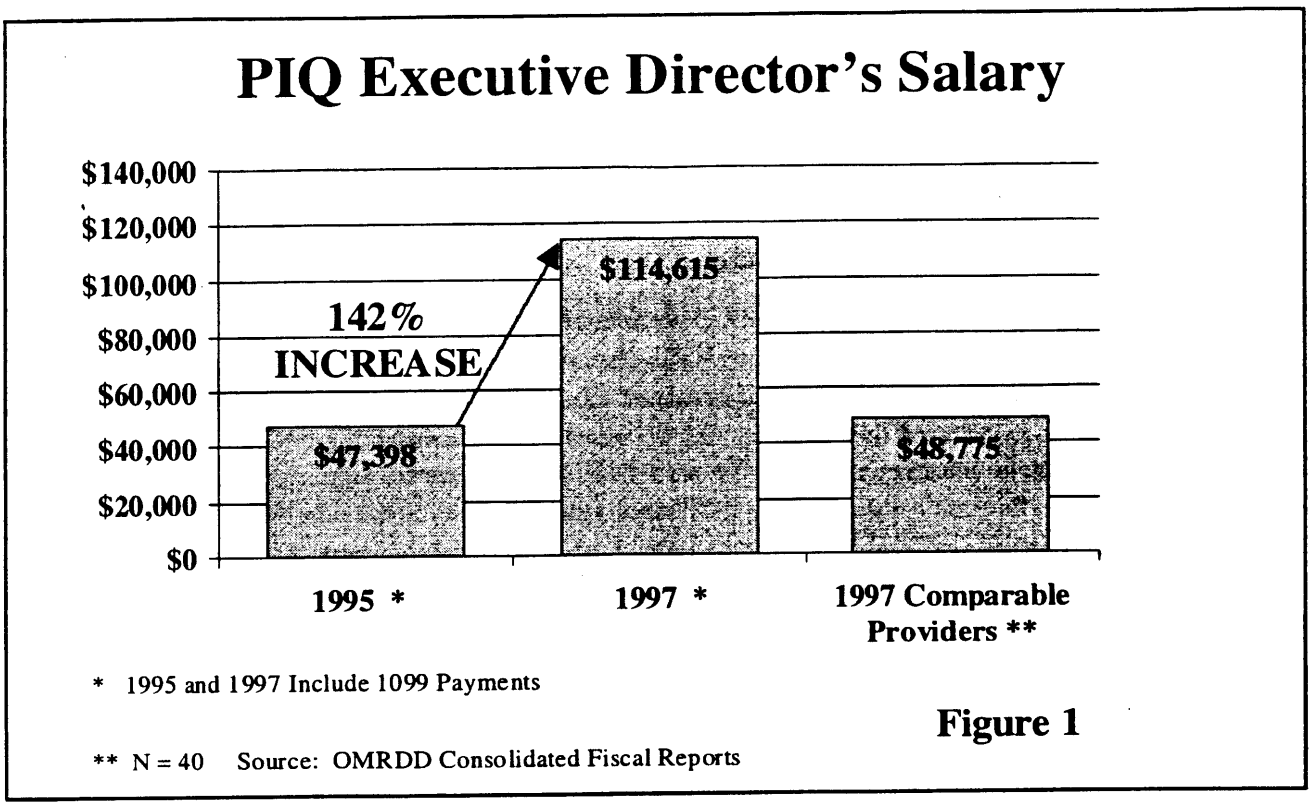

Figure 1

a "bonus" which never received board approval.[16] Yet, during 1997, the agency's cash flow problem had become so pronounced that it had to seek a series of emergency loans totaling $60,000 from the Fund for the City of New York, Inc.[17] A portion of these loan funds appears to have been used to pay for the executive director's salary increases. For example, on August 7, 1997, only eight days before she issued herself the $20,000 "bonus" check, PIQ received a $20,000 loan from the Fund for the City of New York.

During the Commission's 1997 payroll review, it found that the $20,000 check had not been recorded in the payroll system and no Internal Revenue Service (IRS) Form 1099 was on file at the agency to indicate

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[16] PIQ's response letter states that the payments constitute salary earned in prior years that were deferred because the executive director chose not to withdraw her full salary during the early stages of agency development.

However, the record shows that the salary of the executive director was not set by an affirmative vote of the majority of the board pursuant to the New York Not-For-Profit Corporation law (N-PCL) §715 (e) and (f). To the contrary, it is clear that the executive director arranged for the payments to herself from corporate funds without the authority of the board which is an unauthorized diversion of corporate funds returnable to the corporation. *Drivas v. Lekas* 1944, 292 N.Y. 204, 54 N.E.2d 365.

PIQ's contention that "deferred salary" is reflected as a liability on PIQ's financial statements in 1995-96 and 1996-97 carries no weight since the accounting records to prove this statement were not produced during the Commission's review or pursuant to a Commission subpoena. Moreover, there was no corresponding accrued salary expense entry to create the liability or contract in place with specific terms covering the deferred compensation. Again, the Commission must conclude that the required records have not been produced because there is no substantiation for the assertions, or the available information would not support the agency's position.

[17] The cash flow program of the Fund for the City of New York, Inc., a not-for-profit corporation, was started in 1976 in response to nonprofit organizations experiencing financial difficulties arising from payment delays on approved government contracts.

that it was taxable income to the executive director. However, after being made aware that Commission staff had uncovered this check among manual payroll checks which were not recorded in the payroll system, PIQ's comptroller produced to the Commission a Form 1099 covering this transaction. She also agreed that even this 1099 was inappropriate since it allowed both the executive director and the agency to avoid the payment of payroll taxes.

(2) Use of Agency Funds to Purchase a Home

During its review of PIQ's payroll records, the Commission learned that the executive director had moved in the Fall of 1997 from Springfield Gardens to Valley Stream, New York. Furthermore, the Commission learned from deed and mortgage documents obtained from the Nassau County Clerk's office that the executive director had purchased the home in Valley Stream on September 19, 1997 for $190,000. Since there was cause to believe that the executive director's $15,000 salary increase (net check $10,000) on June 23, 1997 and $20,000 "bonus" on August 15, 1997 were related to the home purchase, it subpoenaed the executive director's personal checking account records from Amalgamated Bank of New York. Review of the bank records confirmed that the $30,000 proceeds had been deposited into her checking account and remained there until checks were written to help fund the home purchase on September 19, 1997. On this date, the executive director issued three checks totaling $30,506: two checks to the sellers personally totaling $25,169 and a third check for $5,337 to Guardian Land, a title company.

(3) Personal Use of Agency American Express Cards

At the onset of its investigation, the Commission discovered that certain PIQ staff had been issued American Express Cards to make agency purchases. Its understanding from discussions with agency staff was that the principal uses of these cards was to be limited to meeting some of the agency's incidental expenses, such as travel, emergency residence repairs, mailings, and office supplies. However, PIQ had no written policy governing the use of American Express cards by agency employees. The Commission's examination of the available American Express bills revealed a very high level of activity on this account. The Commission determined that over a sixteen month period (from September 1996 through December 1997), cards had been issued to seven employees and one non-employee who lived in Florida,[18] and they had expended a total of $53,541. The majority of the credit card holders were relatives of the executive director including: fiscal officer (brother), service coordinator (niece), residence manager (brother), and the non-employee residing in Florida (former sister-in-law).

When the Commission asked the agency for supporting receipts for these American Express expenditures, it was informed that PIQ had not retained them.[19] In the absence of receipts, the Commission selected 196 charges totaling $39,907 which appeared to be of a personal nature, and submitted them to the agency to verify whether they were business or personal in nature. For those that were personal, PIQ was asked to indicate whether the employees involved had reimbursed the agency. It took the agency over four months to respond. Analysis of the returned data revealed that agency credit card holders had admitted that $12,410 or 31.1 percent of the questioned American Express charges were personal in nature and not

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[18] Marie Claude Herard, the executive director's former sister-in-law, charged $3,400 to her agency American Express credit card of which $2,408 was reportedly personal. PIQ's response letter states that Ms. Herard is registered in Florida as an "agent" of PIQ to seek funding on its behalf to open a community resource center for disadvantaged children and a community residence for persons with developmental disabilities in North Miami Beach.

[19] Section 3.1 of the agency's accounting manual requires it to keep copies of source documents supporting expenditures for at least six years

PIQ Personal Use of American Express Cards

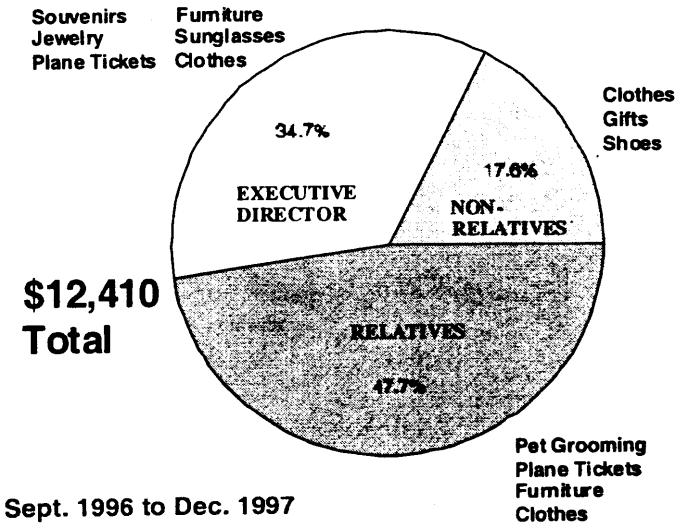


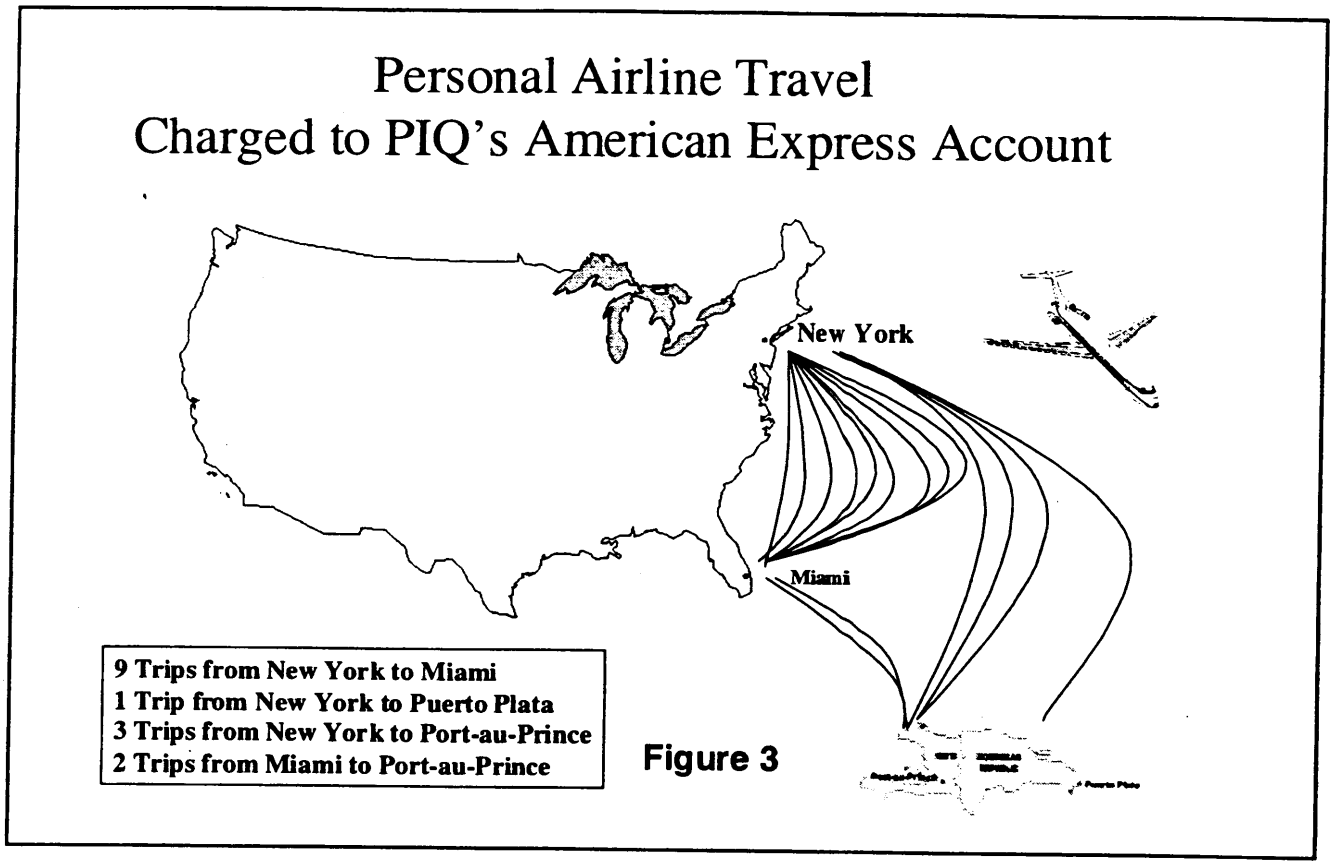
Figure 2

reimbursed to the agency. Although PIQ claimed that the remainder of its questionable charges were business related,[20] it offered no documentary evidence to support this assertion.

As shown in Figure 2, most of these monies were apparently expended for such purposes as taking airplane flights, expanding personal wardrobes, and furnishing personal residences. Some of the more egregious "other charges" included pet grooming and jewelry. An analysis of the air travel revealed that a total of fifteen personal trips from September 1996 thru December 1997 had been taken at agency expense to Florida, Haiti, and the Dominican Republic including some trips by non-PIQ employees (Figure 3).

The Commission's analysis also revealed that most of these abuses of agency funds (82.4 percent) were committed by the executive director and her relatives. PIQ neither sought recoupment from these individuals of the Medicaid/SSI funds which they had converted to personal use, nor canceled their credit

[20] On December 2, 1998, PIQ's comptroller told the Commission "that she appreciates its skepticism about the business nature of many of these charges since it was hard to get a straight answer from agency personnel concerning them."



cards to put an end to this abusive spending pattern until after their propriety was challenged by the Commission.[21]

Nepotism

The Commission confirmed the complainant's allegation that the executive director had engaged in nepotism by hiring 15 of her relatives (34.9 percent of the agency's workforce) to work at PIQ where many were

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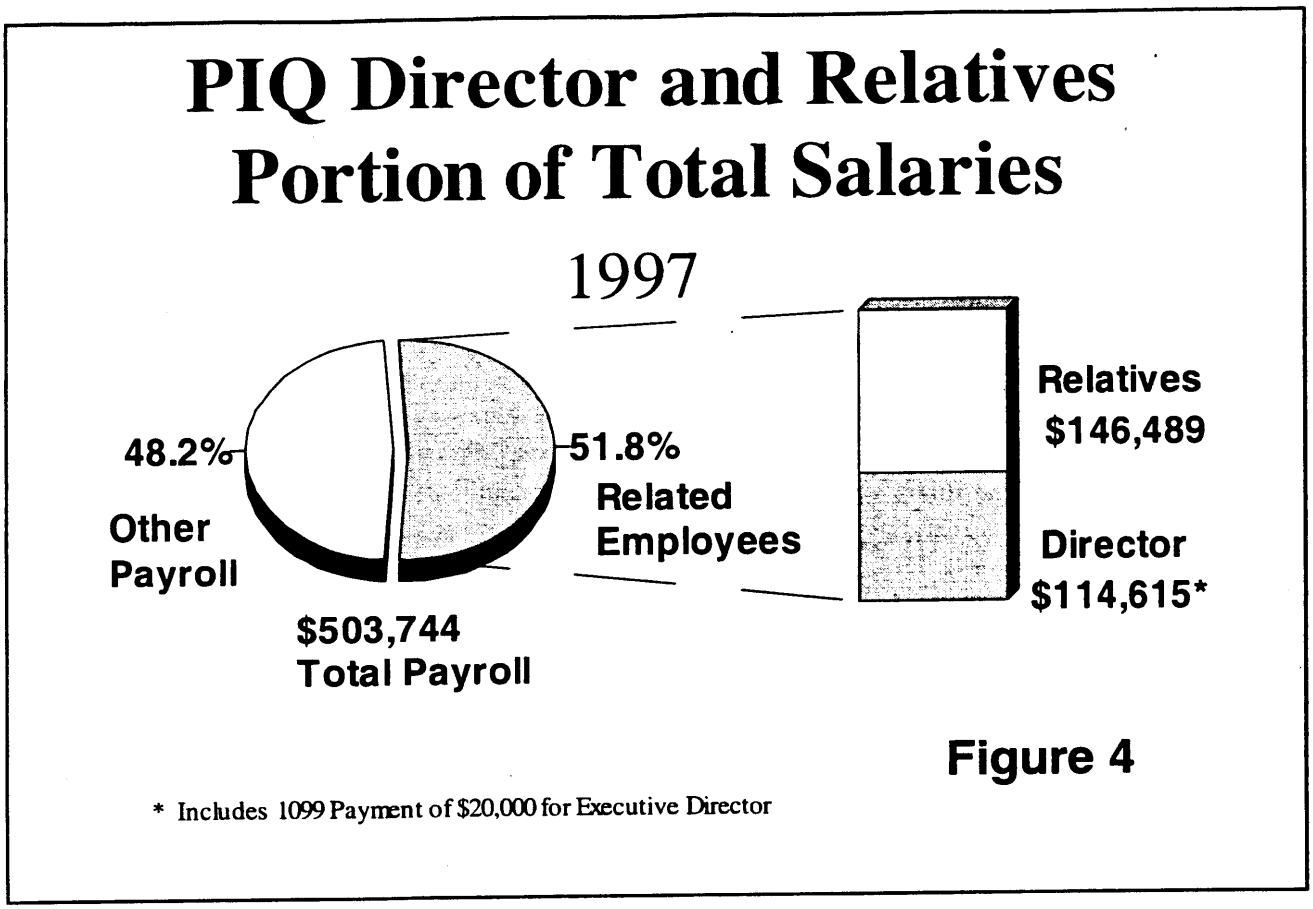
[21] PIQ in its response agrees that the agency's procedures on American Express cards was "inappropriate" and indicates that it has since revised its controls and is seeking reimbursement for personal expenses. However, it challenges the correctness of the Commission findings stating that some of the apparent personal purchases (e.g., sunglasses and Haitian souvenirs) were for the residents or to create a pleasant non-institutional atmosphere in the residence. It also claims that at all times PIQ required employees using the cards for personal use to reimburse the agency. It has also demanded repayment of outstanding obligations through the execution of promissory notes and payroll deductions from the executive director.

It is important to note that during the Commission's review because of the absence of current accurate records pertaining to the American Express expenditures the Commission asked the agency to classify the nature of expenses that were not obvious on their face. As stated previously, even the agency's comptroller concurred that the agency in presenting factual support was less than forthcoming. The relationship of expenses to resident care is an important element of a provider's claim for Medicaid reimbursement and must be documented at the least with original evidences of cost. It is noteworthy also that PIQ did not determine the relatedness of credit card purchases to resident care or aggressively seek reimbursement until after the Commission review.



beneficiaries of the fiscal favoritism documented above.[22] PIQ's human resource manual states, "PIQ permits the hiring of relatives of current employees if the applicant is qualified and selected by the hiring manager/supervisor. The primary consideration for placement is the proximity of the relatives' work areas to each other. Only in extraordinary circumstances, with management approval, should an employee be directly or indirectly supervised by a relative." Review of PIQ's board minutes found that the board approved the hiring of two of the executive director's relatives to work in the agency's IRA program. However, the executive director also hired other family members to work at the residences without the apparent knowledge or approval of the board. The executive director and her relatives accounted for 51.8 percent of the agency's $503,744 payroll for 1997 (Figure 4).

Because of the operational problems which this practice may cause, many government and private businesses have policies discouraging the hiring of relatives of current employees. In fact, when questioned about this practice, PIQ's comptroller stated that "The executive director now realizes that placing many of

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[22] According to *Black's Law Dictionary,* "nepotism involves patronage in appointing others to positions based on a blood or marital relationship to the appointing authority. PIQ's response letter using a definition from *Webster's new Collegiate Dictionary* defines "nepotism" as "***favoritism*** to a relative...on the basis of a relationship" [emphasis supplied] which it states did not occur at PIQ because the relatives hired were qualified and there was an advantage to hiring persons known to PIQ senior staff.

The Commission's essential criticism on this issue is not that there was favoritism in hiring, but of, as evidenced by the deficient conditions and poor staff performance, how the conflicting loyalties created by blood relationships negatively impacted the agency's functioning.

her relatives on PIQ's payroll was a mistake." She added that, "The executive director's brothers refused to recognize their sister's authority as the agency's top administrator."

Since the work performance of family members occupying key positions seemed to be negatively impacting the agency's functioning, Commission staff reviewed their personnel files to ascertain their qualifications. According to PIQ's human resource manual, the personnel file should include: position description and required qualifications, current resume, and completed job application. None of these items were present for the executive director's sister who served as the agency's nurse and whose performance was questioned by Commission quality assurance staff. All of these items were also missing from the personnel file of the executive director's brother who served as the agency's residence manager. This may be indicative of a lack of appropriate job qualifications since, due to the fundamental quality of care concerns being raised about the agency's IRA program by Commission and OMRDD inspectors, the executive director demoted him to assistant residence manager.

Another brother served as the agency's fiscal officer. Most of the required pre-employment background data was in his file except for his resume and references. He had no formal accounting background; however, he had received some on-the-job training from various banks, where he served as a wire transfer clerk, which provided him with marginal qualifications. Throughout the course of the Commission's fiscal review, the comptroller complained about the fiscal officer's poor job performance and she finally convinced the executive director to fire this brother. Paradoxically, on January 18, 1998, the comptroller had filed a memo with the executive director indicating that the fiscal officer had just passed his probation and recommending that he receive a $5,000 raise.

PIQ's Comptroller

Another individual whose effectiveness at the agency was deemed questionable by the Commission was PIQ's part time consultant/comptroller, who was paid $17,865 in 1997 through her corporation, TBA Tax Service, Inc. The comptroller described her PIQ responsibilities as including: supervision of PIQ's fiscal officer, preparation of books, accounting and business records, bank reconciliations, payroll tax reporting, and billings under PIQ's OMRDD contracts. This indicates that she was responsible for the overall fiscal management of PIQ. The Commission identified the following serious problems with the comptroller's fiscal stewardship of the agency: an inability to produce accurate basic business records and accounting reports in response to the Commission's requests; the lack of internal controls over cash disbursements; failure to complete timely bank and payroll reconciliations; and failure to adequately train and supervise the fiscal officer. Overall, the comptroller seemed unable to effectively administer the agency's business office and, more importantly, was not knowledgeable about the agency's current financial condition.

When Commission staff met with the executive director on March 4, 1998 and outlined the serious problems with the comptroller's work, she responded that she had discussed with PIQ's board president the issue of whether the agency had been getting sufficient value for the money which it had been paying to the comptroller. Despite this concern, the Commission received notice in PIQ's March 14, 1999 response letter that effective January 1, 1999, the comptroller's fee was raised to $2,300 per month, or $27,600 yearly.

The comptroller apologized to Commission staff on several occasions for the errors she had made in her fiscal stewardship of the agency. She also sought the Commission's guidance on how to put PIQ's fiscal house in order.

Improper Uses of Medicaid/SSI Funds

During 1997, PIQ reported it had sought to expand its operations beyond New York State through the incorporation of chapters in Miami, Florida and Port-Au-Prince, Haiti. In Miami, PIQ claimed that it had attempted to establish a foster care program for mentally disabled adolescents aged 10 to 16. PIQ asserted that it had tried to establish a number of food canteens in Port-Au-Prince, Haiti, to furnish meals to some of that country's poor. Since PIQ did not establish separate cost centers for these two programs, the Commission was only able to identify a portion of their purported development costs, totaling $767 for Miami and $4,576 for Port-Au-Prince. Since the Commission's analysis of PIQ's revenue revealed that the agency had no other substantial source of 1997 funding other than Medicaid/SSI payments, if the Miami and Port-Au-Prince programs exist, then public monies may have been misapplied to establish them. PIQ's comptroller said that these expenditures were ineligible for government funding and agreed that they should be repaid to the state. PIQ's management asserts that neither of these two programs is currently operational.

PIQ claimed to have paid college tuition and books totaling $3,666 for a Jamaican immigrant woman facing deportation. PIQ purported to have furnished this tuition assistance in response to this young woman's appeal for financial help on the "Help Me Howard" 10:00 p.m. segment of the WPIX television newscast. These expenditures appear to violate New York Mental Hygiene Law §16.32, which prohibits the spending of any state, Medicaid, or SSI funds on charitable contributions.[23] In addition to this improper expenditure, PIQ also made contributions to political fundraisers totaling $2,320. Contributions for political purposes are violative of the N-PCL §515 (c) which limits the distribution of a not-for-profit agency's assets to its corporate purposes, 18 USC 669 which prohibits the misapplication of health care funds, and Internal Revenue Code 501(c)(3) which restricts the use of tax exempt organization funds to corporate purposes.

Resident Personal Needs Allowance Abuse

The Commission's review of the eight resident personal needs allowance (PNA) savings accounts disclosed that they were missing the postings of 34 monthly PNA checks totaling $3,505 that had been issued to the residents, which the residence manager failed to deposit into their bank accounts. OMRDD regulations require that these monies be deposited into the clients' accounts within three working days of receipt.[24] At the Commission's request, the agency's comptroller performed an audit of the client PNA accounts and restored the missing monies. The Commission noted that client personal monies had been inappropriately spent in violation of OMRDD's regulations to pay for cable TV programming on an agency-owned set located in the residence's living room. In addition, the residence manager admitted that PNA funds had been wrongfully expended to pay for staff tickets and meals during consumer recreational outings.[25]

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[23] The agency asserts in its response to the Commission that it had sufficient funds from fund-raising which it could invest in legitimate activities in other areas. The Commission did note from a review of PIQ's records that $7,281 was booked in 1996-97 from fund-raising. However, these receipts were more than offset by $8,503 in agency costs to raise these funds and other expenditures such as political contributions.

[24] 14 NYCRR 633.15.

[25] The agency's response points out that its residence manager was terminated for "misfeasance" prior to the Commission's review and that the obligations were not taken off the books. However, the obligations were not carried as a liability on the books and, although PIQ checks had been written to reimburse the clients, the checks were never deposited into the residents' accounts and remained outstanding (i.e., were never cashed) until the Commission brought this issue to comptroller's attention. PIQ also indicates that its practice of using PNA funds for staff expenses and then "settling up" has been discontinued. Yet, the Commission found no evidence that the staff expenses were reimbursed.

Failures in Board Fiscal Oversight

The Not-For-Profit Corporation Law (N-PCL) requires that as fiduciaries, members of boards of directors have two paramount duties of loyalty and care which they owe to their corporations.[26] Loyalty means that the board must put the interests of the corporation above self-interest and give priority to the corporation over all other parties. The duty of care requires the board to act in good faith and with a degree of diligence, skill and care which ordinarily prudent persons would exercise under similar circumstances in like positions. The N-PCL also indicates that in discharging their duties, directors are expected to rely on information, opinions, reports, or statements prepared by others, including financial statements.[27]

The board is responsible for overseeing the agency's finances and ensuring that its assets are protected through the establishment of an adequate internal control system. PIQ's board lacked a mechanism for discharging this responsibility since it had neither elected a treasurer nor appointed a finance committee. Typically, the treasurer would chair the finance committee and serve as "point person" on financial matters, representing, monitoring and advising the board.[28] Furthermore, the board failed to ensure that the agency's expenditures were adequately planned and covered by the agency's revenue through the comptroller's development of an agency budget. Normally, the board would use the budget to monitor agency spending. Moreover, the board failed to monitor agency spending after the fact by meeting with its certified public accountant to review the results of the agency's annual financial audits.[29]

In fact, the board failed to protect the agency's assets from misappropriation when, on July 1, 1997, in an apparent attempt to legitimize an unauthorized act of the executive director, it gave *ex post facto* approval to a $15,000 pay increase she had already withdrawn from the agency. This increase was granted at a time when the board had been made aware by the comptroller of the agency's poor cash position and was obtaining a bridge loan to meet its basic operating expenses.

Due to the board's failure to see that PIQ had an adequate system of internal control over cash disbursements, the agency's executive director had sole control over this function. She exploited this weakness by issuing herself, without board detection, an unauthorized $20,000 payment on August 15, 1997. On February 10, 1998, the board passed a resolution requiring the board president to countersign all reimbursement checks for the executive director or her relatives and all "large ticket items."

Directors' duty of loyalty requires them to avoid transactions in which they benefit personally to the detriment of the corporation.[30] Any potential conflict should be disclosed to the board and approved prior to its undertaking. To make sure that board members are aware of this duty, many agencies have established written "conflict of interest policies." However, PIQ had no such policy. This led PIQ to contract without board approval with a dance company of a board member and pay it $4,000 to allow participants in PIQ's after-school program to attend classes and perform.[31]

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[26] N-PCL §717 (a)

[27] N-PCL §717 (b)

[28] "Managing Charitable Dollars, Financial Accounting Issues for Non-Profit Boards," New York State Attorney General, April 21, 1998.

[29] PIQ argues in its response that its board approved the agency budget, reviewed financial statements, and received reports on fiscal matters from its treasurer. But, as previously noted, the Commission could find no documentary evidence supporting these assertions.

[30] "Right from the Start-A Handbook for Not-For-Profit Board Members," New York State Attorney General, p. 4.

[31] PIQ asserts there was nothing wrong with this contract since the board knew about it and payments made were consistent with the dance company's established fee schedule.

Overall, the board's failure to effectively and independently oversee the agency's finances fostered a lax control environment which permitted the executive director to exploit the agency for her own and family's benefit at considerable cost to the welfare of the residents of PIQ.

PIQ's CPA Audits

Jane E. Ryan, certified public accountant (CPA), performed PIQ's financial audit for the year ending June 30, 1995. Her May 3, 1996 audit opinion was "qualified" due to the lack of documentation for expenses totaling $18,775 which had been charged to various programs. The bulk of these undocumented expenses involved 33 checks totaling $16,858 which the executive director wrote to herself. When she was interviewed by Commission staff, Ms. Ryan indicated that this audit had been very difficult and time consuming because of PIQ's poor financial record keeping practices and a serious lack of internal controls over cash disbursements, which the Commission believes constituted reportable conditions that should have been brought to the attention of the board and appended to the agency's financial statements as a footnote. Despite these problems, she neither issued a management letter nor followed her usual practice of meeting with the board of directors to discuss them. Ms. Ryan indicated that due to the difficulties she encountered in performing this audit she had to increase the price that she quoted to PIQ for performing the next year's audit. Therefore, PIQ decided to switch auditors.

Consequently, PIQ retained the CPA firm of Charles & Charles to perform the 1995-96 and 1996-97 fiscal audits and prepare OMRDD Consolidated Fiscal Reports (CFRs). Despite the fact that the Commission's review verified the persistence of the agency's record keeping and internal control problems, this firm issued unqualified audit opinions for both years[32] and no management letters. Furthermore, the opinions rendered were addressed to the executive director rather than the board of directors.

When Commission staff began its fiscal review of PIQ, Clifford Charles, CPA was already late in submitting the 1996-97 financial statements and CFR to PIQ. After months of Commission follow up, Mr. Charles finally submitted to Commission staff an unqualified PIQ audit opinion on July 23, 1998.

Commission staff subsequently learned that this opinion had never been formally issued to the agency, apparently because of widespread errors and was later withdrawn by Mr. Charles. The comptroller reported that these financial statements not only contained erroneous account balances, but also included the misallocation of expenses to defunct cost centers and excluded key new ones. Mr. Charles accepted full responsibility for the errors and reportedly apologized to the comptroller. The comptroller indicated that 86 adjusting journal entries were required to correct the errors. Mr. Charles indicated that the prime cause of the statement errors was his inability to properly supervise the staff person performing the audit. Commission staff believe that this violates Generally Accepted Auditing Standards, Standard of Field Work 1, which requires the CPA to properly supervise any assistants working on the audit.

Due to the problems noted above, the Commission decided that it needed to assess the quality of his audit work, and issued a subpoena to Mr. Charles on August 10, 1998 for his working papers for both years. Despite the agency's supplying Clifford Charles with permission to release his work papers to the Commission, he has failed to submit them.

On September 23, 1998, Mr. Charles issued a revised unqualified opinion on PIQ's 1996-97 financial statements. The Commission's comparison of the revised statements to the original ones confirmed the PIQ comptroller's assertions concerning the numerous differences in the account balances reported. Due to the problems experienced with the quality of Mr. Charles' audit work, PIQ decided to have BDO Seidman CPAs prepare the 1996-97 CFR and perform PIQ's 1997-98 audit.

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[32] However, the CPA's reports failed to disclose the nature of PIQ's prior year adjustments as required by Generally Accepted Auditing Standards.

III. Conclusion

The case of PIQ involves an executive director who abused the public trust placed in her and neglected and financially exploited the eight adults residing in its IRA by depriving them of adequate food, services and shelter. The Commission believes that a root cause of these problems was the board's failure to monitor the executive director's activities and hold her accountable for the management of the agency. This abdication of board responsibility freed the executive director to place her family's interests above those of the vulnerable consumers she had pledged to serve. She demonstrated a disregard for the residents' welfare by placing relatives of doubtful competence in charge of their care, and forcing the residents to live in a run-down and roach-infested facility. She also misappropriated money to help buy a new home, took trips out of the country and bought jewelry with public funds, while residents were fed an inappropriate diet of free surplus food and provided limited opportunities to participate in community activities.

In this and other cases, the Commission has found that the misuse of funds almost invariably results in unacceptable levels of care.[33] At PIQ, the diversion of funds as well as the operator's gross mismanagement put the facility in constant jeopardy with care suffering dramatically as a result. OMRDD's response was quick in protecting the residents against "imminent danger." The completion of the Commission's financial audit has answered some of the questions about the reasons for the operator's poor performance.

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[33] *See*, for example, *Profit Making in Not-For-Profit Care: Part III, The Case of Queens County Neuropsychiatric Institute, Inc.*, October 1996; *Missing Accountability: The Case of Living Alternative, Inc.*, June 1994; *Exploiting the Vulnerable: The Case of HI-LI Manor Home for the Aged and Regulation by the NYS Department of Social Services*, May 1992; and *Profit Making in Not-For-Profit Care: A Review of the Operation and Financial Practices of Brooklyn Psychosocial Rehabilitation Institute, Inc.*, October 1986.

IV. Recommendations

■ Referrals

- **The Office of Mental Retardation and Developmental Disabilities:** for the removal of the executive director who has demonstrated a lack of character and competence to administer this agency; the removal of PIQ's board of directors which has failed to adequately monitor the agency's fiscal and programmatic performance; or, transfer of PIQ's program to another responsible operator which will ensure that this program operates in the public interest.

- **New York State Department of Law:** for possible violations of the N.Y. Penal Law and N.Y. Not-For-Profit Corporation Law to recover funds that may have been misappropriated.

- **New York State Department of Education:** for possible violations of regulations relating to the practice of public accountancy.

- **The U.S. Attorney for the Eastern District of New York; Federal Bureau of Investigation:** for investigation of a possible criminal conspiracy to misappropriate federal funds.

■ Statutory Change

- A statute similar to federal statute 18 USC 666 (a)(1)(A) should be adopted at the state level to make it a crime to knowingly convert or intentionally misapply public monies.

Appendix A

George E. Pataki
Governor

Thomas A. Maul
Commissioner

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

February 23, 1999

Mr. Gary O'Brien, Chair
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, NY 12210-2895

Dear Mr. O'Brien:

I have received and reviewed the Commission's draft report of the fiscal and programmatic status of Project Independence of Queens.

As you know, Office of Mental Retardation and Developmental Disabilities (OMRDD) staff have been monitoring the two homes operated by the agency since their creation and have found numerous programmatic and regulatory deficiencies. I have attached a list which summarizes all visits that have been made to the homes to monitor compliance and to ensure consumer care and safety. Please note that OMRDD visited these homes immediately after receiving the anonymous letter on November 12, 1997 and shared our findings with the Commission. OMRDD last visited the homes on January 21, 1999 and found them to be generally in compliance with regulatory requirements although a statement of deficiency was issued.

OMRDD has reviewed and is in support of the Commission's fiscal findings regarding Project Independence of Queens. Based on these findings we have asked the board of the agency to meet with senior OMRDD staff on March 10, 1999 to provide explanation as to the findings and to present a remediation plan. As you know, we delayed the renewal of the two operating certificates held by the agency until we could review the Commission's findings. Unless significant and specific corrective action can be developed and initiated by the agency, OMRDD will be unable to renew Project Independence of Queen's operating certificates. We will advise you as to our recommendations after the March 10, 1999 meeting.

I want to personally thank you for the cooperation and coordination shown by you and your staff during our joint oversight of this agency.

Sincerely,

Thomas A. Maul
Commissioner

TAM/JA

PIQ
DDSO, NYCRO, DQA
MONITORING AND REGULATORY VISITS

Date	
11/30/94	First visit DDSO to first residence
5/18/95	DDSO visit
7/31/95	DDSO visit
11/2/95	QA visit (second residence)
8/23/96	QA visit - Imminent Danger
3/20/97	QA visit - Imminent Danger
8/1-8/97	QA Agency Review - Imminent Danger
8/1/97	CMCM Survey
11/17/97	DDSO visit
11/24/97	DDSO visit
11/28/97	DDSO visit
12/4/97	CQC first visit
12/15-15/97	CQC second visit
1/7/98	DQA visit - 45 day letter
1/29/98	QA visit
2/2/98	DDSO visit
2/6/98	DDSO visit
2/18/98	QA visit
2/25/98	DDSO visit
2/25/98	QA CMCM
2/27/98	DDSO visit
3/30/98	DDSO visit
4/2-4/3/98	CQC third visit
4/21/98	QA visit
4/28/98	DDSO visit
5/7/98	DDSO visit
7/13-14/98	DQA full regulatory review
7/14/98	CMCM review
9/29/98	DQA visit
1/21/99	DQA visit

APPENDIX B

George E. Pataki
Governor

Thomas A. Maul
Commissioner

STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
44 HOLLAND AVENUE
ALBANY, NEW YORK 12229-0001
518-473-1997 • TDD 518-474-4694

CERTIFIED MAIL/RETURN RECEIPT REQUESTED

February 5, 1999

Mr. Rodney P. Smith
President of the Board of Directors
Project Independence of Queens, Inc.
89-15 170th Street Apt. 3A
Jamaica, NY 11432

Dear Mr. Smith:

Enclosed is a draft report dated January 19, 1999, prepared by the New York State Commission on Quality of Care for the Mentally Disabled (CQC) following its review of services, management and governance of Project Independence of Queens New York, Inc. (PIQ). The report alleges that there were instances of improper use of agency resources by Ms. Marie Chantal-Joseph, Executive Director of PIQ and other of Ms. Joseph's family members employed by PIQ. In addition, the report raises many serious program and fiscal issues which cast doubt on whether the Board of PIQ has exercised effective governance and supervision of the activities of PIQ.

Before OMRDD takes any action based on the CQC report, we would like to afford the Board of PIQ an opportunity to review the CQC report, conduct its own internal review, and then advise us as to whether each and every finding and factual representation is valid or not. For those findings and factual representations you deem to be not valid or accurate, please provide us with a detailed explanation with necessary supporting documentation to support your position. For those findings and factual representations which are accurate, please submit by March 5, 1999, a plan with specific time frames describing in detail the actions the Board has taken to remedy the issues identified. The plan should include management systems to be implemented which will prevent future recurrence.

In addition, due to the urgency and seriousness of the CQC report, we are requiring that each board member appear for a meeting with senior OMRDD officials on Wednesday, March 10, 1999, at 6:00 p.m. at 75 Morton Street, 1st Floor Conference Room. Please confirm your personal attendance in writing or by telephone at the number listed below on or before March 5, 1999. You are free to bring legal counsel should you desire to do so. Your failure to appear, however, may be deemed evidence of non-cooperation with an official OMRDD investigation and could lead to an adverse action against your agency.

Should you have any questions on this matter, please contact Mr. David Picker or me at (518) 474-3625.

Sincerely,

Jan Abelseth
Interim Deputy Commissioner
Division of Quality Assurance

JA/md
cc: Mr. R. Johnson
Ms. Broderick
Ms. Wheeler
Mr. Picker
Ms. Lark
Ms. Kagan
Mr. Murray
Ms. Trent
Ms. Podgorski
Mr. Joyce
Mr. D. Johnson
Mr. O'Brien (CQC)
Mr. Surack (CQC)
Dr. McGee (CQC)
Mr. McCarry (CQC)

Copies of this report are available in large print, braille, or voice tape. Please call the Commission for assistance in obtaining such copies at 518-381-7105.

The Commission on Quality of Care for the Mentally Disabled is an independent agency responsible for oversight in New York State's mental hygiene system. The Commission also investigates complaints and responds to requests concerning patient/resident care and treatment which cannot be resolved with mental hygiene facilities.

The Commission's statewide toll-free number is for calls from patients/residents of mental hygiene facilities and programs, their families, and other concerned advocates.

Toll-free Number: 1-800-624-4143 (Voice/TDD)

In an effort to reduce the costs of printing, please notify the Commission if you wish your name to be deleted from our mailing list or if your address has changed. Contact:

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