

Missing Accountability:

The Case of Community Living Alternative, Inc.

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**NYS COMMISSION
ON QUALITY OF CARE
FOR THE MENTALLY DISABLED**

Preface

At the most basic level, this is a report about the president and the executive director of Community Living Alternative, Inc. (CLA), who abused the public trust placed in them and abused, neglected and financially exploited the ten adults residing in an intermediate care facility (ICF) operated by this agency.

As this report documents, over a period of years, these two individuals:

- deprived the residents of adequate food, supervision and shelter (Report p. 4);
- deprived the residents of adequate health and dental care (Report pp. 4-5);
- provided insufficient treatment, habilitation and recreation to meet the needs of the residents (Report pp. 4-5);
- failed to adequately maintain the residence, exposing the residents to unsafe and unsanitary conditions (Report p. 4);
- diverted approximately a quarter of the public funds provided CLA (\$510,000) to unexplained purposes through checks made out to cash (Report pp. 18-21);
- responded to complaints from family members with threats of eviction to their relatives (Report p. 5);
- intimidated the program staff, including moonlighting staff of the Office of Mental Retardation and Developmental Disabilities (OMRDD), into a timorous acquiescence and complicity in a pattern of evasion of state regulation and concealment of noncompliant practices through alteration of records (Report pp. 11-12);
- engaged a certified public accountant (CPA) who facilitated the fiscal improprieties by filing false and misleading audit opinions with OMRDD (Report pp. 16-18);
- filed "plans of correction" in response to repeated citations of deficiencies from OMRDD certification surveys, but failed to implement them (Report pp. 7-10).

This profitable scheme of poor care and evasion of regulations began to unravel when the sister of a resident, unwilling to endure the threats from the executive director in response to her complaints and the inaction by the local OMRDD service office, filed her complaint with the Commission. Site visits by the Commission staff confirmed what OMRDD certification reports had been documenting for years -- seriously deficient conditions in many aspects of CLA's operations. These included insufficient food, noncompliance with special diets, a lack of toothbrushes, sparse recreational activities, and a living environment of peeling wallpaper, chipped paint, leaking faucets and toilets, and inoperable doors, washer, dryer and air conditioners.

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When the executive director attempted to excuse the many deficiencies by complaining about inadequate public funding, the Commission's curiosity was aroused. Was the rate of \$53,000 per resident annually inadequate to provide the basic necessities of life to the ten residents?

equated public funding, the Commission's curiosity was aroused. Was the rate of \$53,000 per resident annually inadequate to provide the basic necessities of life to the ten residents? Our request to see the agency's financial records was met with initial evasion and eventually was rebuffed. When the Commission served subpoenas demanding the production of the records, the executive director abruptly closed the residence on the return date of the subpoenas, stranding the residents at their day programs, cleaned out the records, padlocked the doors and fled the state.

In the ensuing fiscal investigation, the Commission learned that:

- the executive director was using a false name and a false social security number which helped to conceal (a) a prior criminal record; and (b) that the board president was his wife (Report p. 14);
- there was no real board of directors to oversee this not-for-profit agency (Report pp. 15-16);
- the lack of external controls was matched by an equal lack of internal controls or accountability for the expenditure of cash (Report pp. 18-21);
- the large withdrawals of funds by checks payable to cash were ostensibly made in areas where the agency was most deficient (food, housekeeping supplies and recreation) (Report pp. 18-21);
- while the programs suffered from shortages of necessities, including months on end without fruit or vegetables, the president and executive director each had luxury cars provided them by the agency. (Report pp. 15-16);
- CLA appealed to OMRDD for a rate increase in 1989 to hire additional staff. Although CLA was unable to provide financial data to justify a rate increase for almost three years, OMRDD granted the rate appeal in 1992, including a retroactive payment of \$138,798 for staffing costs *which had never been incurred*. Much of this windfall payment was soon dissipated through cash expenditures (Report pp. 21-22).

The nagging question this investigation raises is why weren't these conditions detected earlier by the existing regulatory system? OMRDD maintains a considerable monitoring presence in the programs it certifies -- certification staff from its Division of Quality Assurance conduct annual certification surveys to assess compliance with standards; the Bor-

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ough Developmental Services Office (BDSO), the local branch of OMRDD, provides a case manager who visits residents monthly to monitor their care and condition; BDSO staff are available to investigate complaints; reports concerning the agency's financial condition must be provided to OMRDD by independent CPAs; OMRDD's Division of Administration and Revenue Support ensures that rates are

adequate to meet regulatory requirements; and the Bureau of Management and Fiscal Audit is empowered to conduct financial audits. Yet, as the Commission learned in the course of this investigation, these multiple efforts are neither integrated nor coordinated in any systematic way. Because these functions are conducted in isolation from one another, all the "red flags" that were present in this case were not seen by any single official; those that were seen did not prompt a re-evaluation of the effectiveness of the regulatory effort or of the operator's character and competence. Thus:

- the case manager making monthly visits remained unaware of the certification reports which cited myriad deficiencies, or of the operator's promised corrections which were never implemented;
- the BDSO supervisors and managers, who not only supervised the case manager but also had granted permission to three other OMRDD staff to moonlight at CLA, also never saw these certification reports. Thus, they did not notice the inconsistency between the continual citations of deficiencies by Quality Assurance staff and the absence of confirming observations by the case manager;
- the BDSO staff and the Regional Office supported CLA's appeals for higher rates to pay for more staff, but neither they nor the rate setting office examined CLA's expenditures to determine if lack of money was the reason for the staff shortage. Moreover, as the rate appeal was processed over a three-year period, no one checked to see if the additional staff had been hired before issuing a check for \$138,798 in *retroactive* payments. In fact, as the Commission learned, such costs were never incurred;
- the Quality Assurance Division remained unaware of the inconsistencies between their findings and the regular monthly reports being filed by the case manager;
- the OMRDD Bureau of Management and Fiscal Audit conducted a CLA audit in 1981 which found 153 checks, totaling \$35,821, written to cash over a two-year period. Although it instructed the operator to stop this practice, it conducted no follow-up to insure that this problem had been corrected. In the absence of follow-up, the operator *increased* this practice more than five-fold so that by 1991 approximately 25 percent of the agency's

revenue was being spent through checks made out to cash. Since neither auditors, certification staff nor program staff were examining this practice, no one noticed that this money was ostensibly being withdrawn for expenditures in areas where the agency was most deficient -- food, household supplies and recreation.

Despite the many shortcomings in OMRDD's regulation and oversight of this agency, when the operator precipitated a crisis by abruptly closing the residence, OMRDD moved with vigor and dispatch to protect the residents' safety and well-being. It

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promptly secured a court-ordered receivership over the program, enlisted the assistance of another provider agency (The Association for Children with Retarded Mental Development, Inc.) to take over operation of the program, and eventually secured alternative placements for some residents in accordance with the wishes they or family members articulated. Throughout the course of this investigation,

OMRDD cooperated fully with the Commission in readily making available information and records needed to understand the events described above.

The Commission has made a number of referrals to law enforcement and professional disciplinary bodies for action within their jurisdiction, and is working actively with them on further actions addressed to the criminal and civil law responsibility of specific individuals.

While this report has a happy ending for the ten residents of CLA, it contains sobering lessons for the service system as a whole. The structural weaknesses in the system of regulation and supervision permitted deficient conditions to exist and persist at CLA for a long period of time. The Commission believes that these structural weaknesses require both legislative and administrative reforms, and we have offered a number of recommendations to this end.

A draft of the report has been reviewed by OMRDD. The OMRDD response indicates a generalized intent to consider the recommendations but objects to several points made in the report. The full text of the OMRDD response is attached to the report (Appendix C). In some instances, the Commission has made revisions to the draft report in response to the OMRDD comments. However, the Commission disagrees with many of the OMRDD comments and has addressed them specifically in a Rebuttal (Appendix D).

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



Clarence J. Sundram
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Introduction

Corporate Background

Community Living Alternative, Inc. (CLA), located at 137-20 45th Avenue, Flushing, New York, was incorporated as a not-for-profit corporation on August 10, 1978. Its purpose, as stated in the corporate charter, was to establish, operate and maintain community residences for persons with developmental disabilities.

Operating under licensure of the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD), CLA since its inception operated only one 10-bed intermediate care facility (group home) at the above location. The agency's funding has been through Title XIX of the Social Security Act (Medicaid);¹ its 1992-93 operating budget was approximately \$530,000.

The operations of this program were summarily ended on November 6, 1992 when CLA officials acted upon their threat to close the agency rather than

cooperate with the Commission's programmatic and fiscal reviews. OMRDD was notified, but not in advance, that the agency was summarily terminating services and that its residents were being abandoned at their day programs while the doors to their home had been locked to prevent their return that very evening.²

On November 10, 1992, OMRDD obtained an Order to Show Cause to seize the property and brought in a receiver, the Association for Children with Retarded Mental Development, Inc. (ACRMD). On November 13, 1992, a locksmith reopened the doors of CLA whereupon ACRMD and Commission staff entered the residence to find that treatment and financial records had been removed from the facility. Later that day, the receiver returned the residents from the Bernard Fineson Developmental Center where they had been receiving temporary shelter.

CLA's executive director was Leslie O. Wright (aka Les White); the board chairperson was later discovered to be his wife, Kay Wright.³ After the

¹ On April 28, 1988, the NYS Department of Health acting on the recommendation of OMRDD determined that CLA did not meet the requirements for participation in the Medicaid program because Life Safety Code deficiencies found in earlier August 26, 1986 and September 16, 1987 surveys had not been corrected. The repeat deficiencies related to the need to replace two fire escapes at the leased facility to assure that residents could be evacuated in an emergency situation. On July 1, 1988, CLA lost its federal financial participation and entered into a one-year contract with OMRDD for 100 percent State funding of its operations until the renovations were made. Effective July 3, 1989, CLA was certified for reentry into the medical assistance program.

² On November 6, 1992, CLA's executive director by facsimile transmission notified the director of the Bernard Fineson Developmental Center, as follows:

Be advised that **EFFECTIVE IMMEDIATELY!**, Community Living Alternatives, Inc. will no longer provide services to the mentally retarded.

YOU MUST ARRANGE FOR TRANSPORTATION FROM DAY PROGRAM FOR ALL CLIENTS.

Please understand that after 12 noon today 11/6/92, There will be **NO SERVICES PROVIDED.**

There will be **NO STAFF ON SITE AND NO ACCESS FOR CLIENTS.**

³ As CLA executive director, Leslie O. Wright concealed his true identity by using a false name (Leslie White) and social security number. This appears to have enabled him to: (1) conceal from OMRDD the conflict of interest that the board chairperson was in fact his wife; (2) withhold disclosure of his CLA income from the Internal Revenue Service and State Department of Taxation and Finance; and, (3) keep secret his past criminal history. Concerning the latter, according to a Certified Transcript of Record from the Clerk of the New York Supreme Court, Queens County, Mr. Wright was convicted of Menacing and sentenced to serve three months time in a City of New York, Department of Corrections' facility.

closure, the Wrights quickly sold their home in Coram, New York and relocated to Davidson, North Carolina.

Commission Involvement With CLA

The Commission's review of CLA was initiated on January 22, 1992 when a CLA employee and a resident's relative complained about the lack of appropriate care and treatment that the residents were receiving. They reported that the facility was not supplying its residents with important services and supplies. There was inadequate food and clothing, community recreation, personal hygiene items, household cleaning supplies, cooking utensils and a general failure to make the necessary repairs to the physical environment.

A Commission site visit on February 6-7, 1992 confirmed the complainants' allegations and additionally found that facility staffing levels consistently did not provide sufficient direct care staff to treat and supervise clients in accordance with individual program plans. Only one counselor was available for the

Only one counselor was available for the home's ten severely disabled residents, who were ambulatory but required care in basic skills of daily living, including eating, dressing and toileting.

home's ten severely disabled residents, who were ambulatory but required care in basic skills of daily living, including eating, dressing and toileting. Direct care staff were regularly scheduled to work alone for a large portion of their 24-hour awake shifts. Many of these deficiencies affecting resident health, safety and quality of life were chronic and continuing and were also cited in prior OMRDD certification in-

spection reports during 1989, 1990, and 1991.⁴

On April 27, 1992, although CLA's executive director submitted a plan of correction to the Commission's letter specifying these findings, nothing changed, as had happened in response to OMRDD's past criticisms of these same deficiencies. The Commission then sent another letter on July 24, 1992 to the executive director which demanded amendment of the plan to ensure accountability and compliance by: (1) specifying the number

It became immediately obvious from the Commission's review of fiscal reports on file at OMRDD that there were heavy "cash" expenditures attributed to areas found to be deficient by the Commission's quality assurance staff, including: food, household and linen supplies, recreational activities and facility maintenance.

of direct care staff during each shift, (2) training staff in charting resident goals and monitoring residents' personal hygiene and clothing, (3) assigning a specific individual to purchase and prepare food, and (4) establishing meaningful recreation programming at the residence.

On August 11, 1992, the Commission's fiscal bureau became involved in this investigation because the executive director attributed many of the agency's shortcomings to insufficient funding. It became immediately obvious from the Commission's review of fiscal reports on file at OMRDD that there were heavy "cash" expenditures attributed to areas found to be deficient by the Commission's quality assurance staff, including: food, household and linen supplies, recreational activities and facility maintenance. The Commission's analysis of CLA's financial statements and detailed general ledgers found that in 1991-92 \$119,138 or 25 percent of agency expenses were alleged to have been made by checks written to "cash" usually in round dollar amounts.⁵

⁴ While noting that there were a substantial number of deficiencies at CLA over a three and one-half year period, OMRDD determined that the deficiencies, according to federal definition, were mostly not "repeat" deficiencies. Accordingly, OMRDD states that it is speculative whether CLA's behavior was routine and therefore indicative of the character and competence problems of the officers of this agency (Appendix A).

⁵ The State has not done a fiscal audit of CLA since 1981. Even at that time, OMRDD itself cited the agency for improper practices because it wrote 153 "cash" checks totaling \$35,821 for the two years ending June 30, 1980, most of which could not be verified because of the lack of invoices and receipts. Although Leslie Wright agreed to stop this practice, by 1991-92 cash outlays had increased more than five-fold. (Community Living Alternative, Inc., Contract Audit Review, July 1, 1978 - June 30, 1980, OMRDD-81-NY-2).

Additionally, the checking account was found to be substantially overdrawn and the agency was incurring penalties for bounced checks and late remittance of payroll taxes to the Internal Revenue Service.

This disturbing fiscal profile led to a decision by the Commission to conduct an on-site financial review. On October 8, 1992, a letter was sent to the CLA executive director requesting an audit entrance conference. However, rather than cooperating with this request, on October 22, 1992 Kay Wright, as "President, Board of Directors," sent a letter to the Commission requesting at least a one-month delay so the agency could "compile and reconcile" its records. Simultaneously, she put the Commission on notice that the OMRDD Commissioner had been asked to either intercede on CLA's behalf or the residents would face closure of the facility on October 30, 1992. CLA also wrote letters to the relatives of residents threatening to close the residence unless the Commission "backed off."

In an October 23, 1992 call to the agency to schedule the fiscal audit, the executive director claimed not to know where the accounting records were located since the board president (not known at that time by the Commission to be his wife) had designated a board member to maintain custody of the records, and he "didn't know who the member was or where the records were kept." Mr. Wright also claimed that the board minutes needed to be redacted to exclude certain information because he said the CLA board oversaw other agencies.

Since the agency's stance seemed to be an attempt to obstruct the fiscal investigation, and its attempt to

use the residents as hostages was clear evidence that its interest was something other than the welfare of the residents, subpoenas were served pursuant to Section 45.09 (c) of the New York Mental Hygiene Law on Kay Wright, Les White and CLA's certified

CLA without prior notice closed its doors on the return date of the Commission's subpoenas, stranding its residents at their day programs.

public accountant (CPA), Richard Brown, demanding production of all financial and board records at the Commission's Albany office by November 6, 1992. However, rather than comply with this demand, and after assuring OMRDD that it would not close the agency, CLA without prior notice closed its doors on the return date of the Commission's subpoenas, stranding its residents at their day programs. A week later, the doors were opened pursuant to a court-imposed receivership, but the books and records needed to help understand the underlying reasons for poor care at CLA had disappeared.

This report summarizes the care and treatment at CLA; OMRDD's monitoring of the facility; and, absent agency books and records, what could be learned about CLA's board oversight and financial operations from independent investigations by the Commission and federal agencies, from the CPA's working papers, and through subpoenas of bank records.

Findings

Program Care and Treatment

As reported earlier, the Commission's first visits to CLA in February 1992 revealed significant problems in many areas of its operation which adversely impacted the quality of resident life. The facility had serious environmental problems and inadequate staffing. Programming documentation was deficient and suggested poor implementation of program goals. The supply of food in the house was inadequate, and special diets were not followed. Residents had few personal hygiene supplies; the observed interactions between staff and residents were harsh and abrupt; and, residents seldom went out into the community for recreational activities. Some specific examples follow:

- Frequently the residence had only one direct care staff person on duty. Typically this person worked an 18-24 hour awake shift.
- Common areas of the residence required substantial repairs and maintenance. The air conditioners, washer and dryer were inoperable. In several bathrooms, faucets or toilets leaked. The door to one bedroom would not close and the closet door in another was inoperable. Plates, silverware, and glasses were mismatched and in short supply. Some of the paint in the residence was chipped, and the wallpaper was peeling.
- In two of six resident records reviewed, data sheets were incomplete or blank. Summaries of work on program goals for two residents compiled in preparation for quarterly reviews were not complete, although the quarterly reviews had been held a month or more earlier. There was evidence that assessments and/or treatment plans were inaccurate. For example, in assessments done only eight weeks apart, a resident was first described as needing to learn to keep his room neat and tidy and adopt appropriate sexual activity, and later described as having kept his room neat and tidy and not having exhibited any

inappropriate sexual behaviors in the past year.

- On the date of our visit, there was insufficient food for the next day's meals. There were no fresh fruits and vegetables on hand, and review of itemized food bills revealed that none had been purchased for several months. Rather, the receipts showed large purchases of pork and beans, frozen waffles, and pancakes. Every resident ate the same evening meal which consisted of canned beef stew, noodles, mixed vegetables, bread and butter, jello or canned pears in light syrup, and fruit punch. Yet, six of the nine residents were on some combination of a low calorie, low cholesterol or low sodium diet.

On the date of our visit, there was insufficient food for the next day's meals. There were no fresh fruits and vegetables on hand, and review of itemized food bills revealed that none had been purchased for several months.

- The failure to accommodate special diets contributed to continuing health problems of several of the residents. Four residents were 25-50 pounds overweight and had been placed on diets by their physicians. Having made no effort to reduce the caloric content of the meals, three of the four individuals had gained an average of two pounds a month in the previous three months. Two residents had high cholesterol counts and had been prescribed a low cholesterol diet. Again, with no attention having been paid to this problem, each had an increased cholesterol count on recheck one year later -- one 48 points higher, the other 12 points higher.
- Although several residents were reportedly working on goals to improve their dental hygiene, few had toothpaste, and those residents who had toothbrushes often stored them unhygienically. There were no supplies for cleaning dentures, and one resident kept his dentures in a filthy

plastic food container. Five residents were continuously noted to have moderate-to-severe gingivitis.

- With Commission reviewers watching, residents were told to "stop talking and get eating" as soon as they began a conversation at supper. With similar insensitivity, the staff member described two residents as the "worst residents in the house" in their presence.

Part-time staff who complained about conditions were reminded that "this is not your concern." Family members who voiced objections to the way the residence was run were told that they were free to remove their family member.

- Finally, no recreation schedule was posted and no documentation kept of recreational activities. Residents stated that on weekday evenings they watched television or listened to the radio. On weekends, the recreation worker came in and did arts and crafts with them. They rarely went out, except for a walk around the neighborhood.

In subsequent visits, the review of more records and other documentation, and conversations with residents, staff, and family members revealed that these problems had been long-standing, and the expression of complaints or concerns was not welcome. Part-time staff who complained about conditions were reminded that "this is not your concern." Family members who voiced objections to the way the residence was run were told that they were free to remove their family member. Residents were intimidated by the executive director who reportedly yelled frequently and told them that he owned everything they saw around them in the residence.

A more careful look at the treatment planning process revealed that reports of quarterly reviews were often merely photocopies of the previous quarter's report. Residents never attended treatment planning meetings, although several were quite capable of not only listening to what was going on, but also of actively participating. Families also rarely attended the meetings because they were not invited. The day program had to make repeated requests to CLA to provide them with updated material which they required.

As the Commission's review of care and treatment issues was concluding and Leslie Wright had closed the program, former staff admitted to Commission reviewers that when the OMRDD certification team was expected -- the agency reportedly had the date down to a one week window -- they would back-date records, order more food, put on more staff and warn the residents that if things didn't go well, they would have no place to live.

A reasonable person looking over the list of problems which the Commission's first two unannounced visits uncovered might ask what type of monitoring had OMRDD been providing to the facility over the years and why it did not ensure the correction of deficiencies. The answer to this question is complex in some respects, yet simple in others, but clearly implicates the job performance of individuals, personal ethics and the short-comings of the certification process.

The Certification Process

CLA, like all non-developmental center intermediate care facilities (ICFs) for mentally retarded and developmentally disabled persons in New York State, is visited annually by a two-person team from OMRDD to determine whether the program is in compliance with State and federal certification standards. If significant problems are found, a certifica-

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tion team may visit more frequently. Without certification, CLA could not receive payment for its operating expenses under the Medicaid program, as occurred during 1988-89. (See, *supra*, footnote note 1, at p. 1).

In addition to this annual inspection by staff of the Program Certification Bureau, the BDSO -- the local branch of the OMRDD -- provided a case manager to act as a liaison with CLA and visit the residence monthly to ensure the well-being of the residents and

provide needed technical assistance. Thus, between the work of the certification and BDSO staff, OMRDD theoretically maintained a regular presence in the CLA ICF.

It is also important to note that several BDSO staff who held second jobs in direct and clinical care at CLA itself should have recognized the inadequate care being rendered and taken appropriate measures to correct the problems. The presence of BDSO staff, which should have served as part of the safety net for the CLA residents, provided no protection whatsoever, and one can speculate whether employment at the licensee compromised their responsibilities as employees of the licenser.

BDSO Monitoring

The failure of the BDSO case manager to alert the BDSO to the significant problems in the quality of life of the CLA residents is attributable both to his poor performance and to the minimal expectations placed on him.

Under oath, in response to a Commission subpoena, the former staff member testified that each of his monthly visits to CLA was announced and scheduled in the afternoon after three o'clock, so that he could see the residents when they returned from program. He noted that he spent most of his time in the dining room and living room area, but toured each bedroom every month. He seldom went into the kitchen. He saw no maintenance problems and no problems with the supply or care of personal hygiene supplies. He did not check on special diets or report that no menus were posted at the residence. He saw no problems with staffing and never checked the staffing schedule.

Although he regularly scheduled his visits so that he could attend the quarterly reviews of the six residents for whom he was responsible, he never reported that they were repetitive (sometimes goals were repeated without revision for years) and never watched the implementation of any program goals. He reported noticing the absence of data on goal implementation in several instances, but because it did not extend over a full month, he did not report it.

He stated that although no activities schedule was posted, he took staff's word that residents were getting out two or three times a month. He further testified that he would review personal allowance records (by appointment only since they were not available unless the executive director accessed them),

although he did not even know how much money residents were supposed to receive monthly.

By his own account, his exchanges with residents were informal, amounting to little more than "How are things going?" He rarely sat down and talked to residents unless the facility had complained about their behavior. Then he would discuss the incident with the individual and tell him or her to change the offending behavior. In the one instance in which he could recall that a resident had complained to him, the case manager did not fill out an incident report on the allegation of psychological abuse because CLA staff had told him the resident was lying.

At the conclusion of each monthly visit, the case manager would fill out a Personal Contact Report form which included a checklist indicating the agency's compliance with basic care standards for the resident identified. The second part of the form provided room for general comments. The checklist contained questions about the site (e.g., was it clean and maintained in a reasonably ordered manner); the client (e.g., was the client appropriately clothed and groomed); and programming (e.g., during the visit, was the client receiving the services corresponding to his/her individual program plan and were there indicators that the client had participated in varied community activities).

Each question on each resident's reporting form for more than two years generally indicated no problems. In the few instances where there was a problem noted, the case manager explained that he had made a mistake and checked the wrong box. In the comments section of the form, he typically wrote the resident's current treatment objectives, his/her medications, family contacts, and the community activities staff had reported. Each of these reports was subsequently signed by the case manager's supervisor.

The case manager told CQC that he had worked for the BDSO from April 1990 until August 1992 when he was terminated for not maintaining timely records. He noted that he had never read a certification report for CLA until he requested to read the agency's copy of the 1991 report. He stated that he did not know he could get a copy of the certification report from the BDSO. In answering questions about OMRDD supervision and training provided to him, the former case manager reported that he met with his supervisor for formal supervision once or twice a month and conferred with her as necessary, approximately two or three additional times each month. He

reported that she expressed no dissatisfaction with the quality or content of the documentation of his activities and observations during his visits and never made any visits with him.

The former staff member concluded his interview with CQC by assuring it that at CLA "clients were not constantly being abused" but that he "felt all along the line that something was wrong there."

He further testified he had received in-service training in infection control and abuse reporting, had been instructed on the requirements of his job and had traveled with another worker for two weeks or so before taking on his own caseload. He carried a caseload of approximately 35 individuals residing in four group homes and five or six family care homes. He was advised to focus his energy on the clients living in family care, as those providers had less training than agency staff and this placed the residents at greater risk.

At the close of the interview, the case manager noted that he had made his first unannounced visit to CLA on May 21, 1992 when he was alerted to problems at the facility by the sister of one of the residents. During that visit, he found insufficient food for the residents for the next day. He alerted the OMRDD certification unit, which also dispatched a team and found the same condition and ensured that adequate food supplies were subsequently secured by CLA. The case manager could not remember a telephone call to him by one of the CQC investigators on May 11, 1992 alerting him to problems and asking for information and follow-up. He also did not think that he had seen a copy of the Commission's March 30, 1992 letter detailing the program deficiencies which had been sent to the OMRDD Quality Assurance Division (which includes the certification teams) and the local BDSO. Further, he was unsure whether the telephone call or the letter had influenced him to suggest to his supervisor that an unannounced visit be made to CLA.

The former staff member concluded his interview with CQC by assuring it that at CLA "clients were not constantly being abused" but that he "felt all along the line that something was wrong there."

There is no documentary evidence that he shared this suspicion with anyone until May 20, 1992 when he made plans for an unannounced visit the next day and found nearly no food in the house.

Certification Activities

-An Overview

Review of the CLA certification records released by the OMRDD to the Commission reveals that in the first three years of CLA's certification history (1985-87), the facility was cited most often for deficiencies in living conditions and fire/safety concerns. On July 1, 1988, the residence was decertified, as it failed to meet life/safety code standards since it did not have two acceptable exits. Active treatment issues took the foreground in 1989 and the facility was judged out of compliance with that condition of participation. This marks the beginning of the agency's downward spiral. Later certifications continued to reveal significant and recurring problems in active treatment, protection of residents' rights, handling of personal allowances, the review of incidents, and health-related matters.

Appendix B summarizes the deficiencies found during the certification visits. It does not necessarily reflect the same language as the OMRDD report, but it is an accurate portrayal of the deficiencies and the frequency with which they occurred as reflected in the OMRDD reports given to the Commission.⁶

In order to better understand what certification activities occurred at CLA and why, a very short and

Later certifications continued to reveal significant and recurring problems in active treatment, protection of residents' rights, handling of personal allowances, the review of incidents, and health-related matters.

simplified guide to the certification process may be helpful: ICFs are judged against some 400 federal standards (each assigned a W tag number) divided into eight general areas called "Conditions of Participation." These include, for example, staffing, client

⁶ CQC correspondence with OMRDD reveals that a certification visit occurred in May 1989. This report was not forwarded to the Commission and thus the 1989 data in this chart reflects only the December 1989 visit.

protection, governing body, and active treatment. There are also State regulations by which compliance is assessed, i.e., 14 NYCRR 624, 633 and 635. Teams of two surveyors visit each program unannounced 90 to 120 days before the expiration of

It appears that serious programmatic deficiencies were cited repeatedly over the next several years and should have signalled that the program was unwilling or incapable of making necessary improvements.

the current provider agreement and operating certificate. (Thus, providers know that they have a 30-day window to expect a recertification survey.) Following each visit, the program is issued a list of deficiencies and must respond in writing with a plan of corrective action. The plan must receive the approval of OMRDD -- generally granted after a review of its contents. Validation visits are sometimes performed to ensure implementation of the corrective action for federal deficiencies.

Failure to pass a certification review can result in several actions, depending on the severity of the problem.

- If, after consultation with the survey team and review by administrators in the OMRDD Program Certification Bureau, it is determined that a program is out of compliance with one of the Conditions of Participation, the program is informed that it has no more than 60 days to come into compliance or it will not be recertified. A monitoring (60-day) visit is scheduled to ensure that the agency has corrected the serious problem. If adequate corrective measures have been taken, the program may be issued a standard (one-year) or a shortened provider agreement.
- If it is determined that a program cannot be recertified, but the problems do not present an imminent danger to residents and there is reason to believe that the agency can come into compliance through implementation of its plan of corrective action and is making a good-faith effort to do so, the program is placed on "intermediate sanctions" and given no more than 11 months to come into compliance. During this time there is a ban on new admissions and the program is monitored every six to eight weeks by OMRDD.
- If the conditions at the program place the residents in imminent danger, for example, health/safety issues or evidence of abuse, then

decertification proceedings can begin immediately and be completed in 23 days. In the meantime, OMRDD will take measures to ensure the safety and well-being of the residents, such as mandating that the danger be remediated immediately or that all the individuals residing in the program be relocated to a safe living environment until the danger has been removed or rectified.

Reflecting the recognition that increasing numbers of individuals were being served in small ICFs in the community rather than in large developmental centers, and that their well-being was best ensured by a move from a primarily paper-focused recertification review (42 CFR 442), in 1988 the recertification inspections became outcome-based (under 42 CFR 483). At the risk of over-simplifying, this means that with the exception of those areas of the operation of the facility which are directly related to written documentation (e.g., treatment plans, assessments, the maintenance of Incident Review Committee minutes), if things look all right and interviews with staff and residents suggest that all is well, reviewers generally do not review the supporting documentation. Exceptions include some medical and client rights issues. Thus, for example, if reviewers arrived on-site at CLA and there were two staff present, the residence was clean, residents looked well cared-for, the interactions between the staff and residents were polite and even cordial and caring, and active treatment was taking place, the reviewers would not check staffing schedules to ensure that this was the typical staffing pattern.

~Repeat Deficiencies

As noted above and illustrated in Appendix B, certification activities at CLA began to reveal significant problems in the provision of resident care and treatment in 1989. At that point, it appears that serious programmatic deficiencies were cited repeatedly over the next several years and should have signalled that the program was unwilling or incapable of making necessary improvements.

According to calculations done by OMRDD, the two certification reviews in 1989 and the reviews in 1990 and 1991 showed several instances of deficiencies cited more than once. Specifically, of the 47 tag numbers cited in these four surveys, 14 (30%) were cited two or more times. Thirteen of these 14 citations were related to two Conditions of Participation: Active Treatment and Health Care. Review of the

two recertification surveys (October 1991 and October 1992), the monitoring visits (April 1992), and the 60-day visit (June 1992) revealed that 16 (53%) of the 30 tag numbers were cited more than once. Again, most (94%) of these were related to Active Treatment and Health Care (Appendix A).

Based on its own work and in response to the Commission's observations about the repetitive nature of the deficiencies and the red flags these should have raised, OMRDD concluded that although some standards were repeated more than once they did not meet the Health Care Financing Administration's definition of a repeat deficiency. This definition requires that a regulatory requirement has been identified as out-of-compliance for two consecutive surveys and has been cited as deficient in both instances because of a common originating nature or issue. Applying this definition, OMRDD calculated that there were two repeat deficiencies between the December 1989 and November 1990 surveys and only one repeat deficiency between the November 1990 and October 1991 surveys.

While this explains why a deficiency which is repeated is not necessarily a repeat deficiency, a close examination of the certification records of CLA should have alerted OMRDD to a program which was incapable of providing, as one example, active treatment. Often, though not necessarily in consecutive surveys, reviewers found that the QMRP (qualified mental retardation professional) was not reviewing and revising the program plans; annual reviews were incomplete or otherwise inadequate; data collection was erratic; and goals often lacked target dates, frequency of interventions, or a methodology for implementation.

~Plans of Correction

As indicated earlier, CLA was required to submit a plan of correction for the deficiencies cited by OMRDD after each certification visit. This plan was reviewed, approved and initialled by a staff member of the certification bureau. Commonly, the plan of correction lacked specificity (not unlike the treatment plans) and was often little more than the negative deficiency reworded into a positive statement. The following statement of deficiency and corresponding plan of correction quoted from the December 1989 survey illustrates this practice:

Statement of deficiency: Each client must receive a continuous active treatment program

which includes aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward (1) the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and (2) the prevention or deceleration of regression or loss of current optimal functional status.

Not only did many items in the plan of correction not specify how the facility was going to correct the deficiency, frequently the plans read the same, survey after survey.

Plan of correction: The facility QMRP will ensure by systemic review that each client receives a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described that is directed towards (1) the acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (2) the prevention or deceleration of regression or loss of current optimal functional status.

Not only did many items in the plan of correction not specify how the facility was going to correct the deficiency, frequently the plans read the same, survey after survey. Reading them in sequence, one was struck by the minimal effort that CLA put into the plans and the apparent absence of consideration by the OMRDD staff member giving approval that the facility had made the same promises before and was going to entrust the implementation of the corrective action to the very same people who had failed previously. The CLA certification records are replete with examples. The most flagrant perhaps are the repeated citations regarding the failure of the QMRP to ensure that program plans reflected priority needs and were revised as necessary. The CLA response was the assurance that the QMRP would this time fulfill her duties, and the executive director would make sure this would happen.

The specific illustrations below were chosen because the issues at hand are unambiguous and remediation, if it had occurred, would have been uncontested.

| Deficiency | Plan of Correction |
|---|--|
| <p>■ In the 1989 certification report it was noted that approval for the use a psychoactive medication to control the behavior of two individuals had not been obtained from the Human Rights Committee. These two residents were identified by number and not initials, but both were noted to be receiving Mellaril. The survey reported that for one individual, informed consent for the use of the medication had been secured two months after the medication was prescribed and administered, and there had been no informed consent for four major dosage increases. For the second individual, the informed consent documentation did not include a listing of side-effects and alternative treatments.</p> <p>The 1990 certification report notes no approval by the Human Rights Committee for the use of psychoactive medication for two individuals, MS and RC. (Other entries indicate that RC was taking Mellaril.)</p> <p>The 1991 certification report documents the absence of Human Rights Committee approval for the use of psychotropic medication with MV, RC, and LM (also taking Mellaril). The report also documents that informed consent for the use of the medication had not been secured from or on behalf of RC and LM.</p> <p>■ In 1989, reviewers found that the personal allowances of residents were not being deposited into their accounts within three working days.</p> <p>In 1991, reviewers found the same deficiency.</p> <p>■ A 1989 deficiency statement noted that the carpets throughout the facility were torn, dirty and stained.</p> <p>In 1991, reviewers found that the carpet in the dining room was frayed and torn.</p> | <p>The Plan of Correction stated that the approval of the Human Rights Committee would be secured.</p> <p>The Plan of Correction stated that this approval would be secured.</p> <p>The Plan of Correction stated that approval and consent would be secured.</p> <p>The plan of correction stated that the executive director would ensure that this was done.</p> <p>They were offered the same assurances that the executive director would ensure that this was done.</p> <p>The plan of correction indicated that all of the carpeting would be replaced, noting that the BDSO had been contacted and the agency was awaiting approval of the additional funds.</p> <p>The plan of correction noted that it would be replaced and that henceforth the residence manager would periodically inspect the facility and initiate needed repairs and replacements.</p> |

~Staff on Two Payrolls

The Commission's investigation of CLA from February 1992 until it closed in November 1992 revealed that several Queens BDSO staff were also employed part-time at CLA. These included:

- a full-time developmental aide on the overnight shift of a State-operated ICF who was intermittently employed at CLA for several years, usually working from 9 A.M. on Saturday through Monday morning. (CLA wages: 1990 - \$7,322, 1991 - \$6,605, 1992 - \$6,556)
- a BDSO social worker who worked 8 hours a week at CLA from July 1989 until its closure. (CLA wages: 1990 - \$9,225, 1991 - \$12,000, 1992 - \$8,875)
- a Bernard Fineson DC employee, a behavioral intervention specialist, who worked as a consulting psychologist with CLA from 1983 until 1989, and then became the agency's QMRP, working 10 hours a week. (CLA wages: 1990 - \$10,400, 1991 - \$10,000, 1992 - \$5,680)

In interviews with Commission staff, each gave an account, one very reluctantly, which clearly demonstrated the problems with the program. This report uses pseudonyms to protect their identities.

Anna, the developmental aide, complained that following inspections by the State, the executive director would cut back her hours, and she would often work the weekend alone. She reported that the residents ate poor quality food and, in fact, ate pasta every day for an entire summer. She and another staff member would bring in fresh fruits and vegetables which they had paid for personally. Anna confirmed that recreation trips outside of the house were rare, and in-house activities were limited because of the dearth of supplies. Often the recreation worker personally purchased arts and crafts supplies for the house. She explained that when the auditors were expected, "we would start shopping and backdating records."

Anna told of seeing roaches in the residents' beds which would wake up the men and women and "upset them greatly." Residents' clothing was often ragged and of poor quality. She reported that she spent \$500 of agency money on linens and towels following a CQC visit; some were used by the residents, but the majority, she reported, were carried out of the residence by the executive director and put in the trunk of his Mercedes.

Anna reported that when family members complained to her, she told them to let the BDSO know

about the problems. (A family member who did this reported to CQC that she was told to stop making trouble and be grateful that her brother had a place to live.) Anna said that she finally told her supervisor at the State-operated ICF that something was wrong

She reported that she spent \$500 of agency money on linens and towels following a CQC visit; some were used by the residents, but the majority, she reported, were carried out of the residence by the executive director and put in the trunk of his Mercedes.

at CLA when she heard the executive director threaten the residents that he was going to close the house down.

Marion, the social worker, reported that her duties at CLA included conducting and documenting psychosocial assessments and conducting monthly sexuality group meetings with the residents, writing quarterly and annual reviews, and attending these meetings.

She informed CQC staff that she knew that some of the information which she wrote in these reviews was inaccurate, but she did not correct it. She also said that she signed attendance sheets for the Human Rights Committee meetings when she had not been there. She concluded this portion of the interview by noting that "they were always giving me things to sign, and I didn't read them; I just signed them."

Marion remembered hearing the cook complain about the poor quality of the food and the absence of fresh fruits and vegetables. She also recalled seeing roaches in the residents' bedrooms and observing generally poor living conditions. She reported that when she complained to the executive director that staff were drinking on the job, she was relocated to an isolated office in the back of the residence. She reported that she realized that the agency was having money problems because her payroll check bounced frequently.

Marion told CQC that she had advised the BDSO case manager about the poor quality of the food and "he started coming to the house more frequently."

Ruth, CLA's Qualified Mental Retardation Professional, was very reluctant to talk with Commission staff. She repeated several times that she did not want to "get anyone in trouble." She reported that her duties included reviewing goal data, revising goals,

providing in-service training to direct care staff, and writing Comprehensive Functional Assessments. She offered no explanation for the poor quality of her work cited repeatedly on certification inspection reports. When confronted with the actual client

We recognize that a BDSO staff person taking a second job at a voluntary agency must deal with the problem of divided loyalties. And because this is such a common occurrence in its ranks, especially in New York City, so must OMRDD.

records, she admitted that she would sign off on quarterly and annual reviews without insuring that they were accurate or supported by her own Functional Assessments. She said that when CLA management would add goals to the program plans, her complaints would be answered with a reminder that this was none of her concern, and she would not make it her concern.

Ruth claimed never to have observed other problems at the residence, and she claimed that she was unaware of any deficiencies in staffing or living conditions at the house.

Clearly, some of the actions and attitudes of these staff members lead one to question their professional ethics. Knowingly leaving errors in client information, signing attendance sheets for meetings one did not attend, and failing to ensure that reviews were accurate and reflected current levels of functioning suggest an attitude of carelessness, an attitude that this is not about people's lives, but is about producing paper of sufficient type and quantity.

Beyond the question of how any one individual performed her job duties lies the question of the responsibility of these staff members to effect the remediation of the problems they saw. One would have hoped that they would have taken measures to improve the quality of life for CLA's residents. If they had been unable to do this working with the administration of CLA, then they should have alerted OMRDD to the circumstances that jeopardized the safety and well-being of the residents there.

We recognize that a BDSO staff person taking a second job at a voluntary agency must deal with the problem of divided loyalties. And because this is such a common occurrence in its ranks, especially in New

York City, so must OMRDD. While the potential for indifference and neglect is great, so is the potential that this interweaving of staff could reinforce the safety net for vulnerable individuals in care.

~OMRDD Corrective Actions

We were told by OMRDD that the certification activities did everything they were supposed to. What they did not do is perform their primary function of fixing a program which did not meet minimum standards. Tag numbers, federal definitions, statements of deficiencies and plans of correction are only tools toward an end. When they blind instead of illuminate, they have lost their purpose.

The apparent failure of the certification process to identify CLA as a program which was providing inadequate care to residents over at least a three-year period and take effective action has caused OMRDD to look critically at the certification process. The OMRDD Deputy Commissioner for Quality Assurance offered an analysis of the problem in a letter to CQC regarding the certification process at CLA: "It may be the case that many of the programs experiencing 'chronic' deficiencies do so because existing regulatory content and structure do not provide for any substantive evaluation of the effectiveness of the management and support systems necessary to en-

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sure sustained compliance with program requirements" (Appendix A).

In an effort to aid the identification of programs with chronic deficiencies, the Deputy Commissioner wrote that he is examining the possibility of providing surveyors with a three- or four-year certification history. This information would be used "to identify chronic deficiencies and provide the surveyors an additional means of assessing the need for increased oversight activities between certification periods or more intensive, targeted reviews of one or several specific areas." He concluded that this "should put in place additional early warning signals for surveyors to protect consumers from regulatory deficiencies."

CLA Fiscal Practices and Accountability

The Commission's fiscal investigators began to get a glimpse that there might be financial problems which could help explain the substandard conditions at CLA when they obtained from OMRDD's files the agency's financial statements and an accompanying detailed listing of revenue and disbursements for the year ended June 30, 1991. Obvious from the reports were an unusually heavy number of checks written to "cash" (i.e., \$112,810 or 25 percent of the agency expenditures) and a substantially overdrawn checking account. The outlay included \$14,170 in cash payments to the board of directors.

The drawing of checks to cash is an especially egregious act because the payee is not identified in the check and can be indicative -- absent other supporting documents -- that the goods or services might not have been received by the facility. And, because many of the checks were classified as relating to areas found by the Commission to be deficient (e.g., recreation, household and food), the propriety of a large portion of CLA's expenditures was, therefore, in question.

The Commission also obtained a copy of OMRDD's last audit of this agency which was completed a decade earlier on October 19, 1981. Included in this report was a finding that CLA wrote 153 checks totaling \$35,821 payable to "cash" for the two years ending June 30, 1980. Most of the items could not be verified due to the lack of supporting documentation. The agency responded that it would cease issuing checks payable to cash except when vendors would not accept checks.

Additionally, even though CLA's June 30, 1991 financial statements contained an "unqualified opinion" -- indicating its independent auditor, Brown & Associates, was satisfied in all material respects with the adequacy of the disclosures in the financial statements and that the necessary auditing work was done to support this opinion -- the Commission questioned the adequacy of the auditing work given the more than five-fold increase in cash checks since 1981. It also noted obvious departures from Generally Accepted Accounting Principles (GAAP), such as the omission of notes to the financial statements which, when included, might add some confidence to the CPA's opinion. Notes are an integral part of

formal financial statements and are essential to add completeness and reliability to the basic financial data presented.

The Commission further questioned the board's oversight role as it had learned from complainants that the executive director and board chairperson were keeping secret their relationship as husband and wife by the husband's use of a false identity.

Thus the question emerged: if the State hasn't done an audit of CLA in over ten years, if there is reason to doubt the CPA's "clean" opinion, and if the

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board president by virtue of her relationship to the executive director had negated effective board oversight, who then was watching the store? The Commission set out to answer this question by conducting a fiscal audit.

But, when the executive director attempted to delay the audit and then suddenly shut CLA's doors on the November 6, 1992 return date of the Commission's subpoenas -- taking with him or destroying the agency's books and records -- it became clear that to gain a fuller understanding of the programmatic and financial operation of this agency, information would have to be obtained from other sources. Consequently, subpoenas were issued for CLA bank records and its CPA's working papers, and interviews were commenced with individuals who should have spotted the substandard conditions and financial problems at this agency.

Gradually from the documentary evidence and interviews there emerged a picture that the State of New York through its licensure had entrusted the well-being of 10 of its mentally retarded citizens to a husband and wife team who, with the help of a sham board of directors and a less-than-vigilant CPA, diverted some 25 percent of CLA's annual revenue from the Medicaid program to unexplained purposes. Moreover, during the period in which public monies were being drained from this agency, OMRDD sent CLA a \$138,798 retroactive rate appeal check for direct care staff that had never been added to the

agency's payroll. The Commission also found that three OMRDD employees, who should have noticed the obviously poor client living conditions at CLA, were moonlighting on its payroll, and one of them admitted to helping cover up the treatment problems through the alteration of records.⁷

Despite the attempts by the principals to hide their misconduct in running this group home and to obstruct the ensuing investigation, the findings that follow confirm the Commission's suspicions that wrongful acts were committed at this publicly funded agency.

Executive Directors's Use of a False Identity

In January 1992, the Commission's complainant alleged "[t]his agency is run by Mr. Les White, AKA Les Wright. The Board of Director is Mrs. K. Wright, (Mr. White's spouse). The 'AKA' is used for income tax evasion (sic)." The Commission sought to verify if Leslie White, CLA's executive director, was actually the husband of Kay Wright,

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the CLA board chairperson. If this relationship existed, any expectation of independent board oversight, an important safeguard in the operations of a not-for-profit corporation, would be seriously in question.

The Commission learned from subpoenaed documents from CLA's payroll processing agent that a Leslie White, residing at 144-37 Sanford Avenue, Flushing, NY 11354, and using one social security number, was listed on the payroll and earned \$40,500 in 1990, \$41,250 in 1991, and \$30,150 until the agency's closure in late 1992. The Commission,

however, through motor vehicle records and telephone directories could not verify that a Les White resided at this address and, indeed, upon visiting the address on January 20, 1993, learned that it did not exist. From subpoenaed bank records, the Commission obtained a CLA bank account signature card with yet a second social security number for Les White. A computerized search by the Social Security Administration revealed that neither of these numbers were his.

With the cooperation of a federal agent who was investigating substantial unpaid CLA payroll withholding taxes, the Commission was able to secure a third social security number which was only slightly different than the false numbers. This number belonged to a Leslie O. Wright, living in Coram, New York at the same address as Kay Wright.

A search of Suffolk County Court records found that the Coram property where Kay Wright was known to reside was conveyed to "LESLIE WRIGHT and KAY WRIGHT, his wife" on November 30, 1983. Their signatures on the mortgage documents seemed to match those on CLA communications that the Commission had in its possession.

Thus, the documentary evidence sufficiently shows the executive director used a secret identity, possibly to hide his criminal past from government regulators as well as his relationship to CLA's board chairperson. This concealment of identity and the use of multiple social security numbers raises reasonable suspicions about whether these actions were part of a larger pattern of criminal violations.⁸

Wrights Flee to North Carolina

The day after discovering Leslie Wright's false Sanford Avenue address, Commission investigators drove to the Wright's personal residence in Coram, New York. The house appeared vacant and there was a for sale sign on the front lawn. The realty company said the house was listed for sale at \$180,000 on October 18, 1992 -- ten days after the Commission's audit engagement letter -- and sold for \$135,000 on February 18, 1993. It was the realty company's understanding that the Wrights were relocating to the

⁷ See, *supra*, Discussion at pp. 11-12.

⁸ Deceitful use of another person's social security number to obtain payments or other benefits from publicly funded health and welfare programs to which a person is not entitled or "for any other purpose" (e.g., to open a bank account) is a felony and upon conviction can result in imprisonment for up to five years or fines up to \$25,000, or both (42 U.S.C. Section 408).

South, reportedly because Mr. Wright's job with I.B.M. was transferred there.

Since the listing date appeared to coincide with the Wright's sudden departure from CLA and the acceptance price and false reason for departure were indicative of a distress sale, the Commission sought to determine the Wright's whereabouts.

On February 1, 1993, the Commission learned from the City of New York School District 29 in Rosedale, NY that Kay Wright had gone on extended sick leave on Monday November 9, 1992 -- CLA closed its doors on Friday November 6, 1992 -- and would be using the days in her Cumulative Absence Reserve until March 9, 1993. Because she was not expected to return to school during the 1992-93 school year and her whereabouts were unknown, Mrs. Wright's payroll checks were released to another City of New York teacher. The Commission then learned on February 4, 1993 that a 1992 Lexus ES300 automobile which was leased for \$537 a month in the name of CLA allegedly for the use of its board chairperson was reregistered to Kay Wright, 19510-Y One Norman Boulevard, Davidson, North Carolina. This was also confirmed through a credit reporting agency as being the new address of Kay and Leslie Wright.

Luxury Automobiles

From the onset, the Commission's complainant alleged that despite the deplorable conditions at CLA, the personal lifestyle of Kay and Leslie Wright involved the use of many luxury automobiles. From motor vehicle records, the Commission was able to determine that two late model Lexus' were leased in CLA's name and registered to Kay Wright at the

agency address. The vehicles were eventually reregistered in North Carolina (Figure 1).⁹

Sham Board of Directors

With the disappearance of board minutes, the Commission was unable to learn about the board's knowledge concerning the management of this agency. After its October 8, 1992 audit letter, the Commission received correspondence from Kay Wright implying there was an active CLA board of directors.

For example, in an October 16, 1992 letter to the OMRDD Commissioner, Kay Wright as "Chairperson" of the CLA board of directors said "[a]fter Board consultation with various staff members" and after "[t]he Executive Director informed the Board" about CQC's review, the board had determined that CQC's investigation was of a biased nature. Also, in an October 22, 1992 letter to the Commission from Kay Wright as "President" of the board, she stated that "[a]fter discussing this matter with Board members, accountants and the attorney, we concluded that it would take at *least* a month to compile and reconcile" the records needed for the Commission's financial review.¹⁰

To clarify the board's knowledge concerning the management of the agency, the Commission set out to conduct interviews by obtaining annual disclosure forms from the Department of Social Services (DSS) which had the names and addresses of board members for 1989, 1990 and 1991. However, it soon became apparent after unsuccessful attempts to contact the listed members that the records sent to DSS contained false representations by Leslie Wright.¹¹ Phone calls

⁹ The Commission also found from plate numbers on 1992 gasoline charge slips obtained from Mobil Oil Credit Corporation that CLA was being billed for gasoline purchases on two other autos: a 1989 Mercedes Benz 560 SL convertible leased and registered to Kay Wright, and a 1992 Jaguar XJ6 leased and registered to Leslie Wright. (Another 1985 Mercedes Benz registered to Kay Wright at the Coram, New York address appeared to be owned outright. A 1988 BMW 528 leased and registered to Kay and Leslie Wright at the Coram address was returned to the lessor at the end of the lease term in June 1992.)

¹⁰ Indeed, even when Leslie Wright on November 6, 1992 served notice to OMRDD that he was closing the agency, the letter indicated that a copy of the notice went to the "Bd of Dirs, CLA, Inc."

¹¹ Presenting a false instrument for filing, knowing that it contains false information (concerning the board's composition) which will become part of the public record, with the intent to defraud the State may be punishable as a class E felony under Section 175.35 of the N.Y. Penal Law. Concealing critical information about the board may also violate a federal statute on Statement or Entries (18 U.S.C., Section 1001) and result in fines up to \$10,000 and/or five years imprisonment.

| <p style="text-align: center;">Figure 1</p> <p style="text-align: center;">Luxury Cars Leased by CLA</p> | | | | | |
|--|------------------------------|---------------|------------------------|-----------------------------|--|
| Vehicle | Vehicle Cost When New | Lessee | Monthly Payment | Registered To | Status |
| 1991 Lexus ES250 | \$22,000 | CLA | \$549 | K. Wright at CLA address | Converted to personal lease for Kay Wright on February 1, 1993. Car registered in North Carolina on February 23, 1993. |
| 1992 Lexus ES300 | \$30,000 | CLA | \$537 | K. Wright at CLA address | Car registered by Kay Wright in North Carolina on February 26, 1993. |

and follow-up visits to several of the addresses (one address was for an abandoned house) surfaced no evidence the board members resided at the listed locations. One reported member was located but said she had never heard of CLA or served on its board. The listed agency attorney/vice chairperson for 1990 and 1991 said he never served on the board and had done no legal work for CLA since 1980. Another person listed as a vice chairperson in 1990 and 1991

One reported member was located but said she had never heard of CLA or served on its board. The listed agency attorney/vice chairperson for 1990 and 1991 said he never served on the board and had done no legal work for CLA since 1980.

did not reside at the address listed but was recorded on one of the vehicle lease applications as Kay Wright's sister.

Additionally, though an agency's certified public accountant in performing auditing work is responsible to the board of directors so that it might perform its stewardship duties, CLA's CPA, Richard Brown, in a May 20, 1993 interview indicated that he had

never met with a board member, attended a board meeting, or obtained copies of its minutes. And, over the years while hundreds of thousands of dollars in cash checks were classified as pertaining to agency activities, Mr. Brown did not obtain any documentation showing how the money was spent. Indeed, had the cancelled checks been examined, he might have learned that "Leslie White" (i.e., Leslie Wright) was endorsing them. This should have prompted follow-up procedures to determine whether the board approved the unusual practice of writing checks payable to cash rather than to a vendor and alerted him to the bogus nature of the board.

Professional Misconduct by CLA's CPA

There were a number of significant irregularities concerning the conduct of CLA's "independent" accountant, Richard Brown. First, despite submitting an unqualified opinion to OMRDD on CLA's June 30, 1991 financial statements -- indicating his auditing work was of sufficient scope to support the opinion -- when the Commission subpoenaed these same statements and the working papers supporting the opinion on October 28, 1992, Mr. Brown sent a compilation report indicating *no* auditing work was

done and therefore no opinion could be expressed. No working papers were sent further suggesting there was no audit work. However, when federal agents from the FBI and Health and Human Services Office of Inspector General and Commission fiscal staff conducted an unannounced visit to the office of Brown & Associates on May 13, 1993, they learned that Richard Brown had substantial audit working paper files which had not been produced pursuant to the Commission's subpoena. The FBI immediately took custody of these documents pursuant to a Federal Grand Jury subpoena. Lastly, when the CPA's working papers were examined, it became clear that, while some auditing work was done, the area of cash checks had been ignored.

Had Mr. Brown applied Generally Accepted Auditing Standards (GAAS), as his profession requires, because of the "materiality" of the cash transactions, he would have been required to issue a "disclaimer of opinion" indicating that GAAS was not followed -- not an unqualified opinion or compilation statement. This would have warned the State of the potentially serious financial improprieties at CLA. Instead, the CPA appears to have engaged in a wilful attempt to mislead the State by withholding troubling information from its funding and oversight agencies.

There are other acts of potential professional misconduct which appear to be in violation of State Education Department regulatory provisions (8 NYCRR 29.10) governing the practice of public accountancy. Specifically, Mr. Brown appears to have failed to: (1) comply with GAAS in the examination of CLA's financial statements and accounting records; (2) acquire sufficient information to warrant the expression of unqualified or "clean" opinions on the statements; and (3) direct attention in his audit reports to material departures from generally accepted accounting principles.

GAAS requires the CPA to obtain sufficient competent evidence to support the opinions that financial

statements are fairly presented and free from material misstatement. Evidence includes working papers which document the CPA's inspection of receipts, invoices, etc. to verify that cash was spent as indicated in the accounting records. The accountant's working papers for CLA disclose no examination of

Instead, the CPA appears to have engaged in a wilful attempt to mislead the State by withholding troubling information from its funding and oversight agencies.

supporting documents to substantiate cash expenditures. Checks written to "cash," which represent about one-quarter of CLA's total expenses and over half of its general and operating expenses, are unquestionably material in relation to the financial statements taken as a whole. There is thus reason to believe that Mr. Brown failed to adhere to GAAS by not: (1) verifying the cash expenditures and (2) obtaining sufficient competent evidence to warrant the expression of clean opinions on the four most recent CLA annual financial statements he issued.¹²

GAAS also requires that the CPA determine whether the financial statements adequately disclose all pertinent financial information. To conform to the disclosure requirements of generally accepted accounting principles (GAAP), the financial statements must contain footnotes and a statement of changes in fund balances and cash flows. The CPA must mention in the audit report any departure from GAAP. The CLA annual financial statements for the four years ended June 30, 1992 omit footnotes and statements of changes in fund balances and cash flows. However, Mr. Brown in his opinions makes no mention of the departures from GAAP, but erroneously states that the financial statements conform to GAAP.¹³ There is reason to believe that Mr. Brown additionally violated GAAS by failing to exercise

¹² GAAS requires the study and evaluation of the agency's system of internal controls. Commission staff reviewed the CPA's working papers for the four-year period beginning July 1, 1988 and ending June 30, 1992 and found no documentation relating to internal controls. The working papers fail to mention the serious internal control weakness involving the issuance of a high volume of checks written to "cash" which materially impacts the financial statements. Also, the working papers fail to document any assessment by the CPA of the likelihood that the monies disbursed as cash checks may not have been spent as recorded on the agency's books.

¹³ The omission of the statement of changes in fund balances and cash flows for fiscal year 1990-91 resulted in the failure to disclose several transactions made directly to "Fund Balance" during the year which reduced the account by \$16,689. One of the transactions involved the write off of \$3,600 cash on hand with no disclosure as to how the cash was spent.

due professional care in the conduct of the CLA audit and the preparation of its financial reports.

Heavy Cash Transactions in Program Deficient Areas

In September 1992, when the Commission's fiscal investigators first sought to examine CLA finances by gathering financial reports on file with OMRDD, suspicions were immediately aroused that something was wrong concerning the agency's fiscal integrity. The Commission spotted from a computer-generated listing of CLA financial transactions for the year ending June 30, 1991, \$112,810 in disbursements through checks written to "cash" usually in round dollar amounts. This represented 25 percent of the agency's expenditures of \$452,568 for that fiscal year and 55 percent of its non-payroll expenditures. Writing checks to "cash" is an especially poor practice because the payee is not identified and, without good internal controls, it can be a method for misappropriating funds.

After subpoenaed CPA accounting records and copies of cancelled CLA checks from Citibank were obtained, the Commission was able to determine that

from July 1, 1988 through September 30, 1992, CLA had issued 1,077 checks payable to cash. These disbursements totaled \$472,631 and represented 26 percent of CLA's \$1.8 million expenses for the period (Figure 2).

From October 6, 1992, when the Commission first contacted Mr. Wright by telephone concerning its planned review, until the November 6, 1992 facility

The Commission was able to determine that from July 1, 1988 through September 30, 1992, CLA had issued 1,077 checks payable to cash. These disbursements totaled \$472,631 and represented 26 percent of CLA's \$1.8 million expenses for the period.

closure date, the number and dollar value of the "cash" checks significantly increased. For example, over the last month of operation, 42 checks totaling \$38,120 were cashed by Mr. Wright thereby closing out CLA's bank accounts and increasing the cash check disbursements to \$510,751. (Two of these checks totaling \$4,400 are particularly suspect since they were written on November 9, 1992 three days after the closure.) From July 1, 1991 to June 30,

**Figure 2
CLA Cash Checks
Issued 1988-1992**

| Time Period | Number of Cash Checks | Total Value | Non-Payroll Expenses | Cash Checks as a % of Non-Payroll Expenses | Total Expenses | Cash Checks as a % of Total Expenses |
|-----------------------------|-----------------------|------------------|----------------------|--|--------------------|--------------------------------------|
| 1988-89 | 268 | \$105,735 | \$174,623 | 61 | \$ 389,881 | 27 |
| 1989-90 | 219 | 87,113 | 184,929 | 47 | 401,412 | 22 |
| 1990-91 | 247 | 112,810 | 204,510 | 55 | 452,568 | 25 |
| 1991-92 | 249 | 119,138 | 219,167 | 54 | 473,687 | 25 |
| 7/1 - 9/30/92 | 94 | 47,835 | 64,839 | 74 | 128,019 | 37 |
| 7/1/88-9/30/92 Total | 1,077 | \$472,631 | \$848,068 | 56 | \$1,845,567 | 26 |
| 10/6 - 11/9/92 | 42 | 38,120 | N/A | N/A | N/A | N/A |
| Grand Total | 1,119 | \$510,751 | N/A | N/A | N/A | N/A |

N/A = not available.

1992, the average monthly checks written were half this number (21) and for about one-quarter the total amount (\$9,928).

The large volume of cash checks constitutes a serious internal control weakness relating to the disbursement of agency funds and is a "red flag" warning that disbursed monies may not be properly accounted for. This is especially true when the agency does not maintain any file of invoices or receipts to verify that the funds were, in fact, spent as recorded on the books.

The Commission's fiscal staff examined CLA's cancelled cash checks obtained from Citibank and found that they were co-signed by "Leslie White and Kay Wright" and endorsed individually by him. This means he received one-half million dollars in cash which he used for unexplained purposes. Where did the money go (Figure 3)?

CLA's bookkeeper told Commission staff during a May 12, 1993 interview that Leslie Wright had control of CLA's checkbook and recorded on the check stubs the accounts to which the cash checks were to be charged. Therefore, Mr. Wright had inappropriate control of both the cash handling and cash recording functions at CLA. A good system of internal control would have kept these two functions separate. The bookkeeper pointed out that Richard Brown directed her to use Mr. Wright's check stub notations to determine how the cash was spent and not to review any invoices or receipts. This elimination of a key internal control permitted Mr. Wright to spend the agency's cash with virtually no accountability.

Mr. Brown told the Commission on May 20, 1993 that he first became aware of the cash check situation years earlier through OMRDD's 1981 audit of CLA covering the two-year period ending June 30, 1980. He knew that OMRDD was unable to verify most of the 153 cash checks totaling \$35,821 due to a lack of invoices and receipts. Mr. Brown stated that he had instructed Mr. Wright to maintain a vendor invoice file to support cash checks. However, the CPA said he never asked the executive director to see this file. His working papers evidence no review of invoices, receipts, etc. supporting the cash expenditures which are unquestionably "material" in relation to the CLA financial statements taken as a whole. Since the CPA's audit work was acceptable in areas other than cash, it is likely that Mr. Brown would have reviewed these invoices if they existed. In addition, the CPA

said he did not know who had endorsed the cash checks or what happened to the proceeds.

In 1991-92, Mr. Wright attributed 55 percent (Figure 4) of the cash check amounts to the household supplies, recreation, and food cost categories (Figure 4). The Commission's program staff found these areas to be seriously deficient, which means that it is highly probable that the cash charged to them was not spent as recorded. For example, Mr. Wright expended \$28,425 to household supplies. The Commission found that there were insufficient towels and that bed linens were dirty, worn, tattered and stained. A CLA counselor reported "spending \$500 for sheets and towels after the Commission's program inspection, but Mr. Wright carried the majority of these sheets and towels downstairs and placed them in the trunk of his Mercedes." Also, it found CLA had no disinfectant supplies and the housekeeper had to do all her cleaning with Tide laundry detergent.

During Commission inspections, it was noted that residents who required special diets were mainly being fed cheap bulk foods, such as hot dogs and beans.

Mr. Wright expended \$18,800 to recreation during the period. However, there was no recreational program in place during the weekdays. There was only a weekend on-site arts and crafts program and infrequent community outings. CLA's recreation worker quit in July 1992 because Mr. Wright had frequently failed to fully reimburse her for the cost of these activities, and she had to use her own funds to partially fund them.

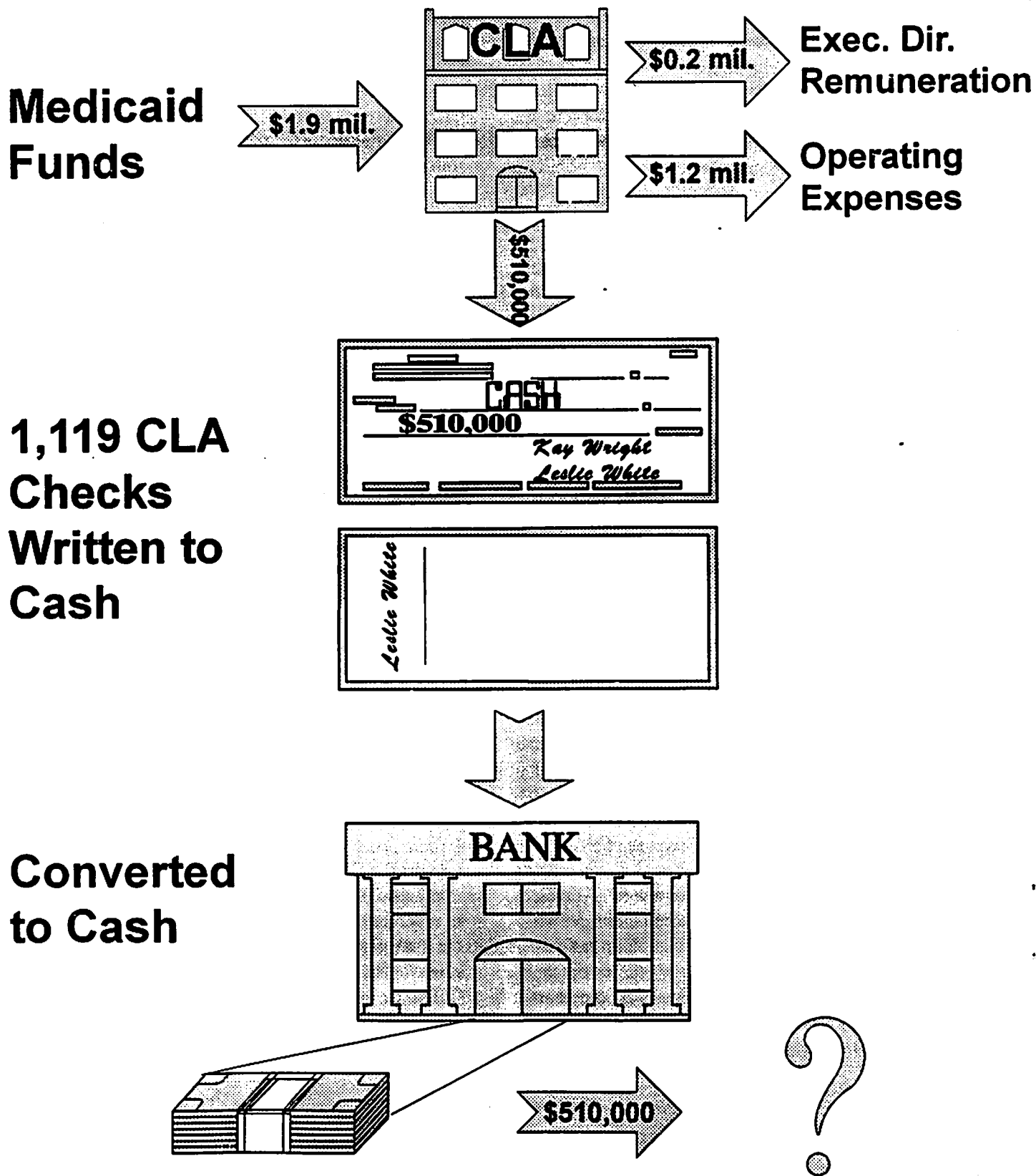
Mr. Wright expended \$18,469 for cash food purchases during 1991-92. In addition, \$11,915 was paid directly to food vendors. On July 3, 1992, OMRDD found no food at the facility. During Commission inspections, it was noted that residents who required special diets were mainly being fed cheap bulk foods, such as hot dogs and beans. The executive director told Commission staff that he had not purchased fresh fruits and vegetables for the facility in several months. During this time, two CLA workers had expended their own funds to buy fresh produce for the residents.

During the period July 1, 1988 through September 30, 1992, Mr. Wright also earmarked 65 "cash" checks totaling \$47,945 to board of directors' ex-

Figure 3

Where Did the Money Go?

1988-1992



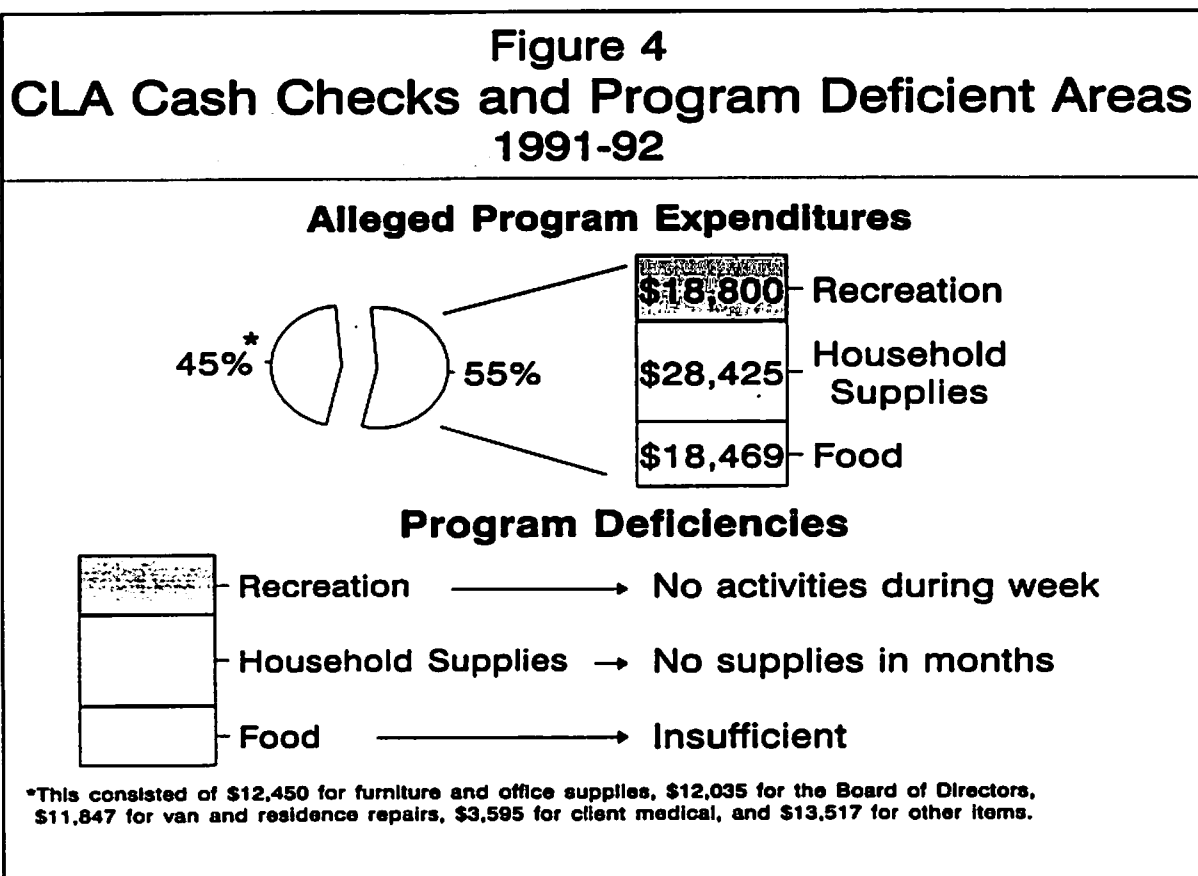
penses. Yet, the Commission questions the validity of these expenses since, as indicated previously in this report,¹⁴ there is substantial evidence to suggest that CLA's board was non-existent as the only confirmed director was Kay Wright, the wife of the executive director.

In summary, the Commission found that Leslie Wright had custody and control of the CLA check-book, and consequently was able to convert \$510,751 of CLA funds into cash during the period July 1, 1988 to November 9, 1992. The executive director closed the agency rather than cooperate with the Commission's request for a fiscal audit which would have held him accountable for his unexplained behavior. The Commission did find that the largest programmatic areas of alleged cash expenditures -- recreation, household supplies and food -- were seriously deficient and that the agency had a phantom board, making it highly unlikely that the cash was spent in these areas and instead was diverted to unexplained purposes.

OMRDD Retroactive Rate Appeal Check

Following CLA's one-year suspension (7/1/88-7/2/89) from participation in the medical assistance program due to noncompliance with the conditions of participation,¹⁵ Leslie Wright on July 24, 1989 appealed to OMRDD for funds to hire three additional direct care employees for overnight awake duty which was not a reimbursable cost in its approved 1989/90 rate of \$107.07 per resident per day. Twenty-four hour awake staff were necessary to comply with Life Safety Code requirements in the event of a fire or other emergency.

Even though OMRDD regional staff immediately supported the increase because "the agency has placed themselves at risk in having so few positions filled," the actual approval of the request was not finalized until almost three years later on June 3,



¹⁴ See, *supra*, Discussion at pp. 15-16.

¹⁵ See, *supra*, Discussion at footnote 1 at p. 1.

1992 when a \$138,798 retroactive check was issued covering the following periods:

\$138,798 check, it immediately began to spend this money on other than direct care staff. Major dis-

| Effective Periods | Base Rate | Retroactive Rate | Annual Impact |
|-------------------|-----------|------------------|-------------------------------|
| 7/1/89-6/30/90 | \$107.07 | \$119.85 | \$ 46,647 |
| 7/1/90-6/30/91 | 116.40 | 130.14 | 50,151 |
| 7/1/91-6/30/92 | 121.62 | 136.22 | <u>53,290</u> |
| Total | | | <u>\$150,088¹⁶</u> |
| Retro check | | | \$138,798 ¹⁷ |

The major reason for the almost three-year delay from the original request to the actual check issuance was CLA's failure to submit cost data to demonstrate that CLA would be running a deficit without the additional staff expense and, therefore, was not receiving enough funds to cover the expanded staffing. Eventually, OMRDD violated its established appeals processing protocol when it granted the appeal without having first examined the 1989-90 expenditures to assure that the operator had actually incurred the increased staffing cost for which it was seeking reimbursement.

In fact, *no additional staff were hired during the almost three-year period* and, when CLA got the

bursements in June 1992 included a \$2,500 cash check reportedly for board expenses but endorsed by Leslie White; an \$8,000 and \$6,000 transfer to the CLA savings account which was withdrawn for unknown purposes just prior to the agency's closure; 35 checks written to cash totaling \$20,530; and, a \$40,000 check to the IRS for unpaid payroll withholding taxes and penalties against an accumulated liability of almost \$100,000. During July 1992, another 28 checks totaling \$13,550 were written to cash and, by the end of July, the \$138,798 "windfall" to CLA caused by flaws in the rate appeal system had largely been dissipated.¹⁸

¹⁶ Includes \$3,861 for pharmacist services to review residents' drug regimens on a quarterly basis in compliance with federal regulation 483.460 (i) (1).

¹⁷ Pro rata check issued for 2 years, 10 months.

¹⁸ The Commission has commenced a separate review of the OMRDD rate appeals process.

Conclusion

Community Living Alternatives, Inc. is an example of an agency that made no secret of its failure. Certification reports from 1989 consistently describe a program which was unable or unwilling to give reasonably good care and treatment to the residents: residents were verbally and psychologically abused and their needs were neglected; the environment was poor; active treatment was not occurring; there was not enough food to eat; documentation was repeatedly missing or erroneous, and recreation consisted primarily of arts and crafts on the weekend.

Complaints from family members and staff also gave warning that something was wrong, but these complaints were met by threats of reprisal from the executive director and inaction by the BDSO. And, those whose job it was to see these deficiencies, either did not see them or did not appreciate their persistence or their connection to other warning signs of a program out of control. Some did not see because they did not wish to see or were blinded by conflicts of interest; some did not see because they did not know what to look at or how to look at it; and others did not see because they followed strict rules of certification procedure that did not permit them to characterize the chronic shortcomings of this agency as "repeat" deficiencies. Thus, they accepted repeated plans of correction which were never implemented. Surely, if no one was really seeing what was happening and taking effective action, then no one was asking questions about why it was happening.

The investigation of CLA points out many of the problems of not-for-profit corporations which the Commission has found in prior studies and highlights the need for the mental hygiene offices to change some standard ways of doing business.

Not-for-profit corporations are an essential part of the State's system for providing services to people with mental disabilities. The majority of providers competently and ethically operate in the public interest, and to allow their work to be besmirched by the corrupt and greedy behavior of

a few of their colleagues would be an injustice. Clearly, changes are needed in how the OMRDD monitors programs, both in terms of certification procedures and in the provision of case management services and technical assistance. In addition, it must clarify its expectations of staff who have second jobs in certified or funded programs when they encounter seriously deficient conditions to which the provider is unresponsive. Finally, OMRDD needs to ensure that prompt and effective correction occurs when substantial deficiencies in programs are found, rather than accepting vague plans of correction. These changes should significantly strengthen the safety net that OMRDD provides to the individual in its service system.

Other measures are also necessary, some on the part of OMRDD and some on the part of voluntary agencies themselves. The State is challenged to ensure that: (1) operators lacking moral character and competence are

The majority of providers competently and ethically operate in the public interest, and to allow their work to be besmirched by the corrupt and greedy behavior of a few of their colleagues would be an injustice.

not granted licenses to care for the State's most vulnerable citizens, (2) each agency is governed by an active, qualified and truly independent board of directors, (3) CPAs are performing diligent and comprehensive audits of an agency's financial dealings, (4) State regulators are alert to "red flags" in the programmatic and fiscal performance by operators, and (5) effective enforcement of laws and regulations and the provision of vigilant monitoring and technical assistance occurs.

To clarify and expand, OMRDD, in issuing CLA an operating certificate, was supposed to make a determination on the "character and competence" of the principal executives giving reasonable assurance of their moral and financial ability to conduct the affairs of the corporation and operate the facility in the public interest. This up-front review should have included a background check on previous history at other facilities,

professional licenses, formal education, employment history, criminal record, etc. But, as a prior Commission review found, OMRDD does not routinely perform such reviews because of the time and resources required and because important information such as prior criminal records are not available to OMRDD under current law.

Instead, the burden of assessing the "good moral character" of the licensee falls to the OMRDD quality assurance reviews *after* the program becomes operational. Although annual financial reports are used to set rates and monitor financial viability, fiscal audits (ICF audits are primarily the responsibility of DSS because of their Medicaid funding) are rarely conducted because they seldom reveal problems of sufficient magnitude to make them cost effective.¹⁹ Thus, in reality, the burden of monitoring falls on program staff and an "existing regulatory content and structure [that] do[es] not provide for any substantive evaluation of the effectiveness of the management and support systems necessary to ensure sustained compliance with program requirements."²⁰

If some providers enrich themselves by providing poor care and diverting public funds into their own pockets, absent board oversight and honest assessments by their own CPAs, there is little that can be done by State Medicaid overseers, such as the Deputy Attorney General for Medicaid Fraud Control (aka Special Prosecutor), to control "program fraud". Once medical assistance payments are "legally"

obtained, these agencies assert that they have no jurisdiction to ensure that the funds are expended for the intended purpose.

While the Charities Bureau in the Department of Law has jurisdiction to protect the assets of not-for-profit agencies, it views such misappropriation problems as more properly the responsibility of boards of directors or as problems to be dealt with by the licensing agency.

It was for these reasons that the Commission turned for assistance to the FBI and Health and Human Services, Office of Inspector General, under the direction of an Assistant United States Attorney, Eastern District of New York, and its broader prosecutorial powers in combatting program fraud.

Finally, this investigation also identified weaknesses in the OMRDD rate appeal process that permitted a payment of \$138,798 to CLA on June 3, 1992 for retroactive reimbursement of staffing costs without ever verifying that the agency had actually incurred such costs. The Commission believes there is a clear need to strengthen both the programmatic and fiscal oversight of provider agencies like CLA which have consistently exhibited "red flags" in their program and fiscal operations. In particular, improving the communication between the fiscal and certification areas of OMRDD would strengthen the ability to follow up on the implementation of recommendations as well as permit OMRDD staff to examine the connection between programmatic deficiencies and fiscal practices.

¹⁹ DSS audits focus on billings to the medical assistance program and not expenditures. Therefore "program fraud" of the nature that appears to have taken place at CLA, even though easy to detect, would likely go undetected.

²⁰ See, Appendix A.

Recommendations

Based on the findings of this report, the Commission has or will refer the findings of this investigation to the following agencies for follow-up actions within the scope of their respective jurisdictions.

Referrals

- **The Office of Mental Retardation and Developmental Disabilities:** for follow-up corrective statutory and regulatory changes as listed below.
 - **The U.S. Attorney for the Eastern District of New York; Federal Bureau of Investigation; and, U.S. Department of Health and Human Services:** for possible criminal violations relating to misappropriation of medical assistance funds, use of false social security numbers, and filing false instruments.
 - **Internal Revenue Service:** for possible violations of the tax laws concerning the reporting of income.
 - **State Education Department:** for possible violations of regulations relating to the practice of public accountancy.
 - **Deputy Attorney General for Medicaid Fraud Control:** for possible strengthening of its statutes to control program fraud.
 - **Department of Law:** for possible violations of the N.Y. Penal Law and N.Y. Not-For-Profit Corporation Law.
- Establish a privity relationship between a provider's independent accountant and the State licensing agency so the CPA can be held liable for negligence in its audit of the mental hygiene facility.
 - Authorize the suspension or revocation of a provider's license when it has failed to operate a program in a fiscally responsible manner which would include failure to furnish fiscal records to the State which are required to be maintained by law or regulation. Fiscal audits are an important tool in establishing "financial responsibility."

Statutory Changes

State statutes and/or regulations should be amended to:

- Permit State agencies which grant operating certificates to providers of human services to access computerized criminal history data maintained by the Division of Criminal Justice Services so that they can independently verify whether an officer or senior executive of a licensed agency has a criminal background.

Internal Regulatory Changes

OMRDD should:

- Review the performance expectations for case manager (liaison) positions and take whatever measures are necessary to ensure that expectations are sufficiently rigorous to safeguard the well-being of clients. OMRDD also needs to ensure adequate supervision of the individuals in these positions, particularly since these are para-professional positions which require the exercise of independent judgement in the field. As a start, these expectations should include the requirement to document actual activities on site as well as observations. It should not be acceptable to simply check boxes on the Personal Contact Report without indicating the information/observation which supports the response. OMRDD must train case managers (liaison staff) in the identification of serious and persistent problems and articulate the expectation that such problems will be documented and brought to the attention of supervisory personnel.
- Determine and implement whatever measures, in addition to providing historical certification data to surveyors, that are appropriate to enable them to identify recurring deficiencies. OMRDD also

needs to establish a method for effectively dealing with facilities which demonstrate an inability to remediate serious problems which are not technically "repeat deficiencies." Similarly, it needs to develop special procedures for the review of plans of correction submitted by problematic facilities to ensure that they are substantive and not repeat recitations of the same measures that have failed to work in the past. A protocol for unannounced site visits to ensure the effective implementation of plans of correction in troubled facilities should be developed.

- Strengthen lines of communication among the certification unit, fiscal areas and the B/DDSOs. It must make clear the expectation that certification reports will be shared with B/DDSO personnel who are directly involved with these residences and require that they be read by the case managers and fiscal staff which provide funding and conduct audits. Conversely, fiscal information should be shared with certification staff. OMRDD also needs to determine whether its system for sharing information from the B/DDSO to the certification unit functions well enough to ensure that the certification unit is aware of situations under its jurisdiction which place individuals at risk.
- Revise its policy on outside employment. The present policy requires that only those individu-

als in a grade 23 position or higher receive written approval for outside employment. The Commission recommends that in addition written approval be required for outside employment *in an agency licensed or funded by OMRDD* for all persons in a grade 14 or higher. The present policy addresses the need to avoid a conflict of interest or the appearance of one. The Office needs to take additional measures to identify the responsibilities of an employee who witnesses or has knowledge of serious problems in an agency by virtue of his/her employment there which are not being addressed by the agency. A written description of these responsibilities should be presented to the individual requesting permission to work a second job in an OMRDD certified or funded facility, and written acknowledgement that they have been read and understood should be required.

- Verify during its character and competence reviews of licensees key background data on their officers or senior executives including: education, employment history, social security number and criminal record (requires statutory change).
- As part of its rate appeal process, not pay retroactive appeal awards without verifying that the expenditures were actually incurred.

Appendix A



STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

44 HOLLAND AVENUE • ALBANY • NEW YORK • 12229-0001

ELIN M. HOWE
Commissioner

THOMAS A. MAUL
Executive Deputy Commissioner

June 2, 1993

Ms. Elizabeth J. Chura
Director, Quality Assurance Bureau
Commission on Quality of Care for
the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, New York 12210-4143

Dear Ms. Chura:

Since the meeting you, I and Walter Saurack had regarding Community Living Alternatives, Inc., I have had the opportunity to review the data we received as a result of our visits. This was, in part, prompted by you stating that the repeat deficiencies should have been an indicator that something was missing and the occurrence of these repeat deficiencies should have stimulated us to respond extraordinarily.

Other than a concerted effort to assist the agency to remedy the problem, I am not sure that more could have been done. The deficiencies were not indicative of the problems with the Executive Director nor revealing about the character and competency or relationship of the Board Chairperson and the Executive Director.

CQC originally visited this program on February 6th and 7th of 1990 in response to an anonymous complaint about the overall care and treatment of the residents and discovered many deficiencies. Subsequent to this visit, CQC requested and received the Statements of Deficiencies and Plans of Corrective Actions generated by the program and CLA during the program's 1989-1991 recertification surveys. CQC concluded that the deficiencies noted during its February visit had been previously cited in one of the recertification surveys. But were these repeat deficiencies?

For our review two possible definitions for recognizing a survey deficiency as a repeat deficiency were considered. A repeat deficiency is:

- 1) A regulatory requirement that has been identified as out of compliance for two consecutive surveys and has been cited as deficient in both instances because of a common originating nature or issue. (This definition is used by the Health Care Financing Administration and by this Division.) or;
- 2) Any tag number that reoccurs. The episodes do not necessarily relate to the same specific issue or occur between consecutive surveys. (It is assumed that this definition, or something similar, may have been used by CQC in its assessment.)



Right at home. Right in the neighborhood.

Three additional DQA survey/visits which were conducted after CQC's February visit and the four 1989-1991 recertification surveys were included within the scope of this review.

Deficiencies identified during the following seven surveys and visits were included:

| <u>DATE</u> | <u>SURVEY/VISIT TYPE</u> |
|---------------------|--------------------------|
| 1. May 4, 1989 | Recertification Survey |
| 2. December 7, 1989 | Recertification Survey |
| 3. November 6, 1990 | Recertification Survey |
| 4. October 8, 1991 | Recertification Survey |
| 5. April 9, 1992 | Monitoring Visit |
| 6. June 29, 1992 | 60 Day Visit |
| 7. October 20, 1992 | Recertification Survey |

The October 8, 1991 survey is the pivotal survey. The degeneration of the program was initially observed during this survey. During the November 6, 1990 survey six Federal deficiencies (and six state deficiencies) were cited. During the October 8, 1991 survey fifteen Federal deficiencies (and sixteen state deficiencies) were cited and while the program was recertified, the surveyors recognizing a potential problem, recommended a monitoring visit for April of 1992.

To coincide with CQC's investigation and to emphasize the benchmark October 8, 1991 survey the above noted surveys and visits were reviewed as two separate groups. Each group comprises four surveys/visits. The first group includes #1 through #4. The second group includes #4 through #7.

During the first four surveys (ending with the October 8, 1991 survey):

- a) 47 Federal ('W') tag numbers were cited: 33 or 70% were cited one time; 14 or 30% were cited two or more times (12 - twice; 2 - three times);
- b) The overwhelming majority of the tag numbers (42 of 47 - 89%) were related to two of the eight Conditions of Participation: Active Treatment (27 of 47 - 57%) and Health Care (15 of 47 - 32%);
- c) 13 of the 14 (93%) instances of reoccurring tag numbers were also related to the same two Conditions of Participation;
- d) 9 tag numbers cited during the October 8, 1991 survey had occurred at least one other time during the previous three surveys.

A legitimate case for labeling these recurring tag numbers as chronic deficiencies could be made based on the second definition of a repeat deficiency. (This supports CQC's judgement and could provide a method of determining if agencies are experiencing long term problems of a general nature if not of a specific

regulatory requirement.) However according to HCFA's standard the surveyors determined that there was only one repeat deficiency between the October 1991 and the November 1990 surveys and only two repeat deficiencies between the November 1990 and the December 1989 surveys.

The program was specifically notified of these repeat deficiencies, informed of the urgency of their rectification and was not recertified until they were corrected.

During the last four surveys/visits (beginning with the October 8, 1991 survey):

- e) 30 Federal ('W') tag numbers were cited: 14 or 47% were cited one time; 16 or 53% were cited two or more times (14 - twice, 1 - three times and 1 - four times);
- f) Again, the overwhelming majority of the tag numbers (24 of 30 - 80%) were related to the same two Conditions of Participation: Active Treatment (16 of 30 - 53%) and Health Care (8 of 30 - 27%);
- g) 15 of the 16 (94%) instances of reoccurring tag numbers were also related to the same two Conditions of Participation;
- h) 8 tag numbers cited during the October 20, 1992 survey had occurred at least one other time during the three previous visits.

Again, a case for labeling these recurring tag numbers as chronic deficiencies could be made based on the second definition of a repeat deficiency.

After CQC's and DQA's intensive remedial and monitoring efforts, during the period of February 1992 through September 1992, there was no noticeable change in the program at its October 20, 1992 recertification survey. CQC required them to submit more meaningful plans of corrective actions and DQA increased its monitoring of compliance. Then CQC, in correspondence dated September 21, 1992 to CLA, approved of the program's revised POCA, concluded its review of care and treatment but reserved its decision concerning the staff's responsibilities. DQA, while noting that the facility achieved compliance of two Conditions of Participation, recommended and planned to continue close monitoring of the program.

But to reiterate, there was no noticeable change in the program as a result of this oversight. During 1989-1991 the program averaged 11.75 Federal deficiencies, with an average number of 10.5 (89%) of these deficiencies related to active treatment and health care. During its 1992 recertification survey the program had 11 Federal deficiencies, with all 11 of these deficiencies related to active treatment and health care. In addition, six of the eleven deficiencies from the October 1992 survey were, according to HCFA's standard, repeat deficiencies from the October 1991 survey. Therefore, it would seem that despite the efforts of both CQC and DQA, the agency failed to make the expected improvements because of its own lack of effort.

While we can speculate if this program's behavior was too routinely accepted, the above information (indicating corrections of Conditions of Participation) does not

demonstrate that stronger regulatory action would have been permitted in conformity with HCFA procedures. However the review did reveal a substantial number of deficiencies had been cited more than once during the three and a half year period reviewed. While it may not be feasible to expand DQA's current repeat deficiency criteria (since it is defined by HCFA), we are examining the possibility of utilizing existing data to provide surveyors with a three or four year certification history. This historical information could be used to identify chronic deficiency problems and provide the surveyors an additional means of assessing the need for increased oversight activities between certification periods or more intensive, targeted reviews of one or several specific areas. While this process will not ensure regulatory compliance by agencies which may lack the experience and/or motivation to maintain the operation of satisfactory programs, it should put in place additional early warning signals for surveyors to protect consumers from regulatory deficiencies.

It may be the case that many of the programs experiencing "chronic" deficiencies do so because existing regulatory content and structure do not provide for any substantive evaluation of the effectiveness of the management and support systems necessary to ensure sustained compliance with program requirements. Therefore, some providers achieve compliance during the period of regulatory oversight activity only to return to a diminished level in the intervening period. They are unwilling and/or on an ongoing basis unable to assess systems and regulations, and there is a lack of any self-assessment activity. Our process and our regulations must do better promoting these needed improvements. Often agencies, such as CLA, need systemic improvements which will ensure sustained compliance with program requirements.

I would appreciate your thoughts on this matter and would welcome the opportunity to discuss this with you, particularly our plans for the needed improvements.

Very truly yours,



Thomas J. Cuite
Deputy Commissioner
Division of Quality Assurance

CW4-10

cc: QA Area Directors
Al VanDeloo
Chuck Wenzel

Appendix B

Summary of Deficiencies

| | SEP 85 | AUG 86 | SEP 87 | 88 | DEC 89 | NOV 90 | OCT 91 | APR 92 |
|---|-----------|-----------|-----------|----|-----------|-----------|-----------|-----------|
| Active Treatment | | | | | | | | |
| Goals lack specificity re: target dates, frequency of interventions | x | | | | | | x | x |
| Data re: accomplishments is not in measurable terms | | x | | | x | | x | x |
| Gaps in data collection | x | | | | x | | | x |
| Behavior plans: insufficient info re: performance | | | | | x | | | |
| Review & revision of program plan by QMRP not occurring | | | | | x | x | x | x |
| Plans of care not reviewed monthly | | x | | | | | | |
| Annual reviews incomplete/inadequate | | | x | | x | | x | x |
| Human Rights Committee must be established | | | | | x | | | |
| Quarterly reviews incomplete | | | x | | | | | |
| Human Rights Committee must review psych. meds | | | | | x | x | x | |
| Must secure informed consent for meds | | | | | x | | x | x |
| Speech services inadequate | | | | | x | | | |
| No or inaccurate activities schedule | | | | | | x | | x |
| Condition of Participation Not Met: Active Treatment | | | | | | | | |
| Insufficient staff at inter-disciplinary team meetings | | | | | | x | | |
| Client & family involvement not occurring | | | | | x | | | |

| | SEP 85 | AUG 86 | SEP 87 | 88 | DEC 89 | NOV 90 | OCT 91 | APR 92 |
|--|-----------|-----------|-----------|----|-----------|-----------|-----------|-----------|
| Functional assessments not reviewed annually | | | | | | | x | |
| Speech and social assessments missing | | | | | x | | | |
| <i>Condition of Participation Not Met: Staffing</i> | | | | | | | | |
| Treatment program does not specify method | | | | | x | | x | x |
| Program planning does not reflect priority needs | | | | | | | | x |
| Health Issues | | | | | | | | |
| No quarterly review of health status | | | | | | | x | x |
| No notification of rights | | | | | | x | | |
| No policies re: HIV info. | | | | | | x | | |
| Failure to obtain preventive & general health care | | | | | | | x | |
| Accommodate special diets | | | | | | x | | |
| Obtain annual physicals | | | | | | | x | |
| Dispose & store meds properly | | | | | x | | | |
| Meds not administered per order | | | | | x | x | | |
| Staff administering drugs not trained to do so | | | | | x | | | |
| Pharmacy reviews not completed quarterly | | | | | | x | | |
| No evaluation of residents' abilities to self-medicate | | | | | | | x | x |
| Oral hygiene training inadequate | | | | | | | | x |
| Comprehensive dental services lacking | | | | | | | | x |

| | SEP 85 | AUG 86 | SEP 87 | 88 | DEC 89 | NOV 90 | OCT 91 | APR 92 |
|--|-----------|-----------|-----------|----|-----------|-----------|-----------|-----------|
| Living Conditions/Life Safety | | | | | | | | |
| Hot water too hot | x | x | | | | | | |
| All staff not safety trained | x | | x | | | | | |
| House not accessible (waiver requested) | x | x | x | | | | | |
| Sanitation problems: dirty tooth brushes, roaches, dirty refrigerator | x | | | | | | | |
| Maintenance problems: wallpaper stained and peeling, exposed plaster | x | x | | | | | | |
| Emergency procedures not posted | | x | | | | | | |
| Inadequate documentation of fire drills | | x | | | | | | |
| Sanitation problems: frozen meat not dated, some windows lacked screens | | x | | | | | | |
| Maintenance problems: carpet worn & torn, ceiling water damage, damaged window frame | | | x | | | | | |
| No smoke detector in living room | | x | | | | | | |
| Doors do not have single function locks | | x | x | | | | | |
| Insufficient exits (no secondary means of escape) | | x | x | | | | | |
| Evacuation diagram not accurate | | | x | | | | | |
| Insufficient night-time fire drills | | | x | | | | | |
| Sanitation problem: bathroom lacks soap & personal towels | | | x | | | | | |
| No preventive maintenance program | | | x | | | | | |

| | SEP 85 | AUG 86 | SEP 87 | 88 | DEC 89 | NOV 90 | OCT 91 | APR 92 |
|---|-----------|-----------|-----------|----|-----------|-----------|-----------|-----------|
| Maintenance problems: 3 windows will not open, range hood and wall greasy, 2 closet doors off track, headboard not secured to bed frame | | | x | | | | | |
| Safety problem: bathtub does not does not have slip protection | | | x | | | | | |
| Fire alarm too soft | | | x | | | | | |
| Fire doors not functioning properly | | | x | | | | | |
| Bedroom door does not latch | | | x | | | | | |
| No emergency lighting | | | x | | | | | |
| Maintenance problems: carpets worn, stained & torn, 4 bedroom dressers damaged, living room walls dirty, broiler door damaged, hampers damaged, all closets disorganized, roaches | | | | | x | | | |
| Maintenance problems: bedroom doors will not close | | | | | | x | x | |
| Facility lacks manual fire alarm station | | | | | | | x | |
| Fire protection system not monitored quarterly | | | | | | | x | |
| Maintenance problem: carpet in dining room worn and torn | | | | | | | x | |
| Management | | | | | | | | |
| Governing body not providing oversight | | | | | | | | x |
| No Incident Review Committee minutes | | | | | | | x | |
| Unsure if IRC meets quarterly | | | | | x | | x | |

| | SEP 85 | AUG 86 | SEP 87 | 88 | DEC 89 | NOV 90 | OCT 91 | APR 92 |
|--|-----------|-----------|-----------|----|-----------|-----------|-----------|-----------|
| Unsure if IRC reviewed all reportable incidents | | | | | | | x | |
| No annual incident trend report | | | | | x | x | | |
| Executive director shall not be member of IRC | | | | | x | | x | |
| Personal Allowances | | | | | | | | |
| No tracking system for clothing allowance | x | | | | | | | |
| Accounting for personal funds inadequate | x | | | | | | | |
| Personal funds not deposited within 3 working days | | | | | x | | x | |
| Inaccurate crediting of personal accounts | | | | | x | | | |
| Personal accounts not reconciled quarterly | | | | | | x | | |
| Personal funds ledgers not initialled | | | | | | x | | |
| Residents not receiving full personal funds | | | | | | | x | |
| Receipts for withdrawals missing | | | | | | | x | |
| Quarterly reconciliation inaccurate | | | | | | | x | |

Appendix C



**STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES**

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THOMAS A. MAUL
Commissioner

ULUSS THOMPSON
Executive Deputy Commissioner

April 13, 1994

Clarence J. Sundram, Chairman
New York State Commission on Quality
of Care for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, NY 12210-2895

Dear Mr.  Sundram:

Thank you for your February 18, 1994 letter and draft report concerning the Commission's investigation of Community Living Alternative, Inc. (CLA). Considering the collaborative efforts between staff of our two agencies working on programmatic oversight of CLA prior to its abrupt closure, it must have been as unwelcome a surprise to you as it was to me when the full scope of the apparent fiscal fraud came to light.

I am very distressed that persons with developmental disabilities were subjected to poor living conditions over many years, were provided with less than adequate treatment which may have slowed their growth and personal development, and were exposed to potentially serious physical health consequences. For an executive director and a board member to promote a climate of fear, isolation and despair in order to reap illegal personal financial gain is inexcusable. I support the Commission's efforts and am willing to assist in appropriate criminal prosecution to the fullest extent allowed by law. Fortunately, the persons who were served by CLA are now doing much better under the care and supervision of the Association for Children with Retarded Mental Development, Inc. (ACRMD) and appear to have suffered no irreparable harm.

The CLA case provides an opportunity to evaluate our regulatory and fiscal systems and our mutual involvement to bring about appropriate improvements. It is fortunate that you and your staff have reflected on this matter and have offered comments we may use to improve the effectiveness of OMRDD. I support your conclusion that state regulators be alert to "red flags" in the programmatic and fiscal performance of operators. As you correctly point out, "improving the communication between the fiscal and certification areas of OMRDD would strengthen our ability to follow up on the implementation of recommendations as well as permit OMRDD staff to examine the connection between programmatic deficiencies and fiscal practices." Better communication may well have prevented or enabled earlier identification of the fraud perpetrated by CLA.

Right at home. Right in the neighborhood.



We have no disagreement that more could have been done to deter such fraud, and more needs to be done to prevent a recurrence of these circumstances. My staff believes that the CQC draft report reflects a justifiable anger and outrage over the actions of the principal parties associated with CLA. However, some of the anger and outrage may have been misdirected to OMRDD. The draft report utilizes hyperbole, omits key facts, relies on hindsight to reach certain conclusions without sufficient factual support, and trivializes the need to adhere to regulatory procedures.

Within your report, the following are examples of the use of hyperbole which may result in the reader being misled:

- "The certification of CLA is reminiscent of the doctor proclaiming that the operation was a success, but the patient is dead."
- "But those whose job it was to see these deficiencies did not ... because they were enveloped in a morass of tag numbers and bureaucratic paper-pushing like someone marching in place which presented the image of movement and fatigued the players but gained no ground."

Both of these statements are unduly dramatic and do not accurately depict the situation. CQC should make its points in a more straightforward manner. When your staff reviewed the program, they found similar deficiencies and also accepted a plan of correction from the agency. This occurred only weeks before the fraud came to light. Your reminiscing, "of the doctor proclaiming that the operation was a success, but the patient is dead," would seem to also have to apply to the process in which your staff engaged. However, I do not believe this is a fair characterization of the work of either of our agencies. It does point out, dramatically and unfairly, that two separate agencies with two separate but similar purposes made similar decisions at the time the issues were active.

You also indicate, "those whose job it was to see the deficiencies did not." I don't think you contend anywhere in the report that deficiencies were not observed nor reported accurately by certification staff. We were not, however, enveloped in a morass of tag numbers or bureaucratic paper-pushing. We feigned no movement, and there is no evidence presented that any of OMRDD's employees were fatigued. You too quickly diminish the use of tag numbers and imply they are counterproductive. In reality, they promote efficiency, permit tracking of pertinent information, and assist in making the appropriate decisions. They reduce the morass of information which would otherwise envelop or possibly smother certification activities. The figures of speech in your report provide little clarification, are inapt comparisons and establish the tone to which we object.

There is no mention of the open and cooperative relationship that existed and still exists at the staff level between CQC staff and OMRDD certification staff, not only in the downstate area and regarding CLA specifically, but also across the entire state. This relationship allowed us to exchange our certification reports freely with your staff concerning CLA. The report omits any mention of this relationship and the beneficial impact it had for the overall CLA investigation.

The CQC analysis relies too heavily on hindsight. During the months immediately preceding the closure of CLA, CQC was seeking to obtain access to CLA's financial records in order to conduct a fiscal audit of the agency. At that time, CQC did not inform OMRDD, and, I presume, CQC did not suspect that there was fiscal fraud of the nature and scope as later events suggest occurred at CLA. CQC staff had approved CLA's plan to correct programmatic deficiencies and even indicated the high degree of satisfaction with how CLA would be implementing this plan (see letter of September 21, 1992 from R. Holloway, of CQC, to CLA--attached). This letter was sent only weeks before the program closed and without the slightest suggestion on CQC's part of the existence of the fraudulent activities. I trust that you are not suggesting that OMRDD should have made the connection between CLA's identified program shortcomings and the fiscal fraud which was being carried out by CLA management. We acknowledge that CQC did have ongoing questions at the time concerning the incongruity between funds received by CLA and the level of expenditure on program services, which led to the decision to press forward with a fiscal audit. But there is a substantial difference between ongoing questions and a specific suspicion of fraud. Based on what was known to our certification staff and your program reviewers at the time, it is only through hindsight that one can link CLA's programmatic problems to the fraud. The difficulty of detecting fraud is thus not acknowledged sufficiently in your report, and I think it must be in the interest of presenting an accurate report.

The CQC report appears to belittle the need to follow the procedural requirements associated with various regulatory enforcement options, particularly those of federal origin. OMRDD, as a regulatory entity with state licensure authority and delegated authority to recommend federal provider agreements, must ensure that our regulatory enforcement tools are not rendered impotent due to procedural defects. OMRDD has learned some difficult lessons by losing administrative hearings or judicial proceedings on procedural grounds. Our actions differ markedly from the Commission's activities because all of our reports, statements of charges, and procedural actions must withstand the scrutiny of an impartial hearing officer or judge.

There are several operational issues relating to our experience with CLA which will receive attention by OMRDD. These issues include:

- o Improving the communication and coordination between OMRDD fiscal regulatory staff and OMRDD program regulatory staff. Executive Deputy

Commissioner Gus Thompson will conduct a management review to consider how we may better coordinate these two areas of regulatory oversight to ensure that important information is known to key staff with responsibilities in both of these areas.

- o The rate appeal and auditing processes must develop approaches which may deter fraud or assist in detecting it sooner. Upon approval of a prospective rate appeal, we will require the provider to indicate how long they intend to use the funds for the particular purpose embodied in the appeal. Four to six months after a successful appeal, OMRDD will require the provider to submit a written statement which attests to the fact that they are spending the money on the purpose specified in the appeal.
- o Approval of retroactive appeals will require adherence to the practice of reviewing cost data.
- o Ensuring independent and effective boards of directors. We will seek to create better mechanisms to review the character and competence of the executive director and board members at the time of incorporation and during the process leading to the receipt of an initial operating certificate. Periodically thereafter, we will verify the existence and participation of board members in governance of an agency. OMRDD will update its comprehensive training for board members and introduce a mentoring program for board members. This program will be targeted for new agencies and for persons who are new to board service. This activity is not directly related to the CLA issues. It may generally improve agency governance and raise awareness of the importance of program performance and minimize squandering of resources.
- o Improving the review of plans of correction by certification staff and ensuring that enduring and systemic corrections are made. There may be a need to change our system of oversight in order to review for systemic and enduring correction. Additional regulations and/or procedures may be required and requested to allow OMRDD to utilize state standards and processes over and above the rather minimal standards of the federal regulations.
- o Strengthening current requirements for issuance of operating certificates by requiring that all corrections to deficiencies must be made and verified as a condition to issuance of an operating certificate. OMRDD would employ a probationary certification status until we verify compliance with all significant program requirements.

- o Defining more clearly the obligation of all OMRDD employees to report regulatory violations to the appropriate authorities if such employees are engaged in outside employment with an agency licensed or doing business with OMRDD. The Developmental Disabilities Services Office (DDSO) will ensure that any employees previously involved with CLA are advised specifically on how to relate to voluntary agencies and when to report regulatory violations and how to otherwise effect remediation of problems which they see.
- o Developing and implementing improved training programs for case managers to ensure that the case managers are fully cognizant of their responsibility to see what is going on in programs under their purview, understand certification reports and to report any instances of regulatory violations to the appropriate persons at the DDSO and at the program or fiscal regulatory units. As an immediate step to assist case managers, Deputy Commissioner Tom Cuite shall issue an administrative memorandum to all executive directors of state and voluntary agencies advising them that effective May 1, 1994, all case managers may receive copies of any statement of deficiencies and plan of correction issued to any state or voluntary agency for any program licensed by OMRDD, and they should advise their current and new case managers about this information and to ensure accountability to them.

A plan will be developed for my review and approval to address these issues. Activities to bring about these improvements have already begun, and I would be pleased to update you periodically on our progress if you wish.

The circumstances which arose to allow CLA to commit major fraud must be prevented from recurring at other agencies. Nonetheless, it is very important not to jump to conclusions about the system as a whole. As you know, New York State is very fortunate to have a system of not-for-profit and state providers who are quite honest, well motivated and thoroughly professional. OMRDD and CQC, as the overseers of this system, need to fashion a measured response, avoiding overreaction, to reduce the possibility of other persons taking advantage of the system and allow the creative forces in the system to meet their mandate to serve their consumers in a responsible, sensitive and caring manner. Working together, I am confident we can make this happen. OMRDD needs to make clearer its expectations of its employees, train them better, and improve the level of internal coordination. CQC, for its part, needs to continue reviewing systemic issues and being responsive to individuals' complaints while being ever sensitive to remaining as objective and evenhanded as possible.

OMRDD thanks CQC for its activities in dealing with CLA and its diligence in enlisting the assistance of federal law enforcement agencies and Health and Human

Mr. Clarence J. Sundram

- 6 -

April 13, 1994

Services Inspector General staff to pursue and locate the key persons associated with this fraud. I look forward to our continued discussions to further improve the system of services and OMRDD's roles as regulator, facilitator and provider.

Sincerely,



Thomas A. Maul
Commissioner

Attachment

TAM:TC

cc: Mr. Thompson
Mr. Catchpole
Mr. Cody
Mr. Costello
Mr. Cuite
Mr. Hart
Mr. Jones
Mr. Kaplan
Mr. Kietzman
Ms. O'Reilly
Dr. Steindorf
Mr. Walsh



STATE OF NEW YORK
COMMISSION ON QUALITY OF CARE
FOR THE MENTALLY DISABLED
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CLARENCE J. SUNDAM,
CHAIRMAN

Elizabeth W. Stack
William P. Benjamin
JAMES A. CASHEN
COMMISSIONERS

September 21, 1992

Les White
Executive Director
Community Living Alternatives, Inc.
137-20 45th Avenue
Flushing, NY 11355

SEP 23 1992
92096731
DIVISION OF QUALITY ASSURANCE

Dear Mr. White:

The Commission has reviewed the plan of correction which you sent us on August 17, 1992, as well as the correspondence we received from Ms. Kay Wright. We found that this plan appropriately addresses the treatment, staffing, active programming and environmental concerns which we had brought to your attention. We were particularly pleased to see assurances that the agency has assigned responsibility to specific administrative and clinical staff for insuring that programs and services provided by the agency are being consistently and appropriately administered, documented and reviewed.

With the receipt of this letter you may consider the Commission's review of care and treatment at your program to be concluded. We will, however be returning to the residence in several months to review programming and documentation to ascertain if each of the assigned administrative and clinical staff have effectively ensured that adequate services are being provided. Thank you for your cooperation and assistance during the course of our review.

Sincerely,

Randal L. Holloway
Mental Hygiene Facility
Review Specialist
Quality Assurance Bureau

cc: James Walsh
Tom Cuite

Appendix D

Commission Rebuttal to OMRDD Response

The Commission disagrees strongly with the portion of the OMRDD response which attempts to characterize CQC as equally responsible as OMRDD for failing to detect earlier the fraud and neglect at CLA. The facts do not support such a contention.

- It was OMRDD, not CQC, which issued an operating certificate and continued to certify an agency with a phantom board of directors and an executive director with a criminal record who concealed his relationship with the president of the board of directors. CQC *uncovered* these facts.
- It was OMRDD, not CQC, which had three staff moonlighting on CLA's payroll, who should have been aware of many of the deficient conditions and should have reported them, but did not. Instead, they back-dated records and participated in a pattern of concealment of deficient conditions from other divisions of OMRDD. The risks posed by the conflicting loyalties created by their outside employment were apparently not addressed by their OMRDD supervisors.
- It was OMRDD, not CQC, which had a case manager who made monthly visits to CLA but failed to understand his role and obligations and thus failed to report the ongoing deficient conditions. His incompetent performance of his duties was apparently not detected by his supervisors at OMRDD.
- It was OMRDD, not CQC, which repeatedly accepted repetitive plans of correction which were never implemented. By contrast, CQC *rejected* the initial plan of correction, insisted on greater specificity as well as personal accountability for implementation in a revised plan, and specifically informed CLA that we would return to verify that the promised corrections had in fact been implemented. (These CQC actions were acknowledged in Mr. Cuite's letter of June 2, 1993 (p.3) which is appended to the report.)
- It was OMRDD staff, not CQC, who turned away the sister of a client who complained to them about the conditions at CLA.
- It was OMRDD, not CQC, which provided CLA with retroactive rate adjustments for the cost of staff who had never been hired, and failed to verify whether the costs had in fact been incurred by the agency.
- It was OMRDD, not CQC, that failed to follow-up on a 1981 OMRDD audit which cited CLA for a high percentage of checks made to cash. In the absence of follow-up, despite promises to OMRDD of reform by CLA, this practice increased more than five fold.

The Commission's essential criticism is not of OMRDD's certification staff alone, but of the absence of any systematic connection between the multiple arms of OMRDD that were interacting with CLA which would have aided in detecting and preventing both the ongoing neglect and the fiscal fraud.

Unlike OMRDD, the Commission is not the regulatory agency and does not maintain a regular presence in every provider agency. However, when CQC responded to the complaint from a sister of a client and observed the conditions in the residence, it quickly saw the connection between the physical and environmental conditions and the expenditure of money. CQC thus sought fiscal information both from OMRDD and the provider. It was CQC's insistence on gaining access to the provider's financial records that prompted the executive director to abruptly padlock the residence and flee the state with the records. It is precisely this type of connection between programmatic practices and fiscal practices that CQC believes should be occurring on a more routine basis in OMRDD's interactions with providers when there is evidence of significantly deficient conditions, as there was in this case over a period of several years (regardless of whether they met the technical definition of "repeat" deficiencies).

The Commission is clearly not jumping to conclusions about the system as a whole. As noted in the Conclusion to the Commission's report:

"The majority of providers competently and ethically operate in the public interest, and to allow their work to be besmirched by the corrupt and greedy behavior of a few of their colleagues would be an injustice."

Rather, the Commission is concerned that the absence of linkages and communication between certification staff, case managers, rate setting and DDSOs may result in circumstances where everyone at OMRDD may do their jobs as required, but no one

in authority has a comprehensive view of what is occurring at an agency with significantly deficient conditions. These structural weaknesses permitted deficient conditions at an agency like CLA to exist and persist; the Commission is concerned that these same weaknesses may permit other similar situations to exist without detection. Mr. Cuite's letter of June 2 seems to acknowledge as much when it says with regard to CLA's history of deficiencies: "... I am not sure that more could have been done" under the regulatory and oversight system as it presently exists.