

***Pitfalls in the Community-Based Care System:
A REVIEW OF THE NIAGARA COUNTY CHAPTER
NYS ASSOCIATION FOR RETARDED CHILDREN, INC.
AND AGENCIES RESPONSIBLE FOR ITS OVERSIGHT***



**New York State
Commission on Quality of Care
for the Mentally Disabled**

September 1984

**Clarence J. Sundram
Chairman**

**Irene L. Platt
James A. Cashen
Commissioners**

The New York State Commission on Quality of Care for the Mentally Disabled was designated in 1980 as New York State's Protection and Advocacy System for the Developmentally Disabled, pursuant to Public Law 94-103 as amended.

PREFACE

New York State has much to be proud of in the development of a system of community-based care and treatment for individuals with developmental disabilities. The linchpin of this system is a network of community residential facilities that generally provides a homelike environment and opportunities to fulfill an individual's potential for growth and development.

As this system has grown and as the number of sites at which developmentally disabled individuals are housed have multiplied, the task of ensuring quality care through monitoring and regulation has become much more challenging than it once was. Of necessity, providing for appropriate care is a function shared by many actors. Initially, responsibility for meeting the needs of the residents lies with the staff of the program. Where the program is operated by a "voluntary" (not-for-profit) agency, responsibility for ensuring that the agency meets its legal obligations and management duties lies with the board of directors. In some instances, a parent corporation serves as a further check. The ultimate backstop is the Office of Mental Retardation and Developmental Disabilities (OMRDD) which, through its certification process, permits voluntary agencies to operate programs for developmentally disabled individuals and to receive public funds for doing so. It is OMRDD's responsibility to determine, through routine monitoring, through certification

reviews, and through its quality assurance mechanisms, that certified programs substantially comply with State laws, regulations and policies which are designed to ensure quality care. The Legislature created this Commission to monitor the operations of the entire system and to advise and assist the Governor in developing policies, plans and programs to ensure a uniformly high quality of care [NY Mental Hygiene Law §45.07 subd. (a)].

Conceptually, this multilayered assignment of responsibility appears to provide a sensible approach to meeting the primary goal of the community-based system of care. However, as this investigation into the operations of the Niagara County Chapter of the New York State Association for Retarded Children, Inc., illustrates, such a system works only as well as each of the component parts. In this instance, when confronted with credible evidence of client sexual abuse, the staff failed in their responsibility to protect clients from harm. The board of directors made no attempt to intervene and, indeed, resisted the efforts of OMRDD to address some of the problems. OMRDD itself proved too deferential to the management prerogatives of the licensed agency despite its own findings which confirmed serious client abuse and despite the licensed agency's demonstrated reluctance to take steps to protect client welfare. As a result, corrective action was not taken in a timely manner.

In a related vein, the development of the community-based service system has necessitated the acquisition of tens of millions of dollars worth of real property for community-based programs. A variety of methods have been used to facilitate the acquisition of needed real property in a timely fashion, including direct purchase or lease by the State, purchase or lease by the voluntary agency operating the program and, in many instances, purchase by a holding company which leases the property to a voluntary agency. This last method is used largely to circumvent a State law that prohibits reimbursement of interest costs incurred in connection with the purchase of real property, except as part of rental costs paid to the holding company.*

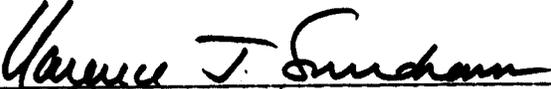
Although procedures have been developed to review the appropriateness of such property acquisitions and the fairness of the purchase or lease terms, as this case history illustrates, compliance with the established procedures does not assure a satisfactory outcome due to inherent weaknesses in the procedures themselves.

In this report the Commission recommends a number of steps to strengthen each layer of responsibility for ensuring

*Chapter 579 of the Laws of 1984 enacted on July 27, 1984 allows 50 percent local assistance funding for interest, depreciation, and the principal portion of rent presently prohibited where a State grant was used to partially finance the capital project.

quality care in the community-based system. The Commission has also recommended a critical review of existing policies and procedures for the acquisition of real property by lease or purchase. The Commission is pleased to note that OMRDD has agreed to implement each of these recommendations.

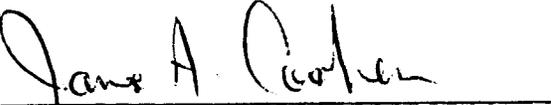
The findings, conclusions and recommendations contained in this report reflect the unanimous opinion of members of the Commission. A draft of this report has been shared with OMRDD, and relevant sections have been reviewed by the New York State Association for Retarded Children as well. They generally concur with the recommendations made by the Commission.



Clarence J. Sundram
Chairman



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Commissioner



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ACKNOWLEDGMENTS

Outstanding contributions were made by the following Commission staff in the conduct of this investigation and in the preparation of this report:

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HISTORY OF COMMISSION'S INVOLVEMENT AND
EXECUTIVE SUMMARY OF FINDINGS

This investigation began with a letter to the Chairman of the NYS Commission on Quality of Care for the Mentally Disabled (Commission) from a parent of a client of Niagara County Association for Retarded Children (NCARC) complaining that her daughter had been a victim of sexual abuse by an NCARC employee and that no satisfactory actions had been taken by the NCARC regarding her complaint. This parent also made this complaint to the Niagara County District Attorney (DA) who called a meeting of representatives from the Office of Mental Retardation and Developmental Disabilities (OMRDD); the Office of the State Attorney General (AG); and the Commission. An investigator from the Commission was assigned to this complaint and attended the meeting.

It was decided at this meeting that:

1. based upon an investigation by the Niagara County Sheriff, the DA would seek to charge this employee with crimes of sexual abuse;
2. OMRDD would proceed with its own previously scheduled investigation of the allegation and of NCARC's failure to act;
3. the AG saw no issues that fell within his Medicaid jurisdiction, but would stand ready to become involved if new information were uncovered relevant to Medicaid concerns; and
4. the Commission would temporarily withhold action until OMRDD finished its investigation.

At the completion of OMRDD's investigation, the Commission investigator spoke with persons who had knowledge

of this sexual abuse incident and heard of other complaints from parents and employees. These complaints concerned serious mismanagement in the community residences including chronic food shortages, dangerous conditions due to lack of maintenance, irregularities in management of the personal funds of clients, and a lack of accountability by NCARC management and the Board of Directors to parent-members of the Niagara County Chapter of the ARC. The Commission authorized a further investigation of these issues.

The Commission decided to begin gathering information without either directly intruding into NCARC's operations or inhibiting OMRDD's investigation or any action it might take on the findings of its own investigation. As a result of its limited investigation, the Commission found good reason, supportable by available evidence, to believe that:

- There was serious mismanagement in the administration of NCARC during the term of the then Executive Director, including:
 1. failure to protect clients from physical abuse while effecting a cover-up of such incidents;
 2. poor nutritional programs and chronic food shortages for clients;
 3. inadequate management of client funds, with the possibility that crimes might have occurred in some cases;
 4. retaliatory dismissals of staff and threats of discharging the children of parents who complained about conditions or disagreed with methods of operation; and
 5. lack of effective oversight of this Executive Director's administration by the NCARC Board of Directors.

- There was serious mismanagement, inefficiency and waste in NCARC finances including less-than-arm's length property transactions on seven of nine buildings leased or owned by NCARC which appear to have cost much more than they should have.
- Finally, there was a lack of adequate monitoring by agencies responsible for one or more aspects of NCARC's operation--New York State Association for Retarded Children, Inc. [NYSARC] (the corporate parent of the Niagara County Chapter), OMRDD, and the Department of Social Services (DSS), specifically:
 1. NYSARC and OMRDD approved or at least acquiesced in certain real property transactions by NCARC, financed with public funds, which involved either unsuitable properties and/or excessive costs and unfavorable terms. Some of these transactions appear to have been at less-than-arm's length.
 2. NYSARC and OMRDD provided inadequate oversight of this incorporated chapter and licensed facility and failed to ensure the safety of its clients in an expeditious manner. After conducting its own thorough investigation which verified allegations of serious acts of sexual abuse committed by staff upon clients, OMRDD entrusted remediation to the officials of NCARC who clearly had already demonstrated gross delinquency in taking ameliorative actions. Indeed, NCARC initially adopted a strong adversarial posture toward OMRDD'S recommendations to correct numerous deficiencies of programs and procedures, including misuse of client funds. Although OMRDD did advocate prompt disciplinary action against the alleged abuser, it permitted NCARC to delay action for over four months during which the alleged abuser continued to work in proximity to female clients. Only NYSARC, once apprised of some of these serious problems by the Commission and OMRDD, took decisive and meaningful action.
 3. OMRDD routinely audited only selected portions of NCARC'S finances. These audits inherently could not uncover a true picture of certain improprieties of a service provider because of this limitation. NYSARC did not initially perform any on-site investigation based on complaints it received from parents.
 4. The State Department of Social Services did not act on complaints of NCARC clients within its jurisdiction, e.g, misuse of personal allowances and other SSI funds.

Conclusions

This investigation illustrates the consequences of ineffective regulation of the rapidly growing community service system for the care of mentally disabled citizens of this State. The system has been created to provide more humane care and treatment in homelike environments. In this case, in part because of fiscal waste engendered by mismanagement and unchecked by oversight, the NCARC not only ran programs that denied clients an opportunity for growth and development in a normalizing environment, but also denied them adequate training, nutrition and protection from harm. When the Executive Director was confronted with reports of sexual abuse and exploitation of clients by staff, she first ignored and then obfuscated the facts and the evidence through incompetent investigations. When parents challenged her, she responded with threats to discharge their children. When staff complained, she summarily discharged them. When confronted with an official investigation by OMRDD, she failed to cooperate as required by law, and did nothing to ameliorate the situation.

For the most part, there was no timely and effective check on the Executive Director and the poor care for which she had direct responsibility.

As for the safeguards of oversight, the NCARC Board of Directors, reportedly handpicked by her through elections that violated corporate by-laws, abdicated its responsibility

for effective oversight. This board apparently did not demand to be informed, nor was it even generally kept informed of important activities of the NCARC. When frustrated parents took their complaints to the State ARC for recourse, there was not timely attention or systemic response by the Executive Director or by the Board of Directors. And, when OMRDD intervened, its actions were limited to the specific complaints and did not take all reasonable measures to compel correction of either the systemic deficiencies which they represented or the lack of ameliorative actions by the Executive Director and the Board of Directors for the pervasive problems.

Many of the problems of the NCARC (condition of its day treatment center and residences, and lack of food for clients) are attributable, in part, to the long-term consequences of real property purchases and leases that were, to put it charitably, extremely poor business judgments. These decisions appear to have wasted hundreds of thousands of dollars in public funds which were meant to provide quality care. Although these transactions were reviewed by OMRDD* and the Facilities Development Corporation (FDC) in

*Some of the events reported herein occurred before the April 1, 1978 reorganization of the Department of Mental Hygiene which created an independent Office of Mental Retardation and Developmental Disabilities. However, for simplicity, no differentiation is made for purposes of this report.

accordance with then-existing procedures (except for a day treatment center which was not reviewed), neither agency was effective in preventing these wasteful expenditures.

This investigation studied a significant series of real property transactions, involving the acquisition, renovation and leasing of properties for community residences, workshops and day programs that appear to involve conflicts of interest and poor judgment. The result of permitting frontline mismanagement to go unchecked is that substantial amounts of public monies have been imprudently spent and consequently client care was seriously and adversely affected to the point of depriving clients of adequate food, nutrition and safe shelter. Specifically, these real property transactions raise substantial questions about the effectiveness of monitoring, regulation and fiscal oversight by NCARC's Board of Directors, by NYSARC as the parent corporation, by OMRDD and by the Facilities Development Corporation. Indeed, a recent consequence of this has been that the OMRDD on April 14, 1984 was forced to suspend the license of the NCARC's day treatment program because of unsafe conditions at the program's leased facility, and the burden of overpriced property is financially hampering efforts to correct the poor conditions of some of the other real estate. This case history suggests an urgent need for a critical review of practices and procedures not only of NYSARC, but those followed by OMRDD and FDC as the governmental agencies responsible for reviewing and

approving the lease, acquisition and renovation of real property to ensure that there are adequate safeguards to prevent wasteful expenditures of public funds.

Summary of Investigation Results

As a result of the Commission's investigation, OMRDD's investigation and reviews, the actions of the New York State Association for Retarded Children and the Niagara County District Attorney, the following actions have been taken:

1. An employee of NCARC was removed and subsequently indicted on two counts of sexual abuse (felony and misdemeanor). He pled guilty to the misdemeanor in full satisfaction of the indictment and thereafter cooperated in giving further information to the Commission and DA.
2. The NCARC Executive Director was removed by the Board of Directors at the insistence of the NYSARC Executive Committee. A new Executive Director has been appointed and has made some meaningful improvements in certain programs, although deficiencies exist in physical plant of some residences and program sites, day treatment programs, and handling of clients' personal funds. NYSARC has been actively monitoring these improvements.
3. New elections for Board of Directors' members have been held and this time a number of previously disenfranchised parents were elected.
4. Appropriate matters were referred to the NYSARC for further verification and correction, particularly in regard to greater scrutiny of real estate acquisition and leasing.
5. On June 12, 1984 OMRDD staff commenced an audit of NCARC finances, real estate transactions, and client funds for the period January 1, 1980 through December 31, 1983.

Summary of Responses of Concerned Agencies

NYSARC

On May 24, 1984 the NYSARC forwarded an extensive response to the Commission's April 30, 1984 site visit report representing NYSARC's preliminary review of programs operated by NCARC and detailing extensive corrective measures including:

1. a 30-day takeover of the NCARC residential program to improve the health and safety of the residences;
2. recommending establishment of a separate NYSARC real estate management corporation;
3. initiating in-service training for NCARC residential staff in recording and documenting personal allowance accounts;
4. assisting the NCARC in finding a new day treatment site; and,
5. providing ongoing technical assistance.

OMRDD

At a June 22, 1984 meeting, members of the Commission and officials of OMRDD reached the following agreements on specific initiatives that are needed to better ensure system integrity:

1. Establishment of a process to make certain that the capability exists within licensed agencies to ensure that programs run properly. The process would minimally include a performance evaluation of agency executives by board members, OMRDD management reviews to identify poorly run agencies, policy guidelines on hiring executive directors, and scrutiny of the qualifications of agency management during OMRDD certification inspections.

2. Initiation of an annual training program for board of director officers and including as a certification requirement that such key officials be trained within one year of appointment. OMRDD agrees to consider allowing through rate making the reimbursement of personal liability insurance related to the management functions of governing boards.
3. Establishment of new policy for expeditious OMRDD response to threats of client abuse involving immediate and irreparable harm including use of judicial proceedings pursuant to the Mental Hygiene Law.
4. Development of a standard property lease for use by voluntary agencies defining landlord/ tenant responsibilities for repair and upkeep.
5. Development of an interagency memorandum of understanding providing for OMRDD to formally assume NYS Department of Social Services' responsibilities for establishing standards for the use of OMRDD client personal funds to eliminate confusion as to how they should be spent and accounted for to ensure that there is adequate enforcement.
6. A complete review, commenced within a year, to be made either by outside consultants or State experts of existing OMRDD, Facilities Development Corporation, and private agency procedures and internal controls for acquiring, managing, leasing, and rehabilitating property. A steering committee composed of OMRDD, Office of Mental Health, Department of Audit and Control, Division of the Budget, Commission on Quality of Care for the Mentally Disabled, and major provider agencies would be appointed to oversee the study.
7. OMRDD, particularly the Division of Quality Assurance, will develop specific procedures and forms for incident review and reporting by voluntary agencies.

Recommendations

The Commission recommends* that the Office of Mental Retardation and Developmental Disabilities should:

1. either through private consultants or with State experts critically examine existing policies and procedures for review and approval of real property transactions, including purchases, leases and renovations, to ensure prudent expenditures of public funds;

[OMRDD maintains it followed established practices. It received approvals of property and rent studies by real estate experts. The procedures used in reviewing acquisitions and leases are said to be consistent with statewide policies. Nevertheless, OMRDD points out important areas of real estate that need to be improved (e.g., review of voluntary agency lease agreements, disclosure statements on ownership, review of property transactions of "flat rate" funded programs, standard leases, code enforcement, site selection procedures, and arm's length reviews). It also agreed at a June 22, 1984 meeting with the Commission to the need for a complete review of the current system of acquiring, leasing, and managing real estate.]

2. expand audits to review real property historical cost data, returns on equity to owner, and lease terms to assure that excessive benefits are not accruing to property owners. OMRDD audits should also scrutinize agency exempt income, voluntary contributions and costs of "flat rate" funded

*OMRDD responses to the recommendations are included in brackets.

programs for consistency with client need and corporate charter;

[OMRDD indicates that it currently examines historical costs if a less-than-arm's length transaction is identified during the course of an audit. It proposes, however, to expand future audits to cover appraisals on acquisition and rent studies on leases to ensure they meet new arm's length procedures. It claims also to audit exempt income and voluntary contributions, but only to be certain they are properly recorded. Because of staffing limitations, audits of flat rate funded programs would be conducted only if discrepancies are found during program reviews.]

3. assure that reports of serious, untoward incidents related to the care and treatment of clients are sent to and receipt acknowledged by the president of the board of directors. Thereafter, the president should approve on behalf of the full board the plan of correction and provide evidence that the matter has been considered at a meeting of the full board;

[Regulatory requirements of OMRDD place responsibility for overall incident management with the agency's governing body which may, in turn, delegate oversight responsibility for this aspect of the program operation to an Incident Review Committee. Essentially, these regulations require that each certified program delineate appropriate incident policies and procedures which include the definition, management, review and reporting of all untoward incidents.

As an adjunct to the regulatory requirements referenced above, the Division of Quality Assurance recently issued several administrative memoranda primarily directed toward further enunciation of the roles and responsibility of the governing body in the overall operation of a program. A grant proposal is currently being prepared to develop a special training program on investigative skills necessary for investigating incidents by OMRDD. A shorter version of this

training program will be made available to the special incident review committees of licensed facilities in the future and offered on a periodic basis. OMRDD will develop policy guidelines for hiring senior management of voluntary agencies, institute performance based management review of voluntary agencies (to include senior executive management staff) and arrange for annual training conferences for officers of the board of directors.]

4. expand financial audits to include all clients' accounts where there may be evidence of questionable withdrawals or systemic deficiencies;

[OMRDD routinely reviews clients' allowance accounts as part of a full agency audit (i.e., the entire agency and all programs). On other occasions it receives and responds to requests to specifically review clients' allowance accounts. Current OMRDD auditing policy is to expand the audit scope where there is evidence of questionable practices concerning client allowance accounts and address these issues for legal resolution where applicable. Therefore, OMRDD believes it is currently in compliance with this recommendation.]

5. clarify policy between DSS and OMRDD with regard to responsibility over personal allowances and give consideration to further referral to the Deputy Attorney General for Medicaid Fraud and/or the DA for criminal investigation. These agencies should also work with federal agencies to establish a clear fiduciary standard for representative payees, service providers and others who receive payments on behalf of clients unable to manage such funds (see, Facilities as Fiduciaries, CQC report, June 1984, p. 62);

[Pursuant to Section 131-o of the Social Services Law, the Department of Social Services has primary responsibility for monitoring the requirements with respect to personal allowances for individuals in residential facilities who received additional State payments under the Supplemental Security Income program. DSS has legal authority to investigate complaints, supply information and enforce payment of personal allowances in facilities under the jurisdiction of other State agencies. Although there is nothing to clarify regarding this authority, DSS can delegate these powers, pursuant to a memorandum of understanding, to other State agencies (i.e., OMRDD) to monitor residential facilities under their respective jurisdiction.]

This matter has been referred to DSS but no memorandum of understanding regarding delegation of authority yet exists. Such a memorandum of understanding would necessarily involve resource and workload analyses and transfers, as appropriate, and some detailed protocols for referrals, investigation, reports and recovery action. OMRDD will endeavor to take over DSS responsibility for monitoring and auditing personal allowance accounts in private residence programs.]

6. promulgate regulations to establish a code of ethics applicable to holders of operating certificates which address issues such as business practices among related parties and standards of behavior for employees of the licensee toward clients. This recommendation was previously made by the Commission to OMRDD (see Profit v. Care, CQC report, March 1981, at p.83);

[OMRDD has previously discussed and considered the establishment of a more comprehensive code of ethics, but believes that the legal difficulties and complexities involved in legislating such a code of ethics and making it binding on the complex array of corporate entities and individual persons necessary would be largely unworkable. At OMRDD's suggestion, the Commission will assist in exploring an acceptable alternative code of ethics.]

7. create an annual training program for the president and officers of boards of directors and for special incident review committees of licensed facilities, which includes instruction as to their legal, ethical and fiduciary obligations; compliance with rules and regulations; and, responsibilities to safeguard the rights of clients and residents and to ensure an appropriate quality of care. Attendance at such training programs by the president and officers should be made a condition of certification or recertification.

[OMRDD on January 18, 1984 sent memoranda to the presidents of governing bodies of each certified provider to clarify and specifically delineate their respective roles and responsibilities. In addition, the same memoranda identified areas which OMRDD considers significant and crucial to the survey process in evaluating the proper functioning of the governing body and adherence to regulatory requirements.

Annual training programs, coupled with the preparation of technical assistance packages and numbered memorandum, should help board members to develop the skills necessary to fulfill the legal and ethical obligations inherent in board membership.]

ADMINISTRATION

Failure to Protect Clients from Abuse

This investigation commenced with a letter dated March 3, 1982 by a parent to this Commission complaining that the NCARC cafeteria cook sexually molested her daughter on January 22, 1982. Copies of the letter were also sent to the District Attorney of Niagara County, OMRDD, the NCARC Executive Director, and the Director of the Niagara County Mental Health Department. The daughter told her parent that the sexual abuse had been occurring for quite some time. Sworn statements by two NCARC employees about the January 22, 1982 incident and similar acts of sexual abuse by the cook against several other clients dating back to December 1980 were sent with the letter.

NCARC's Executive Director had also been made aware of this incident in writing by NCARC staff and the parent during January 1982. One employee stated that oral reports were made to her supervisor as early as October 1981 about similar instances of sexual abuse against this client. Acts of sexual abuse against other clients were also brought to the attention of the Executive Director, but no action was taken regarding the cook's inappropriate behavior with clients. The two employees who produced the sworn statements about the sexual abuse were terminated on March 12, 1982, purportedly due to problems with "funding".

At a March 30, 1982 meeting of representatives from OMRDD, the Niagara County District Attorney (DA), the State Attorney General, and the Commission at the Niagara County DA's office, it was decided that: the DA and OMRDD would pursue allegations of sexual abuse and food thefts within their respective jurisdictions; the Deputy Attorney General for Medicaid Fraud would do no investigation until a specific issue involving Medicaid was referred; and the Commission would allow OMRDD to complete its already scheduled investigation before commencing its own investigation, but would stand ready at the request of the DA to cooperate fully with any investigation of possible criminal behavior by NCARC staff.

The OMRDD initiated its investigation in early April 1982, and on May 25, 1982 issued a draft report essentially verifying the acts of abuse and recommending: disciplinary action against the cook "in accordance with the terms of the union contract," a new policy on incident reporting, and clarification of the purpose and obligation of the NCARC Special Review Committee. The NCARC was given 30 days to respond to these recommendations. The accompanying letter from an OMRDD Associate Commissioner criticized the Executive Director's failure to fully cooperate with OMRDD's investigation, to grant immediate access to records, and to allow interviews of members of the Special Review Committee.

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Despite the physical danger that the alleged abuser posed by continuing to work in close proximity to female clients, in response to an inquiry to OMRDD on July 26, 1982 the Commission was informed that OMRDD did not intend to take any further action to enforce implementation of its recommendations or to effect a removal of the cook from direct client care because it was the NCARC's responsibility to address these serious problems. Also, OMRDD was informed by NCARC that there would be no action to terminate the cook's employment because of the provisions of the NCARC labor contract. On July 27, 1982, OMRDD issued its final report, noting that the NCARC did not respond to the draft report.

Concerned about the NCARC Executive Director's actions and OMRDD's failure to both address the responsibility of the Executive Director and to enforce its own recommendations, Commission Chairman wrote a letter to OMRDD on August 11, 1982 as follows:

These are serious charges against the Executive Director of an agency which is ultimately responsible for the welfare of vulnerable, mentally retarded citizens. Beyond noting her conduct, is there no action that is warranted, either by the governing board of the State ARC or by the licensing agency, the State Office of Mental Retardation and Developmental Disabilities? Or is the Executive Director free to behave as she pleases with impunity? Indeed, were it not for a complaint by the parent to this Commission, followed by OMRDD's considerable investigative effort, these incidents would have gone undetected and the circumstances causing them unameliorated.

In an August 27, 1982 response to the OMRDD final report, the President of the NCARC Board of Directors stated

it was "virtually impossible" in view of the disciplinary procedure in the union contract to take immediate action against the cook, but indicated the OMRDD final report would be placed in his personnel file without further disciplinary action until the facts were verified.

The union contract was obtained and studied by Commission Counsel. Its discipline and job termination procedures were simple and appeared likely to succeed, given the available evidence identified by OMRDD's investigation.* Indeed by comparison, these procedures were much simpler than current disciplinary procedures of State-union contracts. Upon being so advised, the Commission Chairman in a September 8, 1982 letter, reiterated the Commission's concerns to the Executive Director of the State ARC for its failure to act to protect these clients as follows:

As stated in the OMRDD report, the Executive Director of NCARC has indicated that she has not taken immediate and meaningful action in dealing with this employee because of her fear that the employee would take the issue to arbitration. I enclose for your information a copy of the union contract which provides a very simple and direct procedure for discipline and discharge (Section 5.3, Discipline and Discharge, pp. 11-12). Although this contract does provide for arbitration in Article 2, this is hardly a legitimate reason for not taking action in the face of so serious a violation of the rights of the clients of NCARC. To conclude otherwise is tantamount to abdicating clients to the mercy of abusive staff. Moreover, I

*Association for Retarded Children Employee Union (AFL-CIO) and NCARC (January 1981-82), §5.3: "No employee . . . shall be . . . disciplined . . . except for just cause."

am very confused at your statement in your letter to the Executive Director of NCARC that you would hope that the chapter would help the [W.'s] to find an alternative placement for their daughter. Whether or not the [W.] family wishes their daughter to be placed elsewhere, that placement alone will not resolve the continuing danger to other clients who will not be placed elsewhere. I hope that the NYS Association for Retarded Children will focus upon appropriately dealing with the alleged perpetrator rather than merely removing the victim.

On September 14, 1982, OMRDD formally replied to the Commission Chairman's August 11, 1982 letter:

The investigating team makes no recommendations for action against the ARC Executive Director because it is the Board of Directors of the Niagara County ARC that has overall policy-making authority for the agency.

A letter calling for a meeting between the OMRDD Commissioner and the NCARC Board to discuss the actions the Board should take for the protection of clients was sent by the OMRDD Commissioner on this same date. After reviewing the Board's response, the OMRDD Commissioner in his September 14, 1982 letter, urged the Board to change its decision not to initiate disciplinary action against the alleged abuser citing the agency's "obligation to prevent his further abuse of clients."

On another front, the DA investigated this matter through the Grand Jury and communicated with the Commission's Counsel to coordinate joint efforts and share information where it was appropriate. The Commission's investigator received the cooperation and assistance of the Niagara County

Sheriff's Department and in turn assisted their investigators.

Despite informal statements made to Commission staff by Deputy Sheriffs that they had sufficient evidence to arrest the NCARC cook, in May 1982 the case was postponed a number of times from presentation to the Niagara County Grand Jury for reasons of an intervening murder/arson trial, adjournment of the Grand Jury, to allow the DA's office to complete its investigation of reported food thefts, and to permit assignment of an Assistant District Attorney (ADA) who was an expert in prosecuting sex crimes and other crimes against females. After a conference in September 1982, this ADA said that the Commission would be notified when the case of sexual abuse would be presented to the September Grand Jury and if an indictment resulted. On November 1, 1982, an indictment (Niagara County No. 7267) was returned by the Grand Jury which charged the NCARC cook with sexual abuse in the first degree (a felony) and sexual abuse in the second degree (a misdemeanor).

Only after it was evident that the Grand Jury was reviewing this matter and would probably return this indictment, did NCARC's Executive Director on October 7, 1982 remove the cook;* reportedly, on charges of operating an unsanitary cafeteria and serving stale doughnuts. Thus, for

*The effective date of cook's resignation was December 12, 1982.

more than four months after a thorough OMRDD investigation report had concluded that the allegations of sexual abuse were true, the alleged perpetrator remained on the job in direct contact with the mentally retarded females he was accused of sexually abusing.

After months of inaction due to deference to the Executive Director and Board of Directors of NCARC, the Executive Committee and the Executive Director of the NYS Association for Retarded Children (NYSARC) took decisive action by insisting that the NCARC Board of Directors remove the NCARC Executive Director. This was done on September 28, 1982, and the NYSARC Executive Director assumed interim responsibility for the operation of NCARC while recruiting another permanent Executive Director.

From the first reports of sexual abuse incidents by parents to NCARC's officials in January 1982 until action by NYSARC on September 28, 1982, NCARC Executive Director's actions stonewalled all requests to take action to correct the situation, choosing rather to use her energies to obfuscate the culpability of the perpetrator and her own failure to act. For example, the Commission interviewed two members of the NCARC Special Review Committee and obtained other related memoranda in an effort to understand that Committee's remarkable recommendation after review of the allegations of sexual fondling by the cook, that: ". . . human sexuality training be given on how staff should deal with client

flirtations. . ." and that staff be assigned another place (i.e., away from the view of clients) to dress.*

From descriptions of this meeting, the review of the facts of this incident were cursory and the presentation dominated by the NCARC Executive Director. It is noteworthy that she not only served as a member of the Committee but also decided on which incidents the Committee would review and the manner of the review. In this particular case the Executive Director reportedly described the circumstances from the onset as that of a client's flirtatious behavior. A member of this Committee, a professor at Niagara Community College, told the Commission that the Executive Director had provided them with limited documents describing this incident and would not allow interviews by the Committee with the victims or witnesses. Significantly, this professor also told the Commission that the Executive Director herself proposed these recommendations and the Committee simply ratified them and never told the Committee of their function, powers and responsibilities or otherwise allowed the members to act without her control.

The Executive Director began another internal investigation apparently in response to the findings of the

*It should be noted that the NCARC had received a \$34,000 grant under the NYS Developmental Disabilities Program for the period May 1981 to April 1982 to provide training to staff and parents on "appropriate attitudes and behavior associated with normal human sexuality."

OMRDD investigations regarding sexual abuse. However, it was so poorly done that it seemed designed to uncover little. The procedure used was nothing more than a series of standardized, vague questions to clients and employees on their knowledge of alleged incidents. The end product of this inquiry was still inaction, even though some clients confirmed such events.

The Commission was also informed of a sexual affair between a female client (Ms. T.) and a male weekend/night manager (Mr. M.), a resident and employee of NCARC community residence No. 5, respectively. This relationship was apparently well known among staff, and Ms. T. began to complain to them of Mr. M. constantly harassing her. She admitted to having some previous sexual contacts, but sought staff help to gain the assistance of local police to stop the harassment. Staff reported that Ms. T. was high functioning and about to wed another man.

A formal complaint was made to NCARC administration and an investigation was conducted by the then Director of Community Residences (DCR) at NCARC. It violates NCARC's written policies for an employee to engage in sexual relations with a resident. According to the DCR, these interviews with Ms. T., Mr. M. and others were tape-recorded. The tape has inexplicably vanished--the DCR claimed to have left it at NCARC when he left his job and NCARC claimed not to have it in response to the Grand Jury's subpoena. Since the

harassment had apparently ceased by this time, the local police, Deputy Sheriffs, and the Commission concluded that the facts were too ambiguous and obscured by the passage of time to press the investigation. Upon interview by the Commission investigator, Ms. T. seems to have had the mental capacity to make personal decisions, thereby reducing the possibility of criminal charges being lodged.

Nutrition

The Commission was consistently told by employees as well as by parents of residents of poor nutritional conditions at both NCARC community residences and the cafeterias in the administrative and day treatment buildings. Through interviews with former community residence managers, the Commission learned of chronic food shortages and constant reductions of allowances for food. One manager stated that he resigned largely because of this problem, as a result of which in some instances, clients were reportedly fed nothing but cereal at all meals.

In a sworn statement given to the Commission, a senior residence manager discussed how the food budget for the community residence was drastically cut. She said that some monthly checks for food in the spring of 1982 did not come at all causing food shortages; for other months the allotments were cut by as much as half. Food stamps were also being cut under new federal policies which exacerbated the problem, and it became NCARC policy to withhold the cash value of food

stamps of all clients from the residence food budget. Yet, according to the former bookkeeper, during this time monies were taken out of the budget of community residences instead of from the administrative budget for plane fare, hotel, and other expenses related to trips taken almost exclusively by the NCARC Executive Director.

It was also a practice for one residence to "borrow" money from the budget of another to make necessary expenses, or to "borrow" from clients' personal funds to purchase necessities for the operation of the residences. It is not clear whether such monies were repaid.

The former DCR stated that "other financial priorities took money away from the food budget" and the Executive Director was "revising the books" so much that his requests to modify these budget constraints on food were largely ignored.

According to a post-conviction interview with the cook, he reported being instructed in May 1982 by the NCARC Comptroller to cease serving a balanced diet to clients who ate in the cafeteria. Instead, according to the cook, he was told to serve hot dogs, hamburgers, and french fries or other inexpensive meals. The Comptroller also told him that the profits from the cafeteria must increase to equal the level of his wages or he would be fired. The cook earned approximately \$12,000 per year and said that the best yearly profit ever made since the beginning of the cafeteria was \$8,000.

He was doubtful that food costs or quality could be cut enough to increase profits that much. The cook was also instructed for the first time to start transferring the cafeteria's "surplus food" (donated by the State) to a community residence (8022 Buffalo Avenue, Niagara Falls, NY), because of shortages there.

Client Funds

In the Commission's judgment, the manipulation of and possible theft from client funds can only be verified by a financial audit. If allegations made to the Commission are true, criminal conduct might be involved and should be referred to the District Attorney and the Deputy Attorney General for Medicaid Fraud. However, even at this time it does seem clear that NCARC did not properly account for client personal funds. The NCARC administration failed to act despite reports to its officers from residence managers and others that some residences might have been utilizing such personal monies for improper purposes in violation of State and federal laws, e.g., for equipment, food, rent, etc. (See, NY Social Services Law, §131-o.)

A review of personal allowance records of clients in an NCARC residence was initiated by OMRDD, as a result of an October 12, 1981 complaint from a parent to the Commissioner of Social Services regarding missing personal allowance funds. The Department of Social Services which has primary

responsibility for monitoring and enforcement over the use of personal allowances delegated the investigation of the complaint to OMRDD as the supervisory agency.

On May 24, 1982 OMRDD issued a report confirming a misapplication of personal allowance funds. OMRDD's report further found that NCARC failed to promptly apply for client SSI money; used personal allowance money for rent (a misdemeanor, NY Social Services Law, §131-o); could not document large withdrawals from client accounts; and did not fully account for deposits and withdrawals. NCARC which had constantly refused to explain anything about these circumstances to the parents of clients affected also refused to do so to OMRDD.

The OMRDD report was referred on May 26, 1982 to a DSS Deputy Commissioner with the suggestion that criminal and civil enforcement was possible in the case. The Department of Social Services has to date taken no action to enforce the law to protect these clients' funds, but rather has waited for OMRDD to do something about it. NCARC, after first denying that OMRDD could establish a personal allowance rate, eventually conceded and repaid the money to the particular client but without statutory double punitive damages.

Although OMRDD's report is reasonably thorough in terms of this specific complaint, it did not look beyond this client's residence account to see if clients of other residences were being similarly cheated. Having verified such an

instance and concluding it was due to improper agency policy for the handling of client funds, OMRDD recommended that the accounts of all clients be examined when the next inspection of the residences occurred in its next recertification review. Accounting practices used in residences were reviewed during OMRDD's recertification, but individual accounts were not audited. The August 19, 1982 certification report noted that a schedule designating the types of expenses appropriate for personal allowance previously cited as deficient in the January 1978 recertification was still not available. Of course, the problem of deciding the legitimacy of personal allowance disbursements relates to knowing what supplies or services are required to be provided by the agency as part of its basic rate. (See Profit v. Care, CQC Report, March 1981, pp. 46-48.)

The finding of widespread problems in client funds was also confirmed by the statements of former employees, such as the former Director of Community Residences and the former bookkeeper. It was their view that these problems were very prevalent throughout all the residences and programs. For example, the parents of client Ms. K. kept meticulous records of their daughter's care, including her finances. Ms. K.'s personal allowance account showed withdrawals of \$875, \$408, and \$75 which NCARC refused to explain. Ms. K. herself did not know when, where, or why this money was withdrawn. The predicament of the K. family was unnecessarily compounded by a highly questionable policy of the Social Security

Administration (SSA) office in Buffalo which administers the SSI program. The parents had been appointed "guardians" of the person and property of Ms. K. by a judicial decree from a State court. However, because of a technicality based on a legal ambiguity,* the Social Security Administration has refused to honor this court decree and appointed the facility rather than the parents as "representative payee" (i.e., trustee and receiver) of Ms. K's SSI payments.**

The Commission has become aware of two possible instances of outright theft of client funds brought to the attention of NCARC's executives in writing. In an interview with a former senior residence manager, the Commission learned that she sent a memorandum which attached evidence

*In correspondence with the SSA, the Commission was informed that since federal regulations require a determination of "incompetency" and since a NYS guardianship is granted on "incapacity," the guardianship decree does not satisfy federal regulations. This rationale is, however, legally questionable because there is no uniform standard or terminology used to describe such legal disability. For example, New York law provides for three categories of disability from which four fiduciary relationships result: stemming from infancy ("guardianship" for minors), incapability to manage one's affairs ("guardianship"), substantial impairment ("conservatorship"), and incompetency ("committee-ship"). Thus, even though a State court of record found Ms. K. incapable of handling her financial affairs and appointed her parents legal guardians, legal terms notwithstanding, SSA refused to honor this determination, which effectively left control of her money in the hands of the service provider rather than her own parents.

**The Commission notes that the regulations to protect these funds on behalf of mentally disabled recipients are wholly inadequate [20 CFR §§416.20-416.640 (1982)]. This is a problem that urgently needs correction. See Abrams v. Schweiker, 543 F. Supp. 589 (N.D. Ga. 1982).

tending to show that the previous residence manager was possibly stealing client funds in a systematic way. NCAkC did nothing about it, nor was it referred to law enforcement authorities, local, State or federal. Another residence manager told the Commission that his predecessors systematically withdrew client money for their own benefit.

Finally, NCARC employees told the Commission that client personal allowance funds were used for facility rent and for supplies such as kitchen appliances. As stated before, OMRDD found this to be true as well. Reportedly, NCARC was often delinquent in applying for SSI funds to pay a resident's room and board charges. To make up for these funds, NCARC would take client's personal allowance funds to compensate for its own laxity. This might constitute a crime under NY Social Services Law §131-o.

Retaliatory Dismissals and Threats against Parents

Concededly, such allegations are difficult to verify and might well be colored by a bitterness of those reporting such incidents. But the Commission heard numerous complaints of arbitrary behavior by the Executive Director which to some degree were sufficiently corroborated elsewhere as well as by the circumstances surrounding the firings to give them some credibility. For example, an NCARC employee was fired after she reported the sexual abuse incidents by the cafeteria cook and provided a client's mother with information about it. The former bookkeeper was fired without notice the day after

divulging information about financial improprieties to OMRDD in confidence. The former Director of Community Residences was terminated after complaining about poor structural conditions throughout community residences. He provided the Commission with his own copies of memoranda of these complaints to the Executive Director.

In sum, it appears that the then Executive Director had little tolerance for dissent and less for anyone who complained about conditions at NCARC; for them it meant dismissal from their job or if a parent, a threat to "take your child home and see if you like it better!". The K. parents told of such instances and of being ordered to leave an ARC membership meeting by the Executive Director under a threat of being arrested by the police. They also reported threats by her to expel their daughter from the NCARC residence and program. Such intimidating behavior went unchecked, leaving parents alone and powerless against these actions.

Board of Directors' Oversight

Convincing the NCARC Board of Directors to remove the Executive Director was reported by the NYSARC Executive Director to be difficult despite strong evidence of her mismanagement. The Commission had been informed by parent-members and others that the selection of members of the Board had been strongly influenced by the Executive Director and

that the Board exercised little genuine oversight of her administration. Review of Board minutes for 1982 showed little critical inquiry of NCARC operations and virtually no independent oversight of its administration.

As more fully explained in the earlier section concerning the reports of sexual abuse, members of the Board of Directors were apparently unaware of their powers or responsibilities in overseeing the operations of the NCARC. There were credible reports that proper procedures for Board nominations and election were disregarded to keep dissident persons from gaining membership.

Among persons reputed to be friends of the Executive Director on the Board at that time was an individual who was a partner in a real estate concern (GLASS Associates) which owns and leases to NCARC one large commercial building for a day program as well as five of seven NCARC community residences. As further analyzed in the sections on NCARC property, these properties appear overpriced and generally were found to be, based both on site visits by OMRDD and the Commission, in poor condition. Board minutes indicate repeated letters were sent by NCARC to GLASS Associates concerning needed repairs without results. For example, in the case of a badly leaking roof at one of the residences, Board minutes indicate that letters of complaint were sent over the course of a year, but the Board never even received a

response from GLASS. It is apparent that the Board of Directors' oversight role in this instance was adversely affected by the conflict of interest of one of the Directors.

FINANCIAL

Less-than-Arm's Length Dealings

Gathering available information about NCARC's real estate was difficult because it entailed laborious searches of deeds and property transfers recorded in the County Clerk's office and the necessity to locate a real estate expert who could assess the import of such transactions in the Niagara Falls and Lockport real estate markets. However, the Commission put together a picture which shows a pattern of poor quality, over-priced acquisitions at less-than-arm's length. Given the financial problems at NCARC which motivated actions such as reducing staff and cutting food budgets, some of the reasons for this plight surely are attributable to the high on-going costs of these owned and leased properties.

Although admittedly measured imperfectly because of incomplete data due to the absence of an audit, there appears to exist less-than-arm's length relationships in the conduct of NCARC real estate transactions which has led to lease arrangements very favorable to the landlord, as well as imprudent real estate purchases that consumed large sums of public money which should have gone for the care and treatment of retarded clients. Moreover, as this analysis suggests, inadequacies in OMRDD's system of internal control and oversight of regulated agencies and their expenditure of public funds failed to prevent these imprudent transactions

that led NCARC to the fiscal problems it faces today. The same characterization may pertain to NYSARC as the parent corporation of the NCARC chapter.

The following description of NCARC's property acquisitions raises doubts about the reliability and vigilance of the OMRDD's capital budgeting; adherence to policy, procedures and laws to ensure fiscal integrity; economical and efficient use of resources; and effectiveness of feedback through internal audits. However, the less-than-arm's length dealings described herein are not meant to be characterized as improper per se. Rather, they raise legitimate questions of whether such deals were made in the best interests of the clients and of the taxpayer or whether they were inordinately influenced by the relationship between buyer and seller and thus led to imprudent and wasteful expenditures of public funds.

The Commission is aware that OMRDD has historically encouraged voluntary providers to acquire property needed for programs to serve the mentally retarded, and that some of the transactions described herein might be perfectly honest. However, in view of the terms of these arrangements and the circumstances under which they were entered into, there are reasonable grounds to question their propriety. The acquisition or rental of private property for community-based facilities has been a constant source of frustration for OMRDD in the deinstitutionalization program.

1. Administrative and Workshop Building ("Krueger Building"),
1555 Third Avenue, Niagara Falls, NY

This building was purchased by NCARC under less-than-arm's length circumstances and under terms which appear not to have been in the best interest of the NCARC and its clients. Given other available buildings in Niagara Falls and, indeed, its own existing office and program space, this building was purchased above the State-appraised value, which may have also been above fair market value according to a local real estate expert. Its sale appears to have been engineered by partners in a law firm which not only simultaneously represented the bank as the building's corporate owner-seller and NCARC as purchaser, but also where another partner of the law firm was on the Board of Directors of the bank as seller which also became the mortgagee again.

Before this purchase, NCARC administrative offices were contained in a rented 16,600 sq. ft. building which was formerly a supermarket ("Loblaws"). On March 19, 1976 the NCARC Executive Director submitted an offer to purchase this building from the owner, the Paysl Corporation. This letter stated that the NCARC Board of Directors authorized an offer of \$80,000 and referred to previous negotiations over the building, requesting that the seller lower the price to \$65,000 to enable the NCARC "to handle it financially." According to an OMRDD memorandum, the Executive Director in a November 30, 1976 conversation with OMRDD pointed out the purchase price was \$125,000. The cost to rehabilitate and to expand the building to 26,000 sq. ft. would have totalled

about \$500,000. Combining these estimates, it appears the NCARC could have purchased, renovated and expanded the Loblaw building for about \$625,000. A former representative of the Payscale Corporation confirmed the \$125,000 purchase price but reported that suddenly NCARC lost interest and the negotiations with NCARC's attorney went no further. Instead, NCARC purchased a former car dealership building known as Krueger Motor Sales Corporation.*

The Krueger Building has 29,000 sq. ft. and was constructed by specific design to be a contemporary car dealership, i.e., with a small glass showroom in front, a small area of office space in the middle and a cavernous automobile bay area for repairs in the rear. The roof in the repair area is high and the grounds surrounding the building are entirely asphalt covered with high lighting poles as in a parking lot for new cars, used cars, and customer parking. Aside from being in the hub of a busy, heavily trafficked commercial area, the building is near the Niagara Expressway (four-lane super highway) and the Newco refuse dump, an enormous landfill area which reportedly is also used as a chemical dump.

*The President of the Krueger Corporation was reported, in an appraisal by Prozeller Appraisal Consultants, to be on the Board of Directors of Niagara Permanent Savings and Loan Association (NPSLA), the mortgagee. The Chairman of the Board of NPSLA was the law partner of an attorney, who represented NCARC, in the same firm as the Chairman which itself was located in the NPSLA Office Building.

When Krueger Pontiac went bankrupt, the building was sold at a foreclosure sale. In 1975, it was "purchased" by the mortgage holder, the Niagara Permanent Savings and Loan Association, now called Permanent Savings Bank, for the balance outstanding of \$500,000 on the original \$600,000 unsatisfied mortgage. According to a knowledgeable real estate broker who is very familiar with this area of Niagara Falls where he maintains an office, this building was considered a "white elephant", i.e., it was a distressed property unsold for two years and unfit for many uses because of its specialized design. It was a car dealership in an industrial row where there were other vacant car dealerships and vacant commercial buildings. Thus, it seems that the Niagara Permanent Savings and Loan Association was stuck with a half million dollar investment in this building which it could not sell even at a reduced price for almost two years, until NCARC bought it.*

*Not only did NCARC have an opportunity to purchase the supermarket building for hundreds of thousands of dollars less than the cost of the Krueger Building (counting planned expansion roughly equivalent in size to the Krueger Building) which they rented at that time, but NCARC also held title to property in the Town of Cambria. This was purchased with the thought of having a comprehensive community mental retardation center consolidating all operations. Yet, perhaps indicating further abuse in real estate, OMRDD reports that site and soil tests showed that the land cannot be built upon without public water or sewer which it lacks. Indeed, in a comparison of five sites by O'Connor Associates, it was observed that, when "the location of services is considered," the Krueger building and one other were least suited for NCARC client purposes and the most inadvisable to acquire. However, another report by O'Connor Associates, sent to the Commission more recently, yet dated the same day, expresses a totally opposite conclusion.

In 1978 NCARC acquired the Krueger Pontiac Building through a not-for-profit holding company called Opportunities Unlimited, Inc., formed shortly before the purchase for that purpose. The purchase price of \$500,000 (\$536,000 minus sale of the car hoists for \$36,000) was not only \$40,000 above the value appraised by a consultant for the Facilities Development Corporation and possibly \$100,000 above its market price according to an OMKDD memorandum, but, according to the Commission's real estate consultant, was probably more than double its worth assuming it could be sold at all given this depressed area of many vacant commercial buildings. It required \$614,000 in State and federal grants, \$375,000 in mortgages (given by the Permanent Savings Bank), and \$51,000 in other unspecified funding to purchase and transform this car dealership into something usable given NCARC's needs. The total cost including renovations exceeded \$1 million. NCARC has leased the building through August 1998 from Opportunities Unlimited for a fixed monthly payment of \$3,652 to 1989 and \$2,977 to 1998.

According to the Commission's real estate consultant it was "common knowledge" among area real estate brokers that this purchase was made possible by insiders, i.e., businessmen with a financial interest in the property and concomitant associations with NCARC.

In sum, rather than purchasing the Loblaw's building which with renovations would cost between \$600,000 and

\$700,000, NCARC spent over \$1 million for a basically oversized, unsaleable car dealership as follows:

<u>ITEM</u>	<u>FINAL COST</u>
Construction costs	\$ 384,220.00
Fixed equipment	43,856.35
Moveable equipment	67,495.51
Architect fees	35,046.80
Supervisor	9,211.48
Acquisition*	500,000.00
Accounting	<u>969.05</u>
TOTAL	\$1,040,799.19

OMRDD defends its process of project control and oversight which has been approved by the federal government for grant-in-aid projects and developed and reviewed by the Division of the Budget and Department of Audit and Control. In this process OMRDD relies on FDC appraisals to establish market prices in acquiring property. These appraisals are reviewed by FDC specialists as another check. However, as this review indicates, compliance with these procedures does not assure that the transactions will provide the best value for the public dollar. In the case of the "Krueger" building, OMRDD contends it was least expensive to remodel and was "the obvious choice from the standpoint of both cost and functioning." The Commission retrospectively finds that

*A State Comptroller's Audit Report, AL-CH-17-82, lists a State-eligible project acquisition of \$460,000. Recorded deeds, tax stamps, sales contract, and other documents obtained by the Commission indicate a \$500,000 acquisition cost.

although the project was done "by the book," its architect underestimated renovation costs by almost 500 percent rendering useless any comparisons based on cost. The architect also produced two contradictory conclusions and recommendations in the "building reviews." Also, while the private appraisal may have been sound in form and methodology, actual market conditions in Niagara Falls at that time may have dictated a lower price.

The January 14, 1976 building review by O'Connor Associates estimated the above construction costs at \$63,000. Other costs listed for equipment, architect fees and supervision were estimated at 20 percent of basic construction costs. Accordingly, the architect's estimate used for site selection purposes was \$465,000 lower than it actually cost to rehabilitate the Krueger building. In a January 14, 1976 building review O'Connor Associates commented that when the location of service is considered, "a move to a suburban automotive oriented setting would leave a void in their [clients'] daily lives." This report was sent to the NCARC Executive Director and to the then Department of Mental Hygiene. Also, questionable in the documents supporting the Krueger purchase is a second building review by O'Connor Associates (also dated January 14, 1976) which was forwarded by OMRDD in responding to a draft of the Commission's report. This version stated that the Krueger building was one of two preferred sites. In short, the unusually low rehabilitation

cost estimate and conflicting recommendations in documents raise serious questions about the scrutiny given to this transaction by OMRDD.

The Commission has uncovered the following further associations which raise serious questions of the propriety of dealings:

1. NCARC and Opportunities Unlimited were represented by an attorney of the then existing law firm located in the Niagara Permanent Savings and Loan Office Building. A law partner in this law firm was Chairman of the Board of Niagara Permanent Savings and Loan, the mortgage holder and owner of the Krueger Building; the former owner of the building was reportedly also on the Board. Thus, this law firm not only simultaneously represented the buyer and seller, but a law firm partner was also an officer of the seller corporation which also had the president of the bankrupt automotive corporation as a fellow board member for the bank.
2. This purchase was made possible by state and federal grants which covered approximately two-thirds of the total cost. The balance was primarily provided by a \$325,000 first mortgage and \$50,000 second mortgage given by the Permanent Savings Bank, also the previous mortgagee and owner in foreclosure. It is not entirely clear where the NCARC was going to obtain the funds to repay these mortgages, other than through State funds, which by law could not be used to repay principal or interest on property costs for which a state capital construction grant has been received. (See, NY Mental Hygiene Law §41.03.) Through this transaction, the Permanent Savings Bank fully satisfied its preexisting mortgage debt of \$500,000 owed by the bankrupt car dealership and, by new mortgages totaling \$375,000, gave itself a lien on real property which would benefit by substantial renovation at public expense.
3. The treasurer of NCARC's Board of Directors in 1978 worked for the Niagara Permanent Savings and Loan during 1978 to 1980. He also worked for the Marine Midland Bank from 1980 to 1982, and this bank holds a mortgage on another building (Sabre) which NCARC

leases from GLASS Associates* (GLASS), a real estate brokerage which also owns five of NCARC's seven community residences. One of the partners of GLASS sat on the Board of Directors of both NCARC and Opportunities Unlimited.

2. Day Treatment Building ("Sabre Building")
1755 Third Avenue, Niagara Falls, NY

This building is utilized by NCARC for its day program. It is separated by only one building from the Krueger Building and is of a cinder block, commercial-type construction consistent with others in this industrial area.

A site visit conducted by Commission staff found the building is much too large for the needs of the program and it appears that originally only one-third to one-half of the building was renovated to provide program space, leaving the other areas of the building as unfinished floorspace. The building itself appears to have been built on a landfill which is presently settling. According to the NCARC, soil samplings were recently taken to determine the cause of the settling. The results of this settling are quite apparent. One side of the building is approximately 1-1/2 to 2 inches lower than the other side, creating a trip hazard that bisects the entire length of the building. Reportedly, ceilings leak, and at times, some sections of the floor are

*The name "GLASS" is an acronym for the members of the partnership: Messrs. Gross, Levine, Amendola, Smith and Smith. The latter two partners are brothers who also control Smith Brothers Corporation, Inc., a construction firm that has also done work for NCARC.

under water. The winter sun was observed shining through several cracks in the walls.

A heating system failure in the renovated area forced several of the program components to move into the unfinished area of the building. The "structured learning" and cafeteria share a very large room that probably had served as the main production area of this former factory. The room is most notable for its high, leaking ceiling, moldy and cracked cinderblock walls and concrete floors. The "cafeteria" is merely several tables separated from the main floor by three rows of lockers. The "structured learning" area occupies a corner of the floor separated by dividers and tables from the rest of the floor. Demands were made to GLASS concerning needed corrections but were not met. On April 14, 1984 OMRDD withdrew the license of the day treatment program because the building posed potential safety hazards for the approximately 110 clients in the program.

Based upon a title search and the recorded deeds and tax stamps, it was learned that GLASS Associates purchased this property on November 27, 1978 from V.J. Licata Construction, Inc., for the outstanding mortgage of \$158,265.24 held by Marine Midland Bank and "\$1.00 or more." Transfer tax stamps indicate this cash amount was \$87,000 making a total purchase price of \$245,265.24. GLASS rented it to NCARC approximately three months later for a 14-year period from February 1, 1979 to April 30, 1993 at a variable rate averaging approximately

\$55,000 per year. In addition, NCARC as tenant is responsible for liability insurance, fire insurance, utility costs and repairs and maintenance.

The terms of the business transactions here and elsewhere lead to the conclusion that GLASS appears to have had a very favorable relationship with NCARC and its Executive Director. It purchased the building and soon thereafter entered into a low-risk (assuming the building remained certifiable), long-term lease at a rental which will return the original capital outlay for the building in about five years and virtually insulates the landlord from costs of operation of the building other than certain agreed upon property taxes and insurance.

In the Commission's judgment, based upon this information as well as site visits, it is inappropriate in size, condition, location, and construction, and its high real estate costs seem to be a major factor contributing to the very poor financial condition of NCARC. Indeed at times, NCARC was so desperate for cash that the Commission was told by more than one employee of warnings that salary checks might not be on time because NCARC could not meet the payroll. To save money, employee layoffs and firings were increasing, despite already low staff salaries, and the food budgets in the community residences were drastically cut and, in some instances, eliminated altogether.

3. NCARC's Community Residences

There are seven community residences operated by NCARC; five of them are leased from GLASS Associates. The five were purchased by GLASS shortly before being opened as NCARC community residences. Leased residences are located at 8022 Buffalo Avenue and 333 Buffalo Avenue, Niagara Falls, New York, and 109 Niagara Street, 5777, 5785, and 5789 Glendale Drive, Lockport, New York. A residence at 8410 Buffalo Avenue is State-owned.

8022 Buffalo Avenue is leased from GLASS for a ten-year period from November 1, 1976 through October 31, 1986. These lease terms require a monthly payment of \$1,500 (\$18,000 per year) as well as additional amounts for excess real estate taxes (over \$3,700 per year) and fire insurance premiums, as defined in the lease agreement. All utility costs, liability insurance, and normal repairs and maintenance must also be paid for by NCARC. The lease may be renewed for a five-year period from 1986 through 1991, or the property may be purchased by NCARC after October 31, 1986 for \$175,000.

This building was formerly the "Rest-Well Nursing Home." It was offered for sale in 1975. The initial asking price was \$235,000. That same year the price fell to \$195,000; in 1976 it was \$179,000. The price again dropped in 1976 to \$100,000 and was eventually sold to GLASS Associates for

\$75,000 on June 2, 1976.* By October 14, 1976 GLASS entered into a lease with NCARC. NCARC also pays GLASS Associates \$6,374 per year for five years for the cost of \$25,000 in renovations reportedly performed in 1976 by Smith Brothers Construction Company. (These are the same two Smiths who are partners in GLASS.)

An inspection by the Commission on Quality of Care on September 2, 1981, identified 26 deficiencies at the NCARC residence located at 8022 Buffalo Avenue. OMRDD was well aware of the deficiencies at 8022 because a letter from OMRDD on October 14, 1981 questioned why GLASS was not living up to its lease by making repairs. OMRDD refused to unqualifiedly certify these residences until corrections were made. However, in order to have these deficiencies corrected, OMRDD in early 1982 sought to renegotiate the lease to allow pay-back to the landlord GLASS an extra \$50,000 for for needed repairs despite the lease imposing such costs on the landlord.

Eventually, in an effort to make this former nursing home more homelike, the NCARC spent \$40,000 of its own funds to have ceilings lowered, new tiles installed on floors, carpeting installed, and the dining room and office areas renovated. Major expenses also included renovating upstairs and downstairs bathrooms and installing new smoke detectors.

*Price based upon tax transfer stamps.

While some of this work was done by NCARC maintenance staff, a major portion was completed by private contractors, including Smith Brothers Construction Company.

The community residence located at 333 Buffalo Avenue was leased from a private owner for a five-year period from January 1, 1977 through December 31, 1981 for the nominal amount of \$1 per year. The lease terms required the Association to pay all utility costs, fire and liability insurance premiums, and normal repairs and maintenance. After December 31, 1978 the lessor may increase the annual rent to the fair market rental which in no event will exceed \$6,000 per year. The Association may terminate the lease within 30 days of receiving any notice of increase rent if it so desires.

The property at 109 Niagara Street, Lockport, is leased from GLASS Associates for a 15-year period from May 1, 1978 through April 30, 1993. The lease terms require a monthly payment of \$880, as well as additional amounts for excess real estate and fire insurance as limits specified in the lease agreement. The Association must also pay for premiums for public liability insurance at limits specified in the lease agreement, as well as all utility costs and normal repairs and maintenance. The lease may be renewed for a five-year period from 1993 through 1998, or the property may be purchased by the Association after April 1, 1993 for \$120,000.

The community residences located at 5777, 5785, and 5789 Glendale Drive, Lockport, are leased from GLASS Associates for a ten-year period from March 1, 1979 to February 28, 1989. The remaining portion of the lease requires the Association to pay GLASS Associates \$1,950 per month as well as additional amounts of excess real estate taxes and fire insurance premiums as defined in the lease agreement, and all utility costs, normal repairs and maintenance. The lease may be renewed for a five-year period from 1989 through 1994, or the three properties may be purchased by the Association after February 1989 for \$200,000.

Rental Analysis

Because capital expenditure involves the commitment of large sums of money over long periods of time, any error in their evaluation or control can be very serious for the provider. In the case of a sale or lease of facilities to a not-for-profit corporation by an officer or member, there exists the potential to reap profits beyond market norms which may ultimately result in substandard care. For this reason, capital budgeting requires stringent internal controls and specialized organization.

In everyday usage, internal control means staying within acceptable limits. When applied to government, it attempts to assure that approved and appropriate decisions and activities are made and carried out. It is also aimed at

preventing officers and employees from engaging in proscribed and inappropriate activities. Importantly, internal control must be bound to the organizational structure. How an organization assigns responsibilities and authority over functions can act either as an incentive or deterrent to fraud, waste, and abuse. In fact, when financial irregularities do occur, they are often associated with weak organizational arrangements as was evident in the nursing home scandal of the 1970's.*

In the present instance, six of the nine properties operated by the NCARC Board are owned by GLASS Associates. One of the principals in GLASS Associates was also represented on the NCARC Board of Directors, as well as on Opportunities Unlimited--the lessor of the seventh of NCARC's nine facilities. The extent to which these less-than-arm's length arrangements were made to maximize the rental charges to the landlord is difficult to measure in the abstract without some formula for a measurement of return on investment and comparison to acceptable government standards.

Although OMRDD has not developed standards to control self-dealing, scandals in the 1970's compelled the State to do so for nursing homes. In accordance with the

*See, "Reimbursement of Nursing Home Property Costs: Pruning the Money Tree," Report of the New York State Moreland Act Commission on Nursing Homes and Residential Facilities, January 1976.

regulations of the Department of Health, the rental expense paid to a related organization is painstakingly defined in HIM-15 Provider Reimbursement Manual (Medicare/ Medicaid) and Part 86 of the Commissioner's Rules and Regulations. These regulations treat the health facility as though it were owned by the provider, i.e., as though the lease or other realty transaction had not occurred. In such cases, the rent paid to the lessor by the provider is not allowable as a cost. The provider, however, would include in its costs the cost of ownership of the facility. Generally, these would include costs such as depreciation based on the historical cost of buildings and interest on debt. Using this approach, it is not possible to determine the fairness of the payments to GLASS Associates since information on historical cost and lessor debt service is not available without an audit of both the facility, its holding company and third-party sellers.

Simply put, controls similar to those developed in the health care system seem not to exist within the statutes and regulations of the Department of Mental Hygiene. As noted earlier, the Mental Hygiene Law, Article 41, prohibits the reimbursement of interest costs on debt, except when such interest becomes part of "rent" paid to a holding company where it is reimbursable. Instead of the type of controls that exist in the health care system, the mental hygiene system relies upon an evaluation of property by the Facilities Development Corporation, which only issues

opinions on some of the factors that ought to be considered in the process of property acquisition. Furthermore, evidence suggests that in not all instances are the fair market appraisals sought (e.g., day treatment centers, because they are "flat rate" funded) or followed.*

In the case of three of NCARC's community residences owned by GLASS, the following provides some idea of the rent paid to this landlord based on evaluations by FDC:

<u>Location</u>	<u>Actual rent</u>	<u>Rents based on FDC comparables</u>
5777, 5785, 5789 Glendale Avenue Duplexes	\$325/unit/mo.	\$275/mo. \$275/mo. \$300/mo. \$300/mo.

*Recently, FDC rent valuations have contained the following disclaimer:

The Corporation is not in a responsible position for purposes of fully knowing, evaluating or recommending such investors on the basis of their professional experience and reputation as investors or the integrity, responsibility and reliability of the owner of such property and/or respective firm, employees or operating practices. Furthermore, the Corporation cannot establish a basis for the preference of such an investor or facility within a framework of those which might otherwise be known or available locally or on a statewide basis. It is further understood that such rent valuation as calculated would not necessarily dictate investor selections or lease negotiation arrangements on a competitive basis with respect to other investors' properties. Such valuation rent calculations, as a matter of the Corporation responsibility, would also not be made by the Corporation in relation to cost benefit considerations for the provision of care or services to the clients, a primary responsibility of OMR/DD.

It is noteworthy that in its report, FDC points out that the comparables renting for \$275/mo. are in slightly better condition than the Glendale duplexes which rent for more.

The traditional "rate of return" method can also be used for evaluating capital expenditures. The factors used to judge whether property is fairly priced is the annual rate of return to be gained from the investment. Again, this factor is prominently used in the proprietary segment of the health care industry where it is established by the federal government, i.e., a fair rate of return on equity invested. In the following cases of property leased to NCARC by GLASS, where the acquisition price of the property acquired, lease term, and the annual lease payments are known, a discounted rate of return (i.e., considers future dollar returns) can be calculated and compared to costs for the landlord to raise capital for ownership and to the federal rate allowed, i.e., considered fair and equitable.

<u>Location</u>	<u>Lease term</u>	<u>Acquisition price</u>	<u>Average annual payment</u>	<u>Discounted rate of return</u>
1755 Third Avenue	14 yrs.	\$245,000	\$55,571	21.2%
8022 Buffalo Avenue	10 yrs.	75,000	18,000	20.2%

Proximate to the time these leases were negotiated, a 10 percent discounted rate of return was, under federal standards, considered an equitable return to the lessor.

Conditions of the Residences

For these apparently higher rents, the question must be asked: Was the quality of the properties proportionately higher? From all credible accounts, the condition of these residences is generally poor and in some cases dangerous. Similar poor conditions existed at the State-owned residence.

The Commission is aware of memoranda from the former NCARC Director of Community Residences detailing great numbers of needed repairs, including leaking roofs, broken doors and windows, and lack of adequate fire detectors. OMRDD in its recertification review in 1982 refused to grant the full two-year period for an operating certificate because of the great number of deficiencies in every aspect of the community residences' operation, from their structures to management, administration and program. Indeed, OMRDD only issued a temporary six-month period of certification for all seven residences until January 1983 when all corrections were to be accomplished. Yet, a Commission inspection of the outside of several of these homes on October 7, 1982 showed significant deterioration including missing house siding and broken doors and windows.

In a February 8, 1984 follow-up inspection, Commission staff found at 8022 Buffalo Avenue leaking ceilings, a broken toilet and exposed wall studs where windows had been replaced some time ago. It appears that once the windows were installed, there was no attempt to restore the adjoining

walls to their original state. The exterior of the building also was badly in need of painting. At 5777 Glendale Avenue the kitchen floor was sagging beneath the weight of a freezer and range. The freezer was at a severe angle below level and it evinced a serious structural problem of the residence. In addition, there were significant holes in one wall of the kitchen.

The State-owned residence at 8410 Buffalo Avenue was in similarly poor condition. Staff complained about a leaking roof, rotted gutters, and inadequate electrical system. Numerous water marks were on ceilings and walls and the interior was in need of paint. In the basement, one wall was covered with plastic sheeting because the wall reportedly leaked. In a first floor bathroom a hole had been repaired by nailing an unpainted piece of plywood to the ceiling. No attempt had apparently been made to paint the wood or, more appropriately, to use wallboard or plaster to make the repair. Repairs to an upstairs bathroom were similarly unfinished and a mirror taken from the bathroom wall was left in the hallway blocking a fire exit. Outside, an awning had pulled away from one wall of the front porch, leaving it precariously flapping in the breeze.

Parents have complained about dangerous conditions at the residence without meaningful response from NCARC. The persistent state of disrepair in the community residences even led to NCARC sending a form letter to parents suggesting

that they either volunteer to form maintenance repair work crews or stop complaining about conditions.

The consequences of these apparent abuses in the lease purchase and neglect of real property not only placed NCARC on the shaky financial basis it now faces, but more importantly it cheats the clients from having a decent and safe place to live.

Placement of Clients in Inappropriate Programs

OMRDD made a site visit to the day treatment and workshop programs of NCARC on August 2 and 3, 1982. The findings were:

1. There were significant and numerous deficiencies in the program; and
2. Twenty-nine clients were inappropriately transferred from the workshop to day treatment. NCARC was thereby billing Medicaid for day treatment even though some clients were inappropriately placed there and appropriate services were not being provided. It was recommended that such reimbursement cease immediately and the NCARC Program Director was notified of this fact.

The State Office of Vocational Rehabilitation told the Commission of its great dissatisfaction with NCARC's workshop program. OVR also reported that NCARC seemed to use special start-up grants to initially train clients and then dismiss the clients from the workshop, subsequently transferring them to day treatment to garner the then \$35/day flat rate reimbursement. OVR was seriously contemplating disapproval of the NCARC workshop program. The workshop had been running constant deficits, in OVR's judgment, because of the

Executive Director's poor management. More recently, with the departure of the Executive Director, the program has reportedly turned around to a point where contract work has increased significantly and clients are receiving higher wages.

REGULATION

OMRDD

The inability of both the Board of Directors and the NYSARC to check the excesses at NCARC shows a need to strengthen the comprehensiveness and effectiveness of the State's regulatory processes. It is the State which the law establishes as the backstop to protect vulnerable clients from abuse.

In particular, this case indicates the need for a much higher priority to be assigned to ensuring the protection of clients from harm. When credible evidence exists of abuse or neglect of clients, action should be taken to protect the clients immediately by at least suspension or removal of the alleged wrongdoers pending resolution of the charges in the appropriate forum. A repetition of the events that occurred at NCARC with the alleged sexual abuse must not be allowed to happen. Furthermore, when problems are discovered in specific areas of operations, as in management of clients' personal funds, prompt consideration should be given to identifying whether the problem is systemic or idiosyncratic. If the former, the corrective action must be system-wide as well.

In terms of the fiscal integrity of the program, OMRDD's auditing procedure for program is simply too limited. It only looks at specific parts of a financial expenditure without looking at the whole, e.g., because the day treatment

program is reimbursed on a flat rate (\$35/day/client) basis, OMRDD's audit merely measured attendance. It did not look at any other sources of funds, what was being purchased with the money (i.e., quality or substandard services), etc. Additionally, this would necessarily miss excessive costs of building and plant which can adversely impact on the appropriateness and quality of the program. "Exempt income" from sheltered workshops and voluntary fund raising is similarly only audited to ensure it is properly recorded, thereby providing little scrutiny over the use of such funds.

N.Y.S. Department of Social Services

The Commission has learned previously from DSS' official response to the Greenwood report (NYS Commission on Quality of Care, April 1981) that it acknowledges no operational responsibility for either federal or State monies paid to clients of mental hygiene facilities, despite having the clear statutory authority for such responsibilities pursuant to the law. Rather, DSS relies on OMRDD for standards defining how money must be spent in the clients' interests and claims that it has contracted and thereby delegated all investigation and enforcement to the federal Department of Health and Human Services (HHS).

Thus, even though both OMRDD and an NCARC parent have informed DSS of the existence of violations of law, no actions or responses have been made by DSS to this date.

CONCLUSIONS

This investigation illustrates the consequences of ineffective regulation of the rapidly growing community service system for the care of mentally disabled citizens of this State. The system has been created to provide more humane care and treatment in homelike environments. In this case, in part because of fiscal waste engendered by mismanagement and unchecked by oversight, the NCARC not only ran programs that denied clients an opportunity for growth and development in a normalizing environment, but also denied them adequate training, nutrition and protection from harm. When the Executive Director was confronted with reports of sexual abuse and exploitation of clients by staff, she first ignored and then obfuscated the facts and the evidence through incompetent investigations. When parents challenged her, she responded with threats to discharge their children. When staff complained, she summarily discharged them. When confronted with an official investigation by OMRDD, she failed to cooperate as required by law, and did nothing to ameliorate the situation.

For the most part, there was no timely and effective check on the Executive Director and the poor care for which she had direct responsibility.

As for the safeguards of oversight, the NCARC Board of Directors, reportedly handpicked by her through elections

that violated corporate by-laws, abdicated its responsibility for effective oversight. This board apparently did not demand to be informed, nor was it even generally kept informed of important activities of the NCARC. When frustrated parents took their complaints to the State ARC for recourse, there was not timely attention or systemic response by the Executive Director or by the Board of Directors. And, when OMRDD intervened, its actions were limited to the specific complaints and did not take all reasonable measures to compel correction of either the systemic deficiencies which they represented or the lack of ameliorative actions by the Executive Director and the Board of Directors for the pervasive problems.

Many of the problems of the NCARC (condition of its day treatment center and residences, and lack of food for clients) are attributable, in part, to the long-term consequences of real property purchases and leases that were, to put it charitably, extremely poor business judgments. These decisions appear to have wasted hundreds of thousands of dollars in public funds which were meant to provide quality care. Although these transactions were reviewed by OMRDD*

*Some of the events reported herein occurred before the April 1, 1978 reorganization of the Department of Mental Hygiene which created an independent Office of Mental Retardation and Developmental Disabilities. However, for simplicity, no differentiation is made for purposes of this report.

and the Facilities Development Corporation (FDC) in accordance with then-existing procedures (except for a day treatment center which was not reviewed), neither agency was effective in preventing these wasteful expenditures.

This investigation studied a significant series of real property transactions, involving the acquisition, renovation and leasing of properties for community residences, workshops and day programs that appear to involve conflicts of interest and poor judgment. The result of permitting frontline mismanagement to go unchecked is that substantial amounts of public monies have been imprudently spent and consequently client care was seriously and adversely affected to the point of depriving clients of adequate food, nutrition and safe shelter. Specifically, these real property transactions raise substantial questions about the effectiveness of monitoring, regulation and fiscal oversight by NCARC's Board of Directors, by NYSARC as the parent corporation, by OMRDD and by the Facilities Development Corporation. Indeed, a recent consequence of this has been that the OMRDD on April 14, 1984 was forced to suspend the license of the NCARC's day treatment program because of unsafe conditions at the program's leased facility, and the burden of overpriced property is financially hampering efforts to correct the poor conditions of some of the other real estate. This case history suggests an urgent need for a critical review of practices and procedures not only of NYSARC, but those followed by OMRDD and FDC

as the governmental agencies responsible for reviewing and approving the lease, acquisition and renovation of real property to ensure that there are adequate safeguards to prevent wasteful expenditures of public funds.

Summary of Investigation Results

As a result of the Commission's investigation, OMRDD's investigation and reviews, the actions of the New York State Association for Retarded Children and the Niagara County District Attorney, the following actions have been taken:

1. An employee of NCARC was removed and subsequently indicted on two counts of sexual abuse (felony and misdemeanor). He pled guilty to the misdemeanor in full satisfaction of the indictment and thereafter cooperated in giving further information to the Commission and DA.
2. The NCARC Executive Director was removed by the Board of Directors at the insistence of the NYSARC Executive Committee. A new Executive Director has been appointed and has made some meaningful improvements in certain programs, although deficiencies exist in physical plant of some residences and program sites, day treatment programs, and handling of clients' personal funds. NYSARC has been actively monitoring these improvements.
3. New elections for Board of Directors' members have been held and this time a number of previously disenfranchised parents were elected.
4. Appropriate matters were referred to the NYSARC for further verification and correction, particularly in regard to greater scrutiny of real estate acquisition and leasing.
5. On June 12, 1984 OMRDD staff commenced an audit of NCARC finances, real estate transactions, and client funds for the period January 1, 1980 through December 31, 1983.

Summary of Responses of Concerned AgenciesNYSARC

On May 24, 1984 the NYSARC forwarded an extensive response to the Commission's April 30, 1984 site visit report representing NYSARC's preliminary review of programs operated by NCARC and detailing extensive corrective measures including:

1. a 30-day takeover of the NCARC residential program to improve the health and safety of the residences;
2. recommending establishment of a separate NYSARC real estate management corporation;
3. initiating in-service training for NCARC residential staff in recording and documenting personal allowance accounts;
4. assisting the NCARC in finding a new day treatment site; and,
5. providing ongoing technical assistance.

OMRDD

At a June 22, 1984 meeting, members of the Commission and officials of OMRDD reached the following agreements on specific initiatives that are needed to better ensure system integrity:

1. Establishment of a process to make certain that the capability exists within licensed agencies to ensure that programs run properly. The process would minimally include a performance evaluation of agency executives by board members, OMRDD management reviews to identify poorly run agencies, policy guidelines on hiring executive directors, and scrutiny of the qualifications of agency management during OMRDD certification inspections.

2. Initiation of an annual training program for board of director officers and including as a certification requirement that such key officials be trained within one year of appointment. OMRDD agrees to consider allowing through rate making the reimbursement of personal liability insurance related to the management functions of governing boards.
3. Establishment of new policy for expeditious OMRDD response to threats of client abuse involving immediate and irreparable harm including use of judicial proceedings pursuant to the Mental Hygiene Law.
4. Development of a standard property lease for use by voluntary agencies defining landlord/ tenant responsibilities for repair and upkeep.
5. Development of an interagency memorandum of understanding providing for OMRDD to formally assume NYS Department of Social Services' responsibilities for establishing standards for the use of OMRDD client personal funds to eliminate confusion as to how they should be spent and accounted for to ensure that there is adequate enforcement.
6. A complete review, commenced within a year, to be made either by outside consultants or State experts of existing OMRDD, Facilities Development Corporation, and private agency procedures and internal controls for acquiring, managing, leasing, and rehabilitating property. A steering committee composed of OMRDD, Office of Mental Health, Department of Audit and Control, Division of the Budget, Commission on Quality of Care for the Mentally Disabled, and major provider agencies would be appointed to oversee the study.
7. OMRDD, particularly the Division of Quality Assurance, will develop specific procedures and forms for incident review and reporting by voluntary agencies.

training program will be made available to the special incident review committees of licensed facilities in the future and offered on a periodic basis. OMRDD will develop policy guidelines for hiring senior management of voluntary agencies, institute performance based management review of voluntary agencies (to include senior executive management staff) and arrange for annual training conferences for officers of the board of directors.]

4. expand financial audits to include all clients' accounts where there may be evidence of questionable withdrawals or systemic deficiencies;

[OMRDD routinely reviews clients' allowance accounts as part of a full agency audit (i.e., the entire agency and all programs). On other occasions it receives and responds to requests to specifically review clients' allowance accounts. Current OMRDD auditing policy is to expand the audit scope where there is evidence of questionable practices concerning client allowance accounts and address these issues for legal resolution where applicable. Therefore, OMRDD believes it is currently in compliance with this recommendation.]

5. clarify policy between DSS and OMRDD with regard to responsibility over personal allowances and give consideration to further referral to the Deputy Attorney General for Medicaid Fraud and/or the DA for criminal investigation. These agencies should also work with federal agencies to establish a clear fiduciary standard for representative payees, service providers and others who receive payments on behalf of clients unable to manage such funds (see, Facilities as Fiduciaries, CQC report, June 1984, p. 62);

[Pursuant to Section 131-o of the Social Services Law, the Department of Social Services has primary responsibility for monitoring the requirements with respect to personal allowances for individuals in residential facilities who received additional State payments under the Supplemental Security Income program. DSS has legal authority to investigate complaints, supply information and enforce payment of personal allowances in facilities under the jurisdiction of other State agencies. Although there is nothing to clarify regarding this authority, DSS can delegate these powers, pursuant to a memorandum of understanding, to other State agencies (i.e., OMRDD) to monitor residential facilities under their respective jurisdiction.]

This matter has been referred to DSS but no memorandum of understanding regarding delegation of authority yet exists. Such a memorandum of understanding would necessarily involve resource and workload analyses and transfers, as appropriate, and some detailed protocols for referrals, investigation, reports and recovery action. OMRDD will endeavor to take over DSS responsibility for monitoring and auditing personal allowance accounts in private residence programs.]

6. promulgate regulations to establish a code of ethics applicable to holders of operating certificates which address issues such as business practices among related parties and standards of behavior for employees of the licensee toward clients. This recommendation was previously made by the Commission to OMRDD (see Profit v. Care, CQC report, March 1981, at p.83);

[OMRDD has previously discussed and considered the establishment of a more comprehensive code of ethics, but believes that the legal difficulties and complexities involved in legislating such a code of ethics and making it binding on the complex array of corporate entities and individual persons necessary would be largely unworkable. At OMRDD's suggestion, the Commission will assist in exploring an acceptable alternative code of ethics.]

7. create an annual training program for the president and officers of boards of directors and for special incident review committees of licensed facilities, which includes instruction as to their legal, ethical and fiduciary obligations; compliance with rules and regulations; and, responsibilities to safeguard the rights of clients and residents and to ensure an appropriate quality of care. Attendance at such training programs by the president and officers should be made a condition of certification or recertification.

[OMRDD on January 18, 1984 sent memoranda to the presidents of governing bodies of each certified provider to clarify and specifically delineate their respective roles and responsibilities. In addition, the same memoranda identified areas which OMRDD considers significant and crucial to the survey process in evaluating the proper functioning of the governing body and adherence to regulatory requirements.

Annual training programs, coupled with the preparation of technical assistance packages and numbered memorandum, should help board members to develop the skills necessary to fulfill the legal and ethical obligations inherent in board membership.]

2. Initiation of an annual training program for board of director officers and including as a certification requirement that such key officials be trained within one year of appointment. OMRDD agrees to consider allowing through rate making the reimbursement of personal liability insurance related to the management functions of governing boards.
3. Establishment of new policy for expeditious OMRDD response to threats of client abuse involving immediate and irreparable harm including use of judicial proceedings pursuant to the Mental Hygiene Law.
4. Development of a standard property lease for use by voluntary agencies defining landlord/ tenant responsibilities for repair and upkeep.
5. Development of an interagency memorandum of understanding providing for OMRDD to formally assume NYS Department of Social Services' responsibilities for establishing standards for the use of OMRDD client personal funds to eliminate confusion as to how they should be spent and accounted for to ensure that there is adequate enforcement.
6. A complete review, commenced within a year, to be made either by outside consultants or State experts of existing OMRDD, Facilities Development Corporation, and private agency procedures and internal controls for acquiring, managing, leasing, and rehabilitating property. A steering committee composed of OMRDD, Office of Mental Health, Department of Audit and Control, Division of the Budget, Commission on Quality of Care for the Mentally Disabled, and major provider agencies would be appointed to oversee the study.
7. OMRDD, particularly the Division of Quality Assurance, will develop specific procedures and forms for incident review and reporting by voluntary agencies.

RECOMMENDATIONS

The Commission recommends* that the Office of Mental Retardation and Developmental Disabilities should:

1. either through private consultants or with State experts critically examine existing policies and procedures for review and approval of real property transactions, including purchases, leases and renovations, to ensure prudent expenditures of public funds;

[OMRDD maintains it followed established practices. It received approvals of property and rent studies by real estate experts. The procedures used in reviewing acquisitions and leases are said to be consistent with statewide policies. Nevertheless, OMRDD points out important areas of real estate that need to be improved (e.g., review of voluntary agency lease agreements, disclosure statements on ownership, review of property transactions of "flat rate" funded programs, standard leases, code enforcement, site selection procedures, and arm's length reviews). It also agreed at a June 22, 1984 meeting with the Commission to the need for a complete review of the current system of acquiring, leasing, and managing real estate.]

2. expand audits to review real property historical cost data, returns on equity to owner, and lease terms to assure that excessive benefits are not accruing to property owners. OMRDD audits should also scrutinize agency exempt income, voluntary contributions and costs of "flat rate" funded

*OMRDD responses to the recommendations are included in brackets.

programs for consistency with client need and corporate charter;

[OMRDD indicates that it currently examines historical costs if a less-than-arm's length transaction is identified during the course of an audit. It proposes, however, to expand future audits to cover appraisals on acquisition and rent studies on leases to ensure they meet new arm's length procedures. It claims also to audit exempt income and voluntary contributions, but only to be certain they are properly recorded. Because of staffing limitations, audits of flat rate funded programs would be conducted only if discrepancies are found during program reviews.]

3. assure that reports of serious, untoward incidents related to the care and treatment of clients are sent to and receipt acknowledged by the president of the board of directors. Thereafter, the president should approve on behalf of the full board the plan of correction and provide evidence that the matter has been considered at a meeting of the full board;

[Regulatory requirements of OMRDD place responsibility for overall incident management with the agency's governing body which may, in turn, delegate oversight responsibility for this aspect of the program operation to an Incident Review Committee. Essentially, these regulations require that each certified program delineate appropriate incident policies and procedures which include the definition, management, review and reporting of all untoward incidents.]

As an adjunct to the regulatory requirements referenced above, the Division of Quality Assurance recently issued several administrative memoranda primarily directed toward further enunciation of the roles and responsibility of the governing body in the overall operation of a program. A grant proposal is currently being prepared to develop a special training program on investigative skills necessary for investigating incidents by OMRDD. A shorter version of this

training program will be made available to the special incident review committees of licensed facilities in the future and offered on a periodic basis. OMRDD will develop policy guidelines for hiring senior management of voluntary agencies, institute performance based management review of voluntary agencies (to include senior executive management staff) and arrange for annual training conferences for officers of the board of directors.]

4. expand financial audits to include all clients' accounts where there may be evidence of questionable withdrawals or systemic deficiencies;

[OMRDD routinely reviews clients' allowance accounts as part of a full agency audit (i.e., the entire agency and all programs). On other occasions it receives and responds to requests to specifically review clients' allowance accounts. Current OMRDD auditing policy is to expand the audit scope where there is evidence of questionable practices concerning client allowance accounts and address these issues for legal resolution where applicable. Therefore, OMRDD believes it is currently in compliance with this recommendation.]

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[Pursuant to Section 131-o of the Social Services Law, the Department of Social Services has primary responsibility for monitoring the requirements with respect to personal allowances for individuals in residential facilities who received additional State payments under the Supplemental Security Income program. DSS has legal authority to investigate complaints, supply information and enforce payment of personal allowances in facilities under the jurisdiction of other State agencies. Although there is nothing to clarify regarding this authority, DSS can delegate these powers, pursuant to a memorandum of understanding, to other State agencies (i.e., OMRDD) to monitor residential facilities under their respective jurisdiction.]

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6. promulgate regulations to establish a code of ethics applicable to holders of operating certificates which address issues such as business practices among related parties and standards of behavior for employees of the licensee toward clients. This recommendation was previously made by the Commission to OMRDD (see Profit v. Care, CQC report, March 1981, at p.83);

[OMRDD has previously discussed and considered the establishment of a more comprehensive code of ethics, but believes that the legal difficulties and complexities involved in legislating such a code of ethics and making it binding on the complex array of corporate entities and individual persons necessary would be largely unworkable. At OMRDD's suggestion, the Commission will assist in exploring an acceptable alternative code of ethics.]

7. create an annual training program for the president and officers of boards of directors and for special incident review committees of licensed facilities, which includes instruction as to their legal, ethical and fiduciary obligations; compliance with rules and regulations; and, responsibilities to safeguard the rights of clients and residents and to ensure an appropriate quality of care. Attendance at such training programs by the president and officers should be made a condition of certification or recertification.

[OMRDD on January 18, 1984 sent memoranda to the presidents of governing bodies of each certified provider to clarify and specifically delineate their respective roles and responsibilities. In addition, the same memoranda identified areas which OMRDD considers significant and crucial to the survey process in evaluating the proper functioning of the governing body and adherence to regulatory requirements.

Annual training programs, coupled with the preparation of technical assistance packages and numbered memorandum, should help board members to develop the skills necessary to fulfill the legal and ethical obligations inherent in board membership.]



