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DEPARTMENT OF CHILDREN AND FAMILIES

Oversight and Administration of State Mental Health Treatment Facilities

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Auditor General

Department of Children and Families

The Department of Children and Families is established by Section 20.19, Florida Statutes. The head of the Department is the Secretary who is appointed by the Governor and subject to confirmation by the Senate. Mike Carroll served as Department Secretary during the period of our audit.

The team leader was Sabrina Ballew, CPA, and the audit was supervised by Lisa Norman, CPA.

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DEPARTMENT OF CHILDREN AND FAMILIES

Oversight and Administration of State Mental Health Treatment Facilities

SUMMARY

This operational audit of the Department of Children and Families (Department) focused on the oversight and administration of State Mental Health Treatment Facilities (Facilities) and the oversight of the Sexually Violent Predator Program (SVPP) Facility. The Facilities include three Department-managed Facilities and four contractor-managed Facilities. We performed audit procedures at the Department and the three Department-managed Facilities: Florida State Hospital, North East Florida State Hospital, and the North Florida Evaluation and Treatment Center. Our audit disclosed the following:

Department Oversight and Monitoring of Facilities

Finding 1: The Department did not ensure that all Facilities were licensed by the Agency for Health Care Administration in accordance with State law.

Finding 2: The Department's oversight of Department-managed Facilities needs enhancement to ensure that the standard of care for all clients is met and the Facilities comply with State law, Department rules, and Department procedures.

Finding 3: The Department's monitoring of contractor-managed Facilities and the SVPP Facility was not always adequate to ensure that all key contract requirements were subject to monitoring or that adequate supervisory review of monitoring efforts was documented.

Finding 4: The Department did not always ensure that square footage information for Department-managed Facilities was accurately reported in the Florida State-Owned Lands and Records Information System.

Administration of Department-Managed Facilities

Finding 5: Department-managed Facilities staff did not always prepare required incident reports or report to the Department critical events involving clients and staff in accordance with Department procedures.

Finding 6: Department-managed Facility procedures did not specify the factors to be considered in determining minimum staffing coverage or how frequently minimum staffing levels should be evaluated and updated. Additionally, Department-managed Facilities did not always meet minimum staffing requirements.

Finding 7: Department-managed Facilities did not always ensure that pharmaceuticals were properly secured or that pharmacy duties were appropriately separated.

Finding 8: Department-managed Facility controls for accurately and appropriately accounting for pharmaceuticals need enhancement.

Finding 9: Department-managed Facilities did not always properly account for or safeguard seized contraband.

Finding 10: Department-managed Facilities did not always ensure that expenditures were authorized by State law, adequately supported, properly calculated, or subject to appropriate approval.

Finding 11: Department-managed Facility controls did not always ensure that expenditures were appropriately coded or accounted for.

Finding 12: Department-managed Facilities did not always allocate costs in a manner that accurately identified the costs to provide civil and forensic services.

Finding 13: Florida State Hospital and North East Florida State Hospital controls for appropriately accounting for tracking and detection canines need enhancement.

BACKGROUND

State law[1] provides that the Department of Children and Families (Department) is to work in partnership with local communities to protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency. State law also specifies that the Department is responsible for providing various services, including services related to adult protection, substance abuse, and mental health.

Pursuant to State law,[2] the Department is the State's mental health authority and is responsible for planning, evaluating, and implementing a complete and comprehensive Statewide program of mental health. The Department's responsibilities include supervising the mental health programs of, and the treatment of patients at, community facilities, and supervising other facilities for persons who have a mental illness and any agency or facility providing mental health services to patients.

As reflected in ***EXHIBIT A*** to this report, during the period July 2014 through January 2016, the Department managed three State Mental Health Treatment Facilities (Facilities) and contracted for the management of four other Facilities. The Department and its contractors provided services to forensic and civil clients through the Facilities. Forensic clients are defendants who have been determined to be incompetent to proceed to any material stage of a criminal proceeding due to mental illness or adjudicated not guilty of a felony by reason of insanity.[3] Civil clients are persons voluntarily or involuntarily admitted to a Facility pursuant to the Florida Mental Health Act[4] for evaluation or treatment of mental, emotional, or behavioral disorders. The Department, Forensic Admissions Office, is responsible for coordinating the admission of forensic clients to the Florida State Hospital (FSH), the North Florida Evaluation and Treatment Center (NFETC), the South Florida Evaluation and Treatment Center, and the Treasure Coast Forensic Treatment Center (TCFTC). Civil clients are admitted, based on available beds, by staff at the FSH, Northeast Florida State Hospital (NEFSH), South Florida State Hospital, and the West Florida Community Care Center.

[1] Section 20.19, Florida Statutes.

[2] Section 394.457(1) and (2)(a), Florida Statutes.

[3] Section 916.106(7) and (9), Florida Statutes.

[4] Part 1, Chapter 394, Florida Statutes. This part is also known as the Baker Act.

State law[5] also provides that State attorneys may refer individuals to the Department for civil commitment proceedings if the individual is required to register as a sexual offender pursuant to State law,[6] has previously been convicted of a sexually violent offense as defined in State law,[7] and has been sentenced to a term of imprisonment in a county or municipal jail for any criminal offense. The Department established the Sexually Violent Predator Program (SVPP) to facilitate the screening and evaluation of referred individuals to determine whether the individual should be recommended for civil commitment as a sexually violent predator. The Department contracts for the management of the SVPP Facility, which is located in Arcadia, Florida.

According to Department records, expenditures for the three Department-managed Facilities during the 2015-16 fiscal year totaled approximately $196 million and Department expenditures related to the four contractor-managed Facilities and the SVPP Facility totaled approximately $107 million. Table 1 shows, by facility type, Department expenditures for the 2012-13 through 2015-16 fiscal years. Table 2 shows, for each Department-managed Facility, expenditures by category for the 2015-16 fiscal year.

Table 1
Expenditures by Type of Facility
For the 2012-13 Through 2015-16 Fiscal Years

Type of Facility	2012-13	2013-14	2014-15	2015-16
Department-managed Facilities	$191,267,840	$201,997,090	$200,732,542	$195,583,504
Contractor-Managed Facilities	79,773,436	79,293,476	80,967,677	82,425,777
SVPP Facility	24,690,529	23,460,194	24,733,071	24,634,209
Totals	**$295,731,805**	**$304,750,760**	**$306,433,290**	**$302,643,490**

Source: Department financial records.

Table 2
Department-Managed Facility Expenditures by Category
For the 2015-16 Fiscal Year

Expenditure Category	Florida State Hospital	Northeast Florida State Hospital	North Florida Evaluation and Treatment Center
Salaries and Related Expenses	$ 89,337,790	$54,941,032	$19,390,593
Contracted Services	11,009,369	4,645,823	979,666
Pharmaceuticals	5,966,560	4,077,850	690,589
Food Services	1,835,647	1,335,953	370,779
Other	502,961	472,515	26,377
Totals	**$108,652,327**	**$65,473,173**	**$21,458,004**

Source: Department financial records.

[5] Section 394.9125(2), Florida Statutes.

[6] Section 943.0435, Florida Statutes.

[7] Section 394.912(9)(a) through (h), Florida Statutes.

FINDINGS AND RECOMMENDATIONS

DEPARTMENT OVERSIGHT AND MONITORING OF FACILITIES

As discussed in the ***BACKGROUND*** section of this report, the Department is responsible for the operation of seven State Mental Health Treatment Facilities (Facilities) and the Sexually Violent Predator Program (SVPP) Facility. The Department directly manages three Facilities and contracts for the management of four Facilities and the SVPP Facility. During the period July 2014 through July 2016, the Department's Contract Oversight Unit (COU) conducted programmatic and administrative monitoring of the contractor-managed Facilities, the Department assigned to the State Mental Health Treatment Facilities section oversight responsibility for the Department-managed Facilities, and each Facility had a Hospital Administrator who oversaw Facility operations. As reflected in ***EXHIBIT B*** to this report, in July 2016, the Department established the position of Chief Hospital Administrator to manage the operations of Department-managed Facilities through a "one hospital" approach. The State Mental Health Treatment Facilities section continued to oversee policy matters for Department-managed Facilities.

As part of our audit, we evaluated Department controls and processes for overseeing the seven Facilities and the SVPP Facility. As subsequently described, our audit procedures disclosed that improvements were necessary to ensure that all of the Facilities are licensed in accordance with State law, the Facilities and the SVPP Facility are appropriately monitored, and the square footage for Department-managed Facilities is accurately reported.

Finding 1: Facility Licensure

State law[8] specifies that hospitals[9] operating in the State must obtain licensure from the Agency for Health Care Administration (AHCA). The purpose of licensure is to protect public health and safety in the establishment, construction, maintenance, and operation of hospitals and ensure that hospitals comply with the standards of safety and quality established by State and Federal regulations. Licenses issued by AHCA identify the services to be provided and the number of beds authorized for the facility.

State law[10] contemplates that hospitals include institutions providing mental health services in that it specifies that adherence to patient rights, standards of care, and the examination and placement procedures provided by State law[11] is a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment. Pursuant to AHCA rules,[12] licensed hospitals are to be subjected to annual inspections by AHCA to determine

[8] Section 395.003(1)(a), Florida Statutes.

[9] Section 395.002(12), Florida Statutes, defines a hospital to include any establishment that offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease or pregnancy. Hospitals also include any establishment that regularly makes available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent.

[10] Section 395.003(5)(a), Florida Statutes.

[11] Part 1, Chapter 394, Florida Statutes.

[12] Agency for Health Care Administration Rule 59A-3.253, Florida Administrative Code.

whether the hospital is operating in compliance with licensure requirements or, in lieu of an annual licensure inspection, a hospital is to be appropriately accredited.

As part of our audit, we inquired of Department management and examined AHCA licensing records to determine whether the Department maintained for each of the seven Facilities the required license from AHCA. Our audit procedures disclosed that the Department had not obtained licensure for the NFETC, TCFTC, and two FSH residential buildings. As of January 2017, the bed capacities of the NFTEC and TCFTC were 193 and 208, respectively, and the bed capacities of the two unlicensed FSH residential buildings totaled 435. In response to our audit inquiry, Department management indicated that these Facilities and residential buildings were not licensed because the physical structures did not meet the building code standards, including fire code, required for hospital licensure and that updating the Facilities would be cost prohibitive.

The licensure of Facilities promotes public health and safety by ensuring that the minimum standards and operating requirements established by State and Federal regulations are met. Although we noted that the NFETC, TCFTC, and FSH were each accredited by recognized accreditation organizations, and that Facility management made significant efforts to protect the health and safety of residents and staff at the NFETC, TCFTC, and FSH, such efforts do not substitute for the assurances provided by licensure.

Recommendation: We recommend that Facility management continue efforts to the protect the health and safety of residents and staff and take appropriate actions to comply with the applicable standards of safety and quality established by State and Federal regulations. We also recommend that Department management, in consultation with the Legislature, evaluate the licensure needs for the NFETC, TCFTC, and FSH.

Follow-Up to Management's Response

Department management indicated in their written response that the NFETC and TCFTC, as well as the 435 beds at the FSH, were not required to be used as hospitals per Chapter 394 regarding forensic psychiatric treatment. Additionally, Department management indicated that all clinical services are delivered to residents who are in AHCA-licensed beds as required by law. However, our audit procedures, including observations at the Department's Facilities, indicated that clinical services, such as diagnostic, treatment, and therapeutical services, were provided to residents in beds that were not licensed by AHCA. Also, as noted in our finding, our audit procedures disclosed that the Department had not obtained licensure for the NFETC, TCFTC, and two FSH residential buildings pursuant to either Chapter 395, Florida Statutes, as hospitals, or Chapter 394, Florida Statutes, as residential treatment facilities. Consequently, the finding and related recommendation that Department management, in consultation with the Legislature, evaluate the licensure needs for the NFETC, TCFTC, and FSH, stand as presented.

Finding 2: Oversight of Department-Managed Facilities

State law[13] specifies that the Department is responsible for establishing standards, providing technical assistance, and supervising mental health programs, including the treatment of patients at the State's seven Facilities. Our examination of Department procedures disclosed that, while the Department had

[13] Section 394.457(2)(a), Florida Statutes.

established general procedures governing the operation of Department-managed Facilities, the Department deferred to each Facility the responsibility to adopt specific procedures to implement the Department's general guidelines. For example, and as discussed further in Finding 6, while the Department had established procedures[14] for maintaining minimum Facility staffing coverage,[15] the procedures provided that each Hospital Administrator or designee was responsible for determining minimum coverage and did not specify the methodology Facilities were to use to determine minimum staffing coverage or when Facility procedures should be updated for certain circumstances and according to a specified time frame. In addition, in response to our audit inquiry, Department management indicated that the Facilities' procedures were not subject to Department review and approval.

Our audit also disclosed that the Department's oversight of Department-managed Facilities was limited to reviewing specific incidents, such as mortalities, and that the Department had not established a formal monitoring process to determine whether the Facilities operated in accordance with Department and Facility procedures. In response to our audit inquiry, Department management indicated that the Department had previously performed quality assurance reviews of the Facilities, but ceased conducting the reviews when the Facilities gained accreditation through the Commission on Accreditation of Rehabilitation Facilities International (CARF).[16] However, CARF accreditation reviews are conducted only once every 3 years and are not a substitute for Department oversight.

Additional Department oversight, such as reviewing and approving all Department-managed Facility procedures and periodic monitoring of Department-managed Facilities, would help ensure that the standard of care for all clients is met and the Facilities comply with State law, Department rules, and Department procedures. The absence of sufficient Department oversight may also have contributed to the deficiencies noted in Findings 5 through 13.

Recommendation: To ensure the establishment of adequate and consistent procedures, we recommend that Department management review and approve all Department-managed Facility procedures. We also recommend that Department management establish procedures for conducting periodic monitoring of Department-managed Facilities to ensure that the Facilities operate in accordance with State law, Department rules, and Department procedures.

Finding 3: Monitoring of Contractor-Managed Facilities and the SVPP Facility

State law[17] requires the Department to establish a contract monitoring unit and a monitoring process that includes, but is not limited to, performing a risk assessment at the start of each fiscal year and preparing an annual contract monitoring schedule that considers the level of risk assigned; preparing a contract monitoring plan that includes sampling procedures and a description of the programmatic, fiscal, and administrative components that will be monitored on-site; and providing a written report presenting the results of the monitoring within 30 days after the completion of the on-site monitoring. Pursuant to State

[14] Department Operating Procedure CFOP 155-29, *Management of Minimum Coverage in State Mental Health Treatment Facilities*.

[15] Department Operating Procedure CFOP 155-29 defined minimum staffing as the lowest number of direct care staff required to operate a ward, residence, or unit to support a safe and therapeutic environment that met the needs of the residents.

[16] CARF International is an independent, nonprofit accreditor of health and human services in areas such as behavioral health and child and youth services.

[17] Section 402.7305(4), Florida Statutes.

law, the Department created the Contract Oversight Unit (COU) to perform programmatic and administrative monitoring of contracted entities. Additionally, Department contract managers performed contract monitoring and issued monitoring reports.

Effective contract management requires the monitoring of contractor performance to determine compliance with contract provisions and includes supervisory review of monitoring reports and related monitoring tools to ensure the appropriate communication of monitoring results. As part of our audit, we examined Department records for four of the ten on-site monitoring reports issued during the period July 2014 through January 2016 related to the four contractor-managed Facilities and the SVPP Facility.[18] Our examination disclosed that Department monitoring efforts were not always adequate to ensure that all key contract requirements were subject to monitoring or that adequate supervisory review of monitoring efforts was always documented. Specifically, we noted that:

- The Department's monitoring activities did not include an evaluation of compliance with contract requirements related to the provision of medical, dietary, and clinical pharmacy services. Additionally, the Department's monitoring activities did not include an evaluation of the Facilities' compliance with contractually required incident reporting procedures and a determination of whether incidents, such as deaths, escapes, and elopements, had been reported as required. According to Department management, the COU established the monitoring scope using a core set of items universally applied to all contracts and, for some programs, added a programmatic core set of items for a particular program or service. However, the COU had not developed a programmatic core set of items for the Facility and SVPP Facility contracts.
- Department records did not evidence adequate supervisory review of the monitoring efforts related to one COU and two contract manager reports. For example, there was no evidence of a comparison of the completed monitoring tools to the monitoring reports.

The monitoring of all key contract requirements would better enable the Department to demonstrate that contractor-managed Facilities and the SVPP Facility are operating in accordance with applicable legal, contractual, and other requirements. In addition, maintaining evidence of adequate supervisory review of monitoring efforts would better demonstrate the sufficiency of the monitoring performed and the appropriateness of the conclusions made.

Recommendation: We recommend that Department management enhance procedures for monitoring contractor-managed Facilities and the SVPP Facility to ensure that the monitoring scope includes all key contract requirements. Additionally, Department management should ensure that adequate supervisory review of Facility monitoring efforts is documented in Department records.

Finding 4: Facility Property Records

In 2010, the Legislature directed[19] the Department of Environmental Protection (DEP) to create, administer, and maintain a comprehensive real property database of all State lands and real property leased, owned, rented, or otherwise occupied and maintained by a State agency, the judicial branch, or water management district. Pursuant to State law,[20] the Department of Management Services (DMS) is

[18] The reports examined included a COU and contract manager report on the SVPP Facility and a COU and contract manager report on SFSH.

[19] Chapter 2010-280, Laws of Florida.

[20] Section 216.0152, Florida Statutes.

responsible for maintaining an automated inventory of all facilities owned, leased, rented, or otherwise occupied or maintained by a State agency, the judicial branch, or water management district. Accordingly, the DEP and the DMS collaborated to establish the Florida State-Owned Lands and Records Information System (FL-SOLARIS).

FL-SOLARIS is designed to record State-owned facility data such as square footage, construction year, and description, and provide a mechanism for State agencies to annually identify and report real property and facilities recommended for sale or other actions. State agencies are to report facility information in FL-SOLARIS on or before July 1st each year and the Department, Office of General Services, is responsible for entering information into FL-SOLARIS for all Department-owned facilities, including FSH, NEFSH, and NFETC. The DEP, in coordination with the DMS, is to utilize the reported information to submit an annual report to the Governor, the President of the Senate, and Speaker of the House of Representatives, listing the State-owned real property and surplus buildings recommended for disposition.

As part of our audit, we examined Department records, including insurance certificates and supporting worksheets, for 20 of the 290 permanent buildings located at the FSH, NEFSH, and NFETC to determine whether Department property information was correctly reported in FL-SOLARIS. Our examination disclosed that, the Department reported in FL-SOLARIS for both the 2014-15 and 2015-16 fiscal years, a total of 36,241 square feet for 8 buildings (3 at the FSH, 1 at the NEFSH, and 4 at the NFTEC) that was not supported by Department records. Specifically, although square footage of 228,079 was recorded in FL-SOLARIS, according to Department records, these 8 buildings comprised a total of 191,838 square feet.

In response to our audit inquiry, Department management indicated that the Department had not established policies and procedures for maintaining facility data in FL-SOLARIS. The accurate reporting of State-owned facility information is necessary for Department management to demonstrate compliance with State law and appropriately assess the utilization of space at the FSH, NEFSH, NFETC, and other Department-maintained properties.

Recommendation: We recommend that Department management establish policies and procedures for maintaining facility data in FL-SOLARIS and ensure that facility information reported in FL-SOLARIS is supported by Department records.

ADMINISTRATION OF DEPARTMENT-MANAGED FACILITIES

As part of our audit, we conducted on-site audit field work at the three Department-managed Facilities and performed various audit procedures to determine whether the Facilities were operating and administering mental health programs in accordance with applicable laws, rules, and other guidelines. These audit procedures included, but were not limited to, interviews of Facility management and staff, examination of selected Facility records and procedures, tests of Facility transactions and records, and various analytical procedures.

Finding 5: Incident Reporting

As part of its duty to protect the safety and welfare of Facility clients and staff, the Department established procedures[21] for identifying, reporting, and acting on all critical events.[22] Hospital administrators were required to report all critical events in accordance with Department procedures and take immediate steps to ensure the safety and welfare of any resident who was the victim of suspected abuse, neglect, or exploitation. Staff were required to report any known or observed critical events to the Hospital Administrator or designee, and individuals at any level of management were to report by telephone to the State Mental Health Treatment Facilities Director (Director)[23] or designee, all critical events involving escapes, elopements, or resident, staff, or other nonresident deaths within 1 hour of the event. All other critical events were to be reported by telephone to the Director within 24 hours of the event. If the Director or designee was unavailable, the Assistant Secretary for Substance Abuse and Mental Health was to be called. Department procedures required that verbal contact be made with either the Director, the Director's designee, or Assistant Secretary for all critical events. By the next business day following the critical event, Facility management was required to complete a *Critical Event Reporting* form (CF-MH 1061 form) and e-mail the form to the State Mental Health Treatment Facilities section designee.

In addition to Department procedures, each Facility established procedures that required reporting to Facility management other specified incidents, such as accidents, falls, chokings, assaults, injuries, the discovery of contraband, and property destruction. According to Facility records, 16,248 incident reports[24] were filed during the period July 2014 through January 2016. Table 3 presents, by Facility, the number of incident reports filed during the period July 2014 through January 2016, the average resident population for the 2015-16 fiscal year, and the average number of incidents per resident.

Table 3
Facility Incident Reporting

Facility	Number of Incident Reports Filed During the Period July 2014 Through January 2016	Average Resident Population for the 2015-16 Fiscal Year	Average Number of Incidents Per Resident
FSH	5,308	955	5.6
NEFSH	8,675	583	14.9
NFETC	2,265	192	11.8

Source: Department records.

[21] Department Operating Procedure No. 155-25, *Critical Event Reporting and Processing in State Mental Health Treatment Facilities*.

[22] Department Operating Procedure No. 155-25 defined critical events to include sexual battery; elopement (the unauthorized absence of a civil client); escape (the unauthorized absence of a forensic client); resident death; sexual misconduct; significant resident injury; significant injuries to staff resulting from resident-to-staff altercations; death of staff or other nonresident occurring on the grounds of a Facility; resident suicide attempt; abuse, neglect, or exploitation of a resident verified by an Adult Protective Services investigator, an investigator of the Inspector General's Office, or a law enforcement officer; and other major events not otherwise identified as a reportable critical event that had, or was likely to have had, a significant impact on clients, providers, or the Department.

[23] Effective August 5, 2016, Department Operating Procedure No. 155-25 was revised to require that critical events involving resident, staff, or other nonresident deaths and escapes be reported to the Chief Hospital Administrator within 1 hour of the incident.

[24] Incident report count includes critical events and other specified incidents required to be reported.

As part of our audit, we examined Facility records related to 130 incidents reported during the period July 2014 through January 2016, including 50 incidents at the FSH, 40 incidents at the NEFSH, and 40 incidents at the NFETC. Our examination disclosed that:

- Although FSH procedures[25] required a Resident Incident Report to be completed for all incidents,[26] FSH controls did not appear adequate to ensure that a Resident Incident Report was completed for all incidents. For example, as described below, our examination of workers' compensation claim documentation disclosed numerous instances where FSH staff did not prepare a Resident Incident Report. In addition, as reflected in Table 3, the average number of incidents per client at the FSH did not appear commensurate with the average number of incidents per client at the NEFSH and the NFETC.
- For 7 of the 11 critical events included in our testing at FSH, FSH management did not notify the Director of the critical event in accordance with Department procedures. Specifically, we noted that:
    - Neither the Director nor the Director's designee was notified by telephone within 24 hours of 4 critical events, including 2 suicide attempts and 2 verified incidents of abuse or neglect. Additionally, for one of the suicide attempts and one of the verified incidents of abuse or neglect, FSH submitted the CF-MH 1061 forms to the State Mental Health Treatment Facilities section designee 2 business days after the events, rather than 1 business day after the event as required by Department procedures.
    - For a verified incident of abuse or neglect, although FSH records indicated that the Director's designee had been notified of the critical event, the records did not evidence the manner of notification.
    - For 1 escape and 1 elopement, FSH management did not report the critical events to the Director or designee by telephone, or prepare and submit CF-MH 1061 forms. In response to our audit inquiry, FSH management indicated that at the time of the events the former Hospital Administrator and former Director had an unwritten agreement whereby, if a client left Facility grounds with the intent of returning, the event would not be classified as a critical event. As of April 2015, the Director began requiring that all unauthorized client absences from Facility grounds be reported as critical events.
- For 9 incidents at FSH, including one critical event, nursing staff did not complete the injury portion of the Resident Incident Report in accordance with FSH procedures.
- For 1 of the 4 critical events included in our testing at NEFSH, our examination disclosed that the CF-MH 1061 form and other NEFSH records did not evidence that the Director was notified of the client escape within 1 hour. In response to our audit inquiry, NEFSH management indicated that the employee managing the event was new and the Risk Manager had been out of the office.

To determine whether incident reports were filed as required, we also examined documentation related to 92 workers' compensation claims[27] involving injuries sustained by Facility employees during physical confrontations with residents. Our examination disclosed that, for 34 incidents at the FSH and 2 incidents at the NEFSH, Facility management had not prepared incident reports required by Department or Facility procedures. In response to our audit inquiry, FSH and NEFSH management indicated that incidents were not reported due to oversights by staff. FSH management also indicated that some incidents were

[25] FSH Operating Procedure No. 75-1, *Resident Injury/Event Reporting*.

[26] FSH Operating Procedure No. 75-1 defined an incident as any happening not consistent with the normal operation of the Facility or routine care and treatment of a resident which could result in a liability claim.

[27] The 92 workers' compensation claims related to injuries sustained during physical confrontations with residents and included 70 claims at the FSH, 12 claims at the NEFSH, and 10 claims at the NFETC.

not reported because the employees' injuries did not require medical attention. Notwithstanding FSH management's response, FSH procedures specified that Resident Incident Reports were to be completed for all resident-to-employee or employee-to-resident incidents that resulted in injuries.

Proper documentation and timely and appropriate reporting of incidents would provide Department and Facility management with the data needed to evaluate and help improve client and Facility staff safety.

Recommendation: We recommend that Department and Facility management enhance controls to ensure that incident forms are properly completed for all incidents in accordance with Department and Facility procedures. Additionally, we recommend that Facility management ensure that the appropriate Department personnel are timely notified of critical events in accordance with Department procedures.

Finding 6: Adequacy of Staffing

Sufficient staffing levels are necessary to ensure the delivery of high-quality mental health care services. While multiple, complex factors influence safe staffing levels, variables that affect staffing levels include the number of patients, the severity of the patients' mental and physical illnesses, nursing skill mix, physical environment, technology, and finances. Staffing plans should be developed that consider these variables and others and allow for shift-to-shift adjustments, as appropriate. Additionally, the staffing plan criteria should be periodically evaluated to ensure that safe, high-quality mental health care services are being provided.

To ensure adequate staffing at all times and provide a safe environment in which residents could live and staff could work, Department procedures[28] required Facilities to maintain minimum staffing coverage. The procedures specified that minimum staffing coverage was the fewest number of direct care staff required to operate a ward, residence, or unit to support a safe and therapeutic environment that met the needs of the residents, and that additional staff above the minimum level should be assigned to cover specialized therapeutic observations that required one-to-one staffing. Each Hospital Administrator or designee was responsible for making decisions regarding minimum staffing coverage and each Facility was required to establish an operating procedure that addressed the management of minimum staffing.

As part of our audit, we inquired of FSH, NEFSH, and NFETC management and examined Facility procedures related to minimum staffing coverage. Our audit procedures disclosed that the Facilities' procedures did not specify the factors to be considered to determine minimum staffing or how frequently minimum staffing levels should be evaluated and updated. In response to our audit inquiry, FSH management indicated that patient behavior and the number of patients per unit was considered when determining the minimum coverage needed per unit. NEFSH management indicated that they did not know how the staffing requirements had been developed, but the requirements had been the same for at least 12 years.

Our audit also included an examination of Facility staffing coverage records for the period July 2014 through January 2016. Our examination disclosed that minimum staffing requirements were not always met. Specifically, we found that:

[28] Department Operating Procedure CFOP 155-29, *Management of Minimum Coverage in State Mental Health Treatment Facilities*.

- FSH minimum staffing procedures[29] required each unit to maintain minimum coverage standards for each shift. However, FSH scheduling practices did not always take into consideration specialized therapeutic observations and security escorts that required additional staff. Our examination of 5 daily FSH staffing reports[30] for one unit and one shift each day disclosed that the selected units were understaffed by three staff for 2 of the days and understaffed by four staff another day.
- NEFSH minimum staffing procedures[31] required four staff to be assigned to each living area during day shifts, three staff to be assigned to each living area during evening and night shifts, and additional staff to be assigned for specialized therapeutic observations. Our examination of 3 weekly staff coverage summary reports disclosed that 173 of the 336 shifts were understaffed, on average, by three staff per shift. According to NEFSH management, the shifts were during the Facility's transition from 8-hour to 12-hour shifts and during this period, each unit acted as a stand-alone unit. Additionally, the Facility experienced staff retention and call-in issues, along with high levels of one-to-one staffing usage, which contributed to the staffing shortages.
- NFETC procedures[32] required four staff to be assigned to each three-pod building and three staff to be assigned to each two-pod building. Our examination of 3 weekly staff coverage summary reports disclosed that 11 of the 196 shifts were understaffed, on average, by one staff person per shift. In addition, for another 9 shifts, NFETC could not provide documentation, such as shift logs, to allow for a determination of whether minimum staff coverage requirements were met. In response to our audit inquiry, NFETC management indicated that budget cuts and staff turnover contributed to staffing shortages.

Absent procedures that specify the factors to be considered in determining minimum staffing coverage and require minimum staffing levels to be re-evaluated and updated for certain circumstances and according to a specified time frame, the Facilities have reduced assurance and cannot demonstrate that, when making minimum staffing decisions, Facility management considered all the relevant factors necessary to provide high-quality mental health care services and a safe environment in which residents can live and staff can work.

Recommendation: We recommend that Department management revise Department staffing procedures to provide Facility management with guidelines to consider when developing minimum staffing coverage and to identify the circumstances that would necessitate a review of minimum staffing levels. We also recommend that Facility management enhance procedures to specify the factors to be considered in determining minimum staffing, require periodic evaluation of staffing requirements, and take steps to ensure compliance with established staffing minimums.

Finding 7: Safeguarding of Pharmaceuticals

Each Facility maintained a licensed pharmacy that was responsible for purchasing and dispensing drugs, including controlled substances,[33] such as psychotropic medications, to Facility residents. Controls over pharmaceuticals are necessary to help prevent and detect the loss or theft of pharmaceuticals.

[29] FSH Operating Procedure No. 60-15, *Managing Minimum Coverage*.

[30] The 5 daily FSH staffing reports included 1 report from July 2014, 1 report from January 2015, and 3 reports from January 2016.

[31] NEFSH Operating Procedure No. 02-00-04, *Minimum Living Area Coverage*.

[32] NFTEC Operating Procedure TX-01, *Assuring Minimum Coverage*.

[33] Pursuant to Section 893.02(4), Florida Statutes, controlled substances include the substances named or described in Schedules I through V outlined in Section 893.03, Florida Statutes.

Accordingly, Facility pharmacies should have controls in place to ensure that access to pharmaceuticals is limited to authorized staff and to appropriately separate responsibilities for ordering, receiving, stocking, and dispensing of pharmaceuticals.

As part of our audit, we observed the controls in place at each Facility pharmacy and the process for ordering, receiving, and stocking pharmaceuticals. Our audit procedures disclosed that the Facilities did not always have appropriate controls in place to ensure that pharmaceuticals were properly secured and pharmacy duties were appropriately separated. Specifically:

- FSH procedures[34] required pharmacy management to maintain, in a box secured by a numbered disposable lock, emergency keys[35] to the pharmaceuticals and controlled substances storage areas. The secured box was to be located inside a cabinet accessible only by a pharmacist's key. However, we noted that, while the emergency keys were located in a box inside a locked cabinet, the box was not secured by a numbered disposable lock.
- At NEFSH, the pharmacy technician responsible for ordering pharmaceuticals, other than controlled substances, also received and stocked the pharmaceuticals.
- At NFETC, the two pharmacy technicians responsible for ordering pharmaceuticals, other than controlled substances, received and stocked the pharmaceuticals they each ordered and also filled pharmaceutical orders for the Facility. We noted that controlled substances were locked in the pharmacist's office and only the pharmacist had access to the substances; however, the pharmacist was also responsible for ordering and stocking the controlled substances.

Ensuring the proper security of pharmaceuticals and the effective separation of incompatible duties reduces the risk of pharmaceutical inventory loss and theft.

Recommendation: We recommend that Facility management ensure that pharmaceuticals are properly secured and that ordering, receiving, and stocking duties for pharmaceuticals are appropriately separated.

Finding 8: Pharmacy Inventory

Department of Health rules[36] require pharmacies that dispense controlled substances to maintain inventory records in accordance with Federal regulations.[37] In addition to the Federal requirements, controls related to controlled substances should include documentation of periodic physical inventory counts and the reconciliation of counts to records documenting purchases and distributions of pharmaceuticals.

During the 2015-16 fiscal year, the three Department-managed Facilities purchased pharmaceuticals totaling $10,734,999. Our examination and evaluation of Facility pharmacy records, procedures, and other controls disclosed that the Facilities had not established and maintained appropriate inventory management controls and records to accurately account for pharmaceuticals. Specifically, we found that:

[34] FSH Operating Procedure No. 150-1, *Pharmacy Inventory and Drug Control*.

[35] The emergency keys were to be used by the on-duty pharmacy technician for after-hours access to controlled substances and other pharmaceuticals.

[36] Department of Health, Board of Pharmacy, Rule 64B16-28.140, Florida Administrative Code.

[37] Title 21, Part 1304.04, Code of Federal Regulations.

- Although FSH procedures[38] required pharmacy staff to conduct quarterly physical inventory counts of the most commonly dispensed drugs and reconcile the counts to the perpetual inventory records, during the period July 2014 through January 2016, pharmacy staff conducted only two quarterly physical inventory counts (in December 2014 and December 2015) and did not reconcile the counts to FSH inventory records to identify the causes for noted discrepancies. Our examination of FSH records disclosed that the physical inventory counts for some pharmaceuticals differed significantly from the counts included in FSH inventory records. For example, the December 2015 physical inventory count disclosed differences between FSH inventory records and the physical counts of 2,840 tablets of three antipsychotic drugs costing $37,517, and 351 tablets of a HIV antiviral drug costing $14,144.
- The FSH utilized a contractor to conduct an annual physical inventory count of all pharmaceuticals for the 2013-14 and 2014-15 fiscal years. Our examination of FSH records disclosed that, as a result of the annual physical inventory counts, FSH made significant adjustments to the inventory records to reflect the results of the counts. Specifically, the total dollar value of FSH inventory records was increased by $560,535 (82 percent) for the 2013-14 fiscal year and $354,637 (32 percent) for the 2014-15 fiscal year. In response to our audit inquiry, FSH management indicated that the adjustments were necessary due to an ongoing issue with the perpetual inventory system that caused the system to record negative inventory levels for some drugs.
- Although FSH procedures required pharmacy management to approve all pharmaceutical inventory adjustments and report the adjustments to the Hospital Administrator, pharmacy management did not maintain documentation supporting the investigation of inventory differences and the reasons adjustments were made to FSH inventory records as a result of the physical inventory counts, nor had pharmacy management approved the adjustments or reported them to the Hospital Administrator. In response to our audit inquiry, pharmacy management indicated that documentation for and approval of the adjustments was not practicable due to the large number of adjustments caused by the inventory system issues.
- NEFSH and NFETC policies and procedures[39] did not establish reorder points for pharmaceutical inventories, the frequency of physical inventory counts, or instructions for receiving, stocking, and returning pharmaceuticals. In addition, neither the NEFSH nor NFETC utilized an automated inventory system or database to manage and account for pharmaceuticals and had not accumulated summary records of pharmaceuticals purchased, received, and stocked. Although NEFSH and NFETC management indicated that annual physical inventory counts had been conducted, the absence of an automated inventory system or database to manage and account for the pharmaceuticals on a continuous basis precluded management from appropriately accounting for the pharmaceuticals and utilizing the counts to identify inventory discrepancies to be investigated.

Utilization of an effective perpetual inventory system to account for pharmaceuticals would enable the Facilities to more accurately account for pharmaceuticals, establish appropriate reorder points based on usage, and assess inventory levels to reduce the risk of shortages and waste due to expiration. The establishment of procedures to effectively ensure that physical inventory counts are periodically performed as required, the results of physical inventory counts are reconciled to inventory records, and inventory adjustments are appropriately documented and approved, decreases the risk of waste, loss, theft, or unauthorized use of pharmaceuticals and help ensure the accuracy of inventory records.

[38] FSH Operating Procedure No. 150-1, *Pharmacy Inventory and Drug Control*.

[39] NEFSH Policy and Procedure Manual, *Pharmacy Services*, and NFETC Pharmacy Operating Procedure PH-01, *Pharmacist Duties*.

Recommendation: We recommend that Facility management take steps to maintain pharmaceutical records using a perpetual inventory system that establishes appropriate reorder points, accurately accounts for pharmaceuticals, and can be used to identify and investigate discrepancies noted during physical inventory counts. We also recommend that FSH management ensure that physical inventory counts are periodically performed in accordance with established procedures, differences between physical inventory counts and inventory records are appropriately investigated prior to adjusting inventory records, and all adjustments to inventory records are properly documented and approved.

Finding 9: Control of Contraband

The Department established procedures[40] for the control of contraband,[41] such as intoxicating beverages and firearms, at Department-managed Facilities. The procedures required that, for contraband found in the possession of a client which was not in violation of the law, Facility staff secure and store the contraband at the Facility until the client was discharged or, alternatively, Facility staff confiscate and liquidate the contraband. If contraband was found to be in violation of the law, Facility staff were required to immediately report the violation to the local law enforcement agency. To demonstrate that contraband is properly accounted for and disposed of, documentation should be maintained evidencing the receipt, storage, and disposition of the contraband, including the identity of witnesses to the disposition.

As part of our audit, we inquired of Facility management, evaluated Facility procedures, and examined records and items related to contraband seizures to evaluate the Facilities' accounting for and safeguarding of contraband items seized from employees, visitors, and clients. Our audit procedures disclosed that the Facilities' procedures were not effective to ensure the proper accountability for and safeguarding of contraband removed from the possession of clients. Specifically, we noted that:

- FSH procedures[42] did not require that records demonstrating the receipt, storage, and disposition of contraband be maintained. We examined FSH records related to 20 contraband seizures documented on the FSH Contraband Inventory Listing as of March 30, 2016, to determine whether the contraband was disposed of in accordance with Department procedures and found that:
  - 2 of the 10 contraband items that were to be returned to the client upon discharge had not been returned. In response to our audit inquiry, FSH management indicated that maintaining contraband items in multiple locations and county transports not taking client property back upon the client's release from the FSH may have contributed to the items not being returned.
  - For 8 of the 20 seizures, FSH management indicated that the related contraband items were disposed of after seizure. However, for 4 of the 8 seizures, FSH staff were unable to provide documentation demonstrating that the items, including a zip gun, cigars, and pills, had been disposed of.

[40] Department Operating Procedure CFOP 70-12, *Contraband Control*.

[41] CFOP 70-12 defines contraband as an item or article on State-owned or leased property, or in the possession of a client, employee, visitor, or other person on State-owned or leased property, to include intoxicating beverages, controlled substances as defined in Chapter 893, Florida Statutes, weapons as defined in Section 790.001(13), Florida Statutes, any instrument or device used or designed to be used as a dangerous weapon, or any item that has been specifically prohibited in writing by Department rule, Hospital Administrator, or designee.

[42] FSH Operating Procedure No. 95-4, *Contraband Control*.

We also selected from FSH contraband storage the items related to 7 contraband seizures made during the period July 2014 through January 2016 to determine whether the items were included on the FSH Contraband Inventory Listing and found that, for 3 of the 7 seizures selected from contraband storage, the items (e.g., cellular telephones, radios, and keys) were not included on the FSH Contraband Inventory Listing.

- NEFSH procedures[43] did not require the disposition of contraband items, such as medications and illegal drugs, to be witnessed or documented. Additionally, NEFSH records did not describe the contraband stored, indicate the date and manner of seizure, or, if disposed of, identify the persons witnessing the disposition. In response to our audit inquiry, NEFSH management indicated that the Facility's process of attaching a Security Activity Report to seized contraband provided sufficient accountability for the items. However, as the Security Activity Reports were not sequentially numbered or retained upon disposition of the contraband, the reports did not evidence that NEFSH staff had appropriately accounted for all contraband items.
- NFETC procedures[44] did not require the disposition of contraband, such as medications, to be witnessed or documented. We examined documentation related to 5 contraband seizures made during the period July 2014 through January 2016 to determine whether the seized items were disposed of in accordance with Department procedures or otherwise secured in contraband storage. We found that none of the items related to the 5 contraband seizures were located in contraband storage and NFETC management was unable to provide documentation demonstrating that the items had been disposed of. In response to our audit inquiry, NFETC staff indicated that the contraband storage was periodically emptied and that documentation of the disposals was not maintained.

  We also selected from NEFTC contraband storage the items related to 5 seizures to determine whether the items were included on the NFETC contraband log and found that a shank from 1 of the 5 seizures was not listed on the contraband log. Additionally, for 4 of the 5 seizures, the contraband items were not labeled to identify when the items were seized.

Appropriate procedures and records relating to contraband items seized by Facility staff would better enable Facility management to ensure and demonstrate that contraband items are properly accounted for, safeguarded, and, if applicable, disposed of.

Recommendation: We recommend that Facility management enhance procedures to ensure the proper accountability for and safeguarding of all seized contraband items. Such procedures should require Facility staff to maintain records describing the contraband, evidencing the date the contraband was seized and the date and manner of disposition, and identifying the witnesses to the disposal.

Finding 10: Appropriateness of Expenditures

To ensure the appropriateness of Department expenditures, Facility management should establish and implement controls, including controls designed to ensure that payments are made in accordance with State law and applicable Department procedures, adequately supported, properly calculated, and subject to appropriate approval.

As part of our audit, we examined Department records related to 130 expenditure transactions, totaling $1,645,775, made during the period July 2014 through January 2016, including 70 transactions at the FSH totaling $930,390, 40 transactions at the NEFSH totaling $537,872, and 20 transactions at the

[43] NEFSH Operating Procedure No. 17-01-02, *Traffic and Contraband Control*.

[44] NFETC Operating Procedure SEC-43, *Contraband*.

NFETC totaling $177,513. Our examination disclosed that Facility controls did not always ensure that expenditures were authorized by State law, adequately supported, properly calculated, or subject to appropriate approval. Specifically, we found that:

- For 1 expenditure transaction, NEFSH used general revenue funds to purchase resident Christmas presents totaling $11,229. In response to our audit inquiry, NEFSH management indicated that the transaction was authorized pursuant to statutory provisions[45] related to the rights of patients. However, the rights of patients enumerated in State law, which include the right to individual dignity and treatment and the right to express and informed patient consent, does not include authorization for the expenditure of general revenue funds for gifts or appear commensurate with respecting the rights of patients.
- For 1 expenditure transaction, FSH used welfare trust funds to purchase holiday decorations totaling $572 on behalf of clients of the Agency for Persons with Disabilities Developmental Disabilities Defendant Program (DDDP). However, State law[46] requires welfare trust funds to be used for the benefit, education, and welfare of Facility clients. In response to our audit inquiry, FSH management indicated that, since DDDP clients purchased items at the FSH canteens and gift shop, the proceeds from which were deposited in the welfare trust fund, FSH staff used welfare trust fund moneys to purchase the decorations for the DDDP clients.
- For a $3,315 expenditure transaction related to the purchase of tokens for use in NEFSH vending machines, NEFSH records did not evidence that the number of tokens invoiced were actually received.
- An FSH payment for medical services totaling $29,297 was not properly calculated. In response to our audit inquiry, FSH management indicated that they had an agreement with a regional hospital to pay the Medicaid per diem rate. However, the FSH utilized the incorrect Medicaid inpatient per diem rate to calculate the charges, resulting in the FSH overpaying the hospital $900.
- For 4 FSH expenditure transactions totaling $17,935, the requisitions were initiated and approved by the same FSH employee.

Ensuring that expenditures are authorized by State law, adequately supported, and properly calculated helps ensure and document that State resources are used appropriately. The appropriate separation of purchasing duties reduces the risk that inappropriate transactions may be initiated and approved by the same employee.

Recommendation: We recommend that Facility management ensure that expenditure transactions are authorized by State law, adequately documented, and properly calculated. We also recommend that Facility management ensure that purchasing duties are appropriately separated.

Finding 11: Accounting for Expenditures

State law[47] requires State agencies to record in the Florida Accounting Information Resource Subsystem (FLAIR) all invoices received, approve the invoices for payment, and file the invoices with the State's Chief Financial Officer[48] no later than 20 days after receipt of the invoices and receipt, inspection, and approval of the goods or services, except in the case of a bona fide dispute. If payment of an invoice is

[45] Section 394.459, Florida Statutes.

[46] Section 402.18, Florida Statutes.

[47] Section 215.422(1), Florida Statutes.

[48] Pursuant to Section 20.121, the State's Chief Financial Officer is the head of the Department of Financial Services (DFS).

not issued within 40 days after receipt of the invoice, State law[49] requires the agency to pay interest to the vendor on the unpaid balance.

The DFS issued guidance[50] specifying that, in the FLAIR Transaction Date field, State agencies are to record the later of the date the goods or services were received, inspected, and approved, or the date the invoice was received. For advance payments, State agencies are to record all zeros in the Transaction Date field. The DFS uses the FLAIR Transaction Date field to monitor State agency compliance with statutory prompt payment requirements and identify those transactions for which an agency would be required to pay interest. Our examination of Department records for 70 FSH expenditures transactions totaling $930,390, 40 NEFSH expenditure transactions totaling $537,872, and 20 NFETC expenditure transactions totaling $177,513 disclosed that the Facility staff did not always record transaction dates in FLAIR in accordance with DFS guidance. Specifically, we noted that:

- FSH staff incorrectly recorded the transaction dates in FLAIR for 16 expenditure transactions totaling $417,702. For each of the 16 transactions, the date FSH staff recorded in the FLAIR Transaction Date field differed from either the date the invoice was received or the receipt and approval date, resulting in the transactions being recorded from 4 days earlier to 18 days later than the transaction dates supported by FSH documentation. Had FSH staff correctly recorded the transaction date, the FSH would not have complied with the prompt payment requirements for 2 of the 16 transactions.
- NEFSH staff incorrectly recorded the transaction dates in FLAIR for 9 expenditure transactions totaling $141,279. For 1 of the 9 transactions, an advance payment, NEFSH recorded an actual date rather than all zeros. The transaction dates recorded by NEFSH for the other 8 expenditure transactions ranged from 4 days earlier to 8 days later than the transaction dates supported by NEFSH documentation.
- NFETC staff incorrectly recorded the transaction dates in FLAIR for 2 expenditure transactions totaling $14,230. For 1 of the 2 transactions, an advance payment, NFETC recorded an actual date rather than all zeros. For the other transaction, the date recorded in the FLAIR Transaction Date field was 6 days later than the date supported by NFETC documentation.

Our testing at the FSH also disclosed that, for 1 expenditure transaction for parts totaling $27,286 utilized to rebuild the engine of a Facility garbage truck, FSH staff did not capitalize or add the cost of the parts to the value of the truck in Department property records. For another expenditure transaction for employee recognition items totaling $1,097, FSH staff inadvertently paid for the items utilizing general revenue funds instead of Operations and Maintenance Trust moneys as required by Department procedures.[51]

Without accurate transaction dates, instances of noncompliance with prompt payment requirements may not be identified by the DFS and the Facilities may not make required interest payments. Additionally, effective controls over FSH expenditures increase management's assurance that expenditure transactions are appropriately recorded in FLAIR, paid from appropriate funding sources, and, as applicable, recorded in Department property records.

[49] Section 215.422(3)(b), Florida Statutes.

[50] Chief Financial Officer Memorandum No. 1 (2013-14).

[51] Department Operating Procedure CFOP 70-5, *Recycling Program*.

Recommendation: We recommend that Facility management enhance procedures to ensure that expenditure transactions are accurately recorded in FLAIR. We also recommend that FSH management enhance controls to ensure that expenditure transactions are appropriately recorded in FLAIR, paid from the appropriate funding sources, and, as applicable, recorded in Department property records.

Finding 12: Cost Allocation

Properly designed and executed cost allocation methodologies are essential to ensure Department management and the Legislature have adequate and accurate information related to the costs of Department programs. Such methodologies should provide for the proper identification of costs to be allocated and the use of allocation bases that reasonably associate costs with the program activities that receive the benefits from which the costs are derived. The Department's operating budget for contractor-managed Facilities is based on the costs of providing civil and forensic services, and the FSH, which provides both services, budgets based on the services costs. According to the Department's 2015-16 fiscal year Legislative Budget Request for the Department's contractor-managed Facilities, the costs per bed to operate a forensic facility were higher than the costs per bed to operate a civil facility.

As part of our audit, we inquired of Facility management, evaluated Facility procedures for allocating costs between civil and forensic services, and examined Facility records related to the allocation of expenditures between civil and forensic services. Our audit procedures disclosed that the Facilities did not always allocate costs in a manner that accurately identified the costs to provide civil and forensic services. Specifically, we noted that:

- As of September 1, 2015, the FSH housed both civil and forensic clients with an operating capacity of 490 beds for civil clients and 469 beds for forensic clients. FSH management indicated that the FSH annual operating budget, by category, was used to allocate costs between civil and forensic services. However, expenditures were not always allocated between civil and forensic services based on the established allocation percentage or the activity benefiting from the expenditure. Our examination of Department records for 70 FSH expenditure transactions, totaling $930,390, disclosed that, for 39 transactions totaling $706,197, expenditure amounts were not appropriately allocated or the allocations were not supported by FSH records. Specifically, we found that:
    - 5 expenditure transactions, totaling $363,979, were for the benefit of both forensic and civil clients, but FSH staff allocated each expenditure to only one of the two services. Items and services purchased included utilities, food, medical chairs, and training. In response to our audit inquiry, FSH management indicated that the determination of where to allocate the expenditure was based on where funds were available rather than how the items or services were to be used and, sometimes, FSH staff would alternate the allocation of recurring monthly expenditures between the forensic program and the civil program.
    - FSH staff evenly split 8 expenditure transactions, totaling $33,278, between forensic and civil services rather than allocating the expenditures in accordance with the category's established allocation percentage.
    - Documentation supporting the established allocation percentage for 20 expenditure transactions, totaling $275,939, could not be provided for our review.
    - FSH staff incorrectly allocated 6 expenditure transactions, totaling $33,001. For 4 of the transactions, totaling $20,871, FSH staff did not use the allocation percentages for the correct expense category. For the other 2 expenditure transactions, the use of incorrect percentages

resulted in an over-allocation of expenditure amounts to civil services totaling $5,327. In response to our audit inquiry, FSH management indicated that the 2 expenditure transactions were not appropriately allocated because of employee errors.

- The NEFSH (civil client services) and the NFETC (forensic client services) share several positions, including Chief Financial Officer, Accounting Director, and property custodian, although the positions are funded solely from the NEFSH operating budget. Additionally, NEFSH pharmacy staff assist NFETC staff when needed. In response to our audit inquiry, NEFSH management indicated that, while NEFSH provides administrative support to NFETC, the administrative costs are not allocated to NFETC. NEFSH management also indicated that the Facility had not developed a methodology to allocate the administrative costs because the costs were minimal and did not have a significant effect on the total cost of operating either Facility.

The proper allocation of costs would allow the Facilities to accurately identify and report costs related to civil and forensic services and provide more accurate information for decision-makers regarding funding.

Recommendation: We recommend that FSH management ensure that expenditure amounts are appropriately allocated between civil and forensic services and the basis for allocations is documented in FSH records. We also recommend that NEFSH and NFETC management develop a methodology to appropriately allocate the costs associated with administrative support provided by NEFSH to NFETC.

Finding 13: Accounting for and Management of Canines

Effective controls for the management of tangible personal property[52] require that property items be adequately controlled, safeguarded, and accounted for by Facility management. DFS rules[53] specify that State agencies are to record all tangible personal property with a value or cost of $1,000 or more and having a projected useful life of 1 year or more in the FLAIR Property Subsystem. DFS rules[54] also require the property records for all property items lawfully disposed of to include, among other things, the date of disposition, the authority for the disposition (e.g., agency resolution), and the manner of disposition.

At some point during the period July 2014 through January 2016, the FSH and the NEFSH had a total of nine tracking and detection canines in service or training. Generally, trained tracking and detection canines have values that exceed $1,000 and, as such, would be considered tangible personal property required to be recorded in the FLAIR Property Subsystem. As part of our audit, we inquired of FSH and NEFSH management regarding the processes and procedures used to account for and manage the tracking and detection canines and examined Department procedures and property records. Our audit procedures disclosed that FSH and NEFSH controls needed enhancement to ensure that tracking and detection canines are appropriately accounted for and managed. Specifically, we found that:

- Neither the FSH nor the NEFSH had established procedures to account for the receipt and retirement of tracking and detection canines. In addition, neither the FSH nor the NEFSH had established procedures for managing the use of privately owned canines on Department property or for prohibiting the use of Department resources, such as staff time and equipment, to train

[52] Property is defined in applicable laws and rules as State-owned equipment, fixtures, and other tangible personal property of a nonconsumable or nonexpendable nature, the value or cost of which is $1,000 or more and the projected useful life of which is 1 year or more.

[53] DFS Rule Chapter 69I-72.002, Florida Administrative Code.

[54] DFS Rule Chapter 69I-72.005(5), Florida Administrative Code.

privately owned canines. The absence of such procedures may have contributed to the use of Department resources to train privately owned canines at the FSH.

- Department procedures[55] specified that, as stewards of the public trust, Department employees were to use the powers and resources of the Department to further the public interest and not for any financial or personal benefit or privilege. Our audit procedures disclosed that four privately owned canines received training for either detection or search and rescue services at the FSH. Three of the canines served the FSH during the period July 2014 through January 2016; however, while the fourth canine received training at the FSH, it was never placed into service as its owner retired from State employment.
- Two detection canines donated to the FSH had not been recorded in Department property records. Additionally, one of these two detection canines retired with his handler in September 2015. However, FSH records did not evidence the authority for retiring the canine or document information such as the date and terms of retirement.
- The NEFSH did not record one detection canine in the Department's property records. In response to our audit inquiry, NEFSH management indicated that the canine had not been recorded in Department property records because, at the time of acquisition in July 2010, the canine's value was less than $1,000. However, after receiving training, the canine's value exceeded $1,000. Additionally, although the canine was retired from service in April 2016, the NEFSH did not obtain appropriate Department approval to retire the canine.

Absent effective controls for the management of tangible personal property, including tracking and detection canines, Facility management has reduced assurances regarding the information needed to accurately report and maintain property accountability over canines. Such controls also help to ensure that, in managing and training canines, Department resources are utilized for a public, rather than a private purpose.

Recommendation: We recommend that FSH and NEFSH management establish procedures to account for the receipt, management, use, and retirement of tracking and detection canines. We also recommend that FSH and NEFSH management enhance tangible personal property controls to ensure that Department property records include all tracking and detection canines in accordance with DFS rules, all canine retirements are appropriately authorized and documented, and Department resources are not used to train canines that will not serve an authorized public purpose.

OBJECTIVES, SCOPE, AND METHODOLOGY

The Auditor General conducts operational audits of governmental entities to provide the Legislature, Florida's citizens, public entity management, and other stakeholders unbiased, timely, and relevant information for use in promoting government accountability and stewardship and improving government operations.

We conducted this operational audit from December 2015 through August 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[55] Department Operating Procedure CFOP 60-05, *Code of Ethics for Public Officers and Employees*.

This operational audit of the Department of Children and Families (Department) focused on the oversight and administration of State Mental Health Treatment Facilities (Facilities) and the oversight of the Sexually Violent Predator Program (SVPP) Facility. The overall objectives of the audit were:

- To evaluate management's performance in establishing and maintaining internal controls, including controls designed to prevent and detect fraud, waste, and abuse, and in administering assigned responsibilities in accordance with applicable laws, administrative rules, contracts, grant agreements, and guidelines.
- To examine internal controls designed and placed in operation to promote and encourage the achievement of management's control objectives in the categories of compliance, economic and efficient operations, the reliability of records and reports, and the safeguarding of assets, and identify weaknesses in those internal controls.
- To identify statutory and fiscal changes that may be recommended to the Legislature pursuant to Section 11.45(7)(h), Florida Statutes.

This audit was designed to identify, for those programs, activities, or functions included within the scope of the audit, deficiencies in management's internal controls, instances of noncompliance with applicable governing laws, rules, or contracts, and instances of inefficient or ineffective operational policies, procedures, or practices. The focus of this audit was to identify problems so that they may be corrected in such a way as to improve government accountability and efficiency and the stewardship of management. Professional judgment has been used in determining significance and audit risk and in selecting the particular transactions, legal compliance matters, records, and controls considered.

As described in more detail below, for those programs, activities, and functions included within the scope of our audit, our audit work included, but was not limited to, communicating to management and those charged with governance the scope, objectives, timing, overall methodology, and reporting of our audit; obtaining an understanding of the program, activity, or function; exercising professional judgment in considering significance and audit risk in the design and execution of the research, interviews, tests, analyses, and other procedures included in the audit methodology; obtaining reasonable assurance of the overall sufficiency and appropriateness of the evidence gathered in support of our audit's findings and conclusions; and reporting on the results of the audit as required by governing laws and auditing standards.

Our audit included the selection and examination of transactions and records. Unless otherwise indicated in this report, these transactions and records were not selected with the intent of statistically projecting the results, although we have presented for perspective, where practicable, information concerning relevant population value or size and quantifications relative to the items selected for examination.

An audit by its nature, does not include a review of all records and actions of agency management, staff, and vendors, and as a consequence, cannot be relied upon to identify all instances of noncompliance, fraud, abuse, or inefficiency.

In conducting our audit we:

- Reviewed applicable laws, rules, Department policies and procedures, and other guidelines, and interviewed Department personnel to gain an understanding of the oversight and administration of the Facilities.

- Performed inquiries of Department staff and inspected documents and records to determine whether Department management had adequately designed and implemented controls, including policies and procedures, for the Facilities.
- Examined employment documentation related to 6 of the 16 Department employees working in the Forensic Admissions Office (FAO) and Sexually Violent Predator Program (SVPP) as of February 2016 to determine whether the employees met minimum standards regarding education, experience, and training for their job duties related to the processing of commitments to the Facilities and the SVPP Facility.
- Analyzed data related to referrals received by the FAO during the period July 2014 through January 2016 to determine whether placements of individuals referred to the Facilities were made within 15 days of receipt of a complete commitment packet and the average time from commitment to a determination of whether the individual was competent to stand trial appeared reasonable.
- Inquired of Department management and examined Agency for Health Care Administration licensing records to determine whether the Department had obtained the appropriate licenses to operate the State's seven Facilities.
- From the population of 2,552 commitment packets received by the FAO during the period July 2014 through January 2016, examined 40 selected commitment packets and related records to determine whether the packets were complete, the commitment decisions were properly documented, notifications to commit were timely provided to the appropriate parties, the admissions waiting list was timely updated, and applicable information was accurately entered into the FAO database.
- Analyzed SVPP database data for the period July 2014 through January 2016 to determine whether, prior to an individual's scheduled release from confinement, SVPP staff reviewed and made recommendations on referrals within the required time frame.
- From the population of 7,071 SVPP referrals received by the Department during the period July 2014 through January 2016, examined documentation related to 40 selected SVPP referrals to determine whether referrals were evaluated by qualified personnel and the referrals were assessed in accordance with applicable laws and rules.
- For the Facility and SVPP Facility contracts renewed during the period July 2014 through January 2016, analyzed the contract periods to determine whether renewals and extensions did not exceed the time limits established in State law.
- Examined Department records related to four of the ten on-site monitoring reports (two Contract Oversight Unit reports and two contract manager reports) issued during the period July 2014 through January 2016 related to the four contractor-managed Facilities and the SVPP Facility to determine whether the Department's monitoring was adequate to ensure compliance with contract requirements and the Department timely followed up on the corrective actions taken to address noted findings.
- Evaluated Department processes and procedures for overseeing Department-managed Facilities to determine whether the Department provided sufficient oversight of the Facilities to ensure that the standard of care for all clients is met and that the Facilities comply with applicable laws, rules, and Department procedures.
- From the population of 180 Facility and SVPP Facility contract payments, totaling $181,426,423, made by the Department during the period July 2014 through January 2016, examined Department records for 40 selected contract payments, totaling $42,026,241, to determine whether the payments were correctly recorded in Department accounting records, supported by adequate documentation, and contract payment controls were properly designed and operating effectively.

- Observed, documented, and evaluated the effectiveness of selected Department processes and procedures for:
  - Purchasing, cash management, and fixed capital outlay.
  - The management of tangible personal property in accordance with applicable guidelines. As of February 29, 2016, the Department was responsible for 5,932 property items with acquisition costs totaling $30,194,761.
  - The assignment and use of motor vehicles. As of November 2015, Department property records listed 247 motor vehicles with acquisition costs totaling $3,432,030.
  - The acquisition, assignment, and use of wireless devices with related service costs totaling $3,229,403 during the 2014-15 fiscal year.
- Examined Department records related to 130 expenditure transactions, totaling $1,645,775, made by the Department-managed Facilities during the period July 2014 through January 2016, to determine whether the expenditures were correctly recorded in Department accounting records and supported by adequate documentation, and whether expenditure controls were properly designed and operating effectively. Specifically, we selected the following for each Department-managed Facility:
  - 70 Florida State Hospital (FSH) expenditure transactions, totaling $930,390, selected from the population of 39,616 FSH expenditure transactions totaling $35,690,706.
  - 40 North East Florida State Hospital (NEFSH) expenditure transactions, totaling $537,872, selected from the population of 23,633 NEFSH expenditure transactions totaling $18,969,108.
  - 20 North Florida Evaluation and Treatment Center (NFETC) expenditure transactions, totaling $177,513, selected from the population of 8,458 NFETC expenditure transactions totaling $4,395,159.
- Performed inquiries of Facility personnel and observations of Facility operations, including tours of the Department-managed Facilities, and inspected documents and records to determine whether the Facilities had adequately designed and implemented procedures and controls for the management of the Facilities, including the identification and development of preventive maintenance schedules.
- From the population of 16,248 incidents reported during the period July 2014 through January 2016 by Department-managed Facilities, examined Facility records related to 130 selected incidents to determine whether incidents were reviewed by appropriate management, reported to the appropriate authority, and all required forms were completed appropriately and within the required time frame. We selected the following for each Department-managed Facility:
  - 50 FSH incident reports, from the population of 5,308 FSH incidents reports.
  - 40 NEFSH incident reports, from the population of 8,675 NEFSH incident reports.
  - 40 NFETC incident reports, from the population of 2,265 NFETC incident reports.
- From the population of 1,430 workers' compensation claims reported by Department-managed Facilities for injuries occurring during the period July 2014 through January 2016, examined 138 selected workers' compensation claims to determine whether incidents identified by Department policy were properly reported by the Facilities. Specifically, we selected and examined:
  - 97 of 853 workers' compensation claims reported by FSH.
  - 31 of 441 workers' compensation claims reported by NEFSH.
  - 10 of 136 workers' compensation claims reported by NFETC.

- Examined documentation related to the staffing of Department-managed Facilities during the period July 2014 through January 2016 to determine whether actual staffing levels met the minimum requirements established by Facility operating procedures. Our examination included:
  - For the FSH, one shift for one unit during a 5 day period.
  - For the NEFSH, 336 shifts encompassing a 3 week period.
  - For the NFTEC, 196 shifts encompassing a 3 week period.
- Performed inquiries, observations, and inspections of documents and records related to the Facilities' insurance coverage for the 2014-15 and 2015-16 fiscal years to determine whether the Department had adequately designed and implemented controls to ensure that sufficient insurance coverage was obtained for Department-managed Facilities, including property and inventory, and documentation to support the amounts insured was maintained.
- Examined insurance certificates and supporting worksheets for 20 of the 290 permanent buildings located at the FSH, NEFSH, and NFETC to determine whether insurance values appeared appropriate and were calculated in accordance with applicable policies and procedures and the amounts were correctly reported in the Florida State-Owned Lands and Records Information System. Specifically:
  - From the population of 213 permanent FSH buildings insured during the 2015-16 fiscal year, we selected and examined insurance information for 10 buildings.
  - From the population of 57 NEFSH permanent buildings insured during the 2015-16 fiscal year, we selected and examined insurance information for 5 buildings.
  - From the population of 26 NFETC permanent buildings insured during the 2015-16 fiscal year, we selected and examined insurance information for 5 buildings.
- Analyzed data from FSH's 2014-15 fiscal year incident report submitted to the Agency for Health Care Administration, patient incident reports, and patient clinic visits for the period July 2014 through January 2016, to determine whether adverse and critical events, such as sexual battery, elopement, escape, death, or other events identified by Department policy, were properly reported.
- Performed inquiries, observations, and inspections of documents and records related to census counts conducted during the period April 2016 through June 2016 to determine whether the Facilities had adequately designed and implemented controls to ensure that census counts were performed, recorded appropriately, and accounted for all clients.
- Observed nine distributions of pharmaceuticals to Facility clients to determine whether the Facilities had established and maintained appropriate inventory management controls to accurately account for pharmaceuticals distributed. Specifically:
  - At FSH, we observed four pharmaceuticals distributions during the period April 15, 2016, through May 5, 2016.
  - At NEFSH, we observed three pharmaceuticals distributions during the period June 13, 2016, through June 17, 2016.
  - At NFTEC, we observed two pharmaceuticals distributions during the period June 14, 2016, through June 15, 2016.
- Performed inquiries, observations, and inspections of documents and records related to pharmaceutical inventory management to determine whether the Facilities had adequately designed and implemented controls to provide for the proper separation of duties, adequate records of periodic inventories, and safeguarding of the pharmaceutical inventory.

- Performed inquiries, observations, and inspected documents and records related to contraband items to determine whether the Facilities had adequately designed and implemented controls to ensure the adequate safeguarding of contraband items seized from employees, visitors, and clients; an inventory of contraband items was maintained by the Facilities; contraband items were kept in a secure location until a determination was made as to how the item would be disposed of or returned; and the contraband item was returned upon the client leaving the Facility or properly disposed of.
- Inquired of Facility management, evaluated Facility procedures, and examined records and items related to contraband seizures during the period July 2014 through January 2016 to determine whether seized items were accounted for and disposed of in accordance with Department procedures. Our audit procedures included examining records and items related to:
    - 20 of 242 seizures listed in FSH records, and 7 seizures selected from contraband storage.
    - 5 of 192 seizures listed in NFETC records, and 5 seizures selected from contraband storage.
- Analyzed documentation related to FSH and NEFSH operating capacities and civil patient waiting lists to determine whether FSH and NEFSH management developed and maintained operating capacities in accordance with Department procedures.
- Evaluated the methodology utilized by the FSH and NEFSH to assign patient safety officers and prepare patient safety plans during the period July 2014 through January 2016 and examined FSH and NEFSH policies and procedures to determine whether FSH and NEFSH management established adequately designed controls designed to protect client safety.
- From the population of 4,201 medical clinic admittances listed on FSH and NEFSH medical logs during the period July 2014 through January 2016, examined documentation related to 20 selected medical clinic admittances to determine whether FSH and NEFSH staff properly completed incident reports, as applicable, for clinic admittances.
- From the population of 1,059 FSH employees identified as direct care staff, nurses or nurse practitioners, physicians, or rehabilitation therapists, who were employed during at least some portion of the period July 2014 through January 2016, examined documentation related to 25 selected FSH employees to determine whether FSH management ensured that employee qualifications and training were sufficient to protect employee and client safety.
- From the population of 182 client complaints filed at the FSH during the period July 2014 through January 2016, examined 20 selected client complaints to determine whether the FSH investigated and resolved client complaints in accordance with established procedures. In addition, performed inquiries, observations, and inspections of documents and records related to client complaints to determine whether FSH management had established appropriate procedures for reporting, investigating, resolving, and following up on client complaints.
- Selected a total of 25 property items, with related acquisition costs totaling $295,961, observed at the FSH (10 items), NEFSH (13 items), and NFETC (2 items), and examined Facility property records to determine whether the property items were accurately recorded in the property records.
- Performed inquiries and inspections of annual inventory records to determine whether FSH staff had properly conducted the 2014-15 fiscal year physical inventory and reconciled the results to Department property records.
- Observed 10 selected FSH property items, with acquisition costs totaling $249,322, to determine whether the items were accurately recorded in the property records, which included 1,464 property items, with acquisition costs totaling $5,481,507, as of January 2016.
- From the population of 135 FSH property acquisitions, totaling $617,298, made during the period July 2014 through January 2016, examined records for 15 property acquisitions, totaling

$108,651, to determine whether property information was timely and accurately added to Department property records and recorded at the correct cost.

- From the population of FSH property dispositions, for 226 items with original acquisition costs totaling $428,308, made during the period July 2014 through January 2016, examined records for 30 selected property dispositions, for items with original acquisition costs totaling $218,365, to determine whether property dispositions were appropriately documented and approved, disposed of in accordance with applicable State laws, rules, and Department procedures, properly adjusted in Department property records, and applicable items were properly sanitized prior to disposition.
- Communicated on an interim basis with applicable officials to ensure the timely resolution of issues involving controls and noncompliance.
- Performed various other auditing procedures, including analytical procedures, as necessary, to accomplish the objectives of the audit.
- Prepared and submitted for management response the findings and recommendations that are included in this report and which describe the matters requiring corrective actions. Management's response is included in this report under the heading ***MANAGEMENT'S RESPONSE***.

AUTHORITY

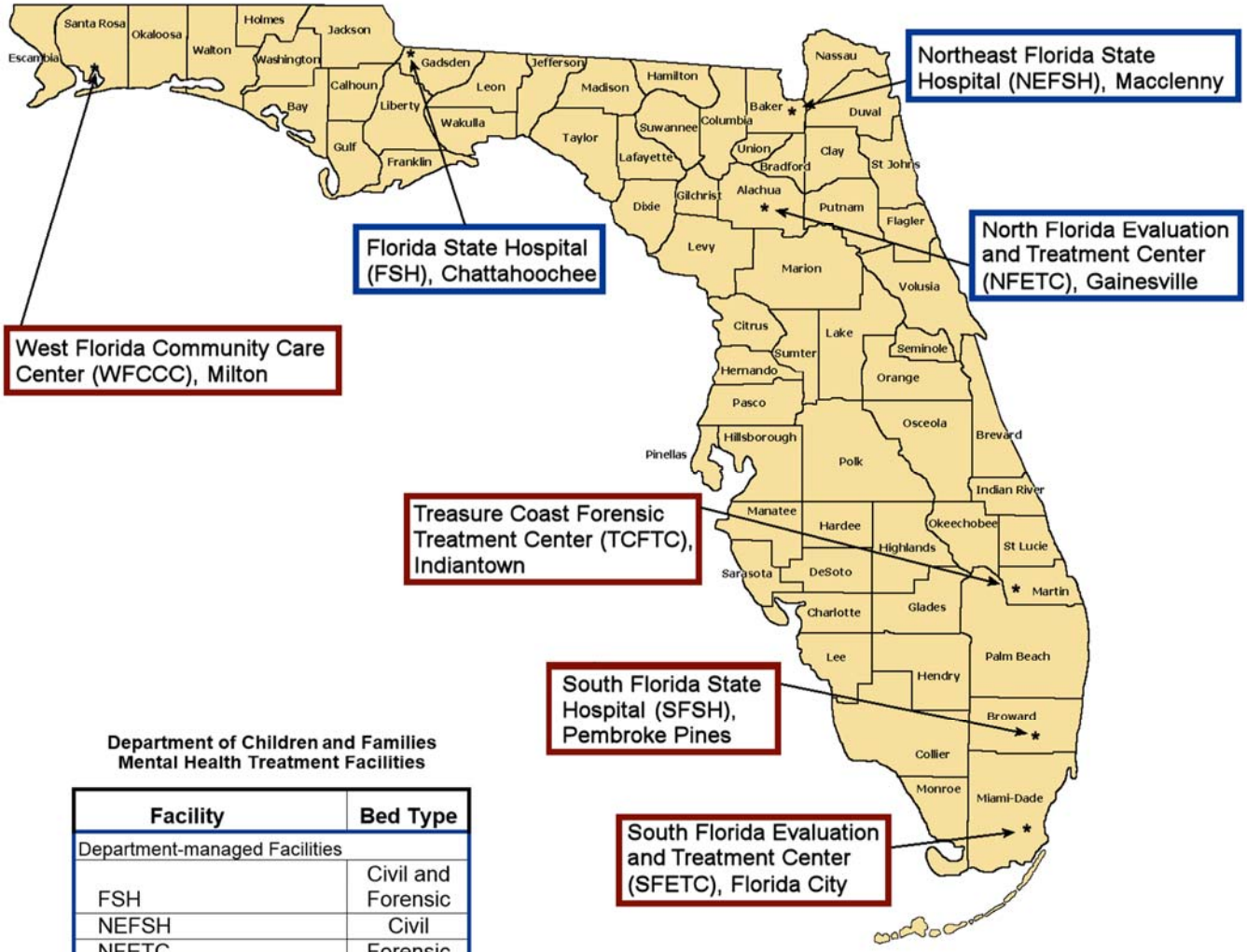
Section 11.45, Florida Statutes, requires that the Auditor General conduct an operational audit of each State agency on a periodic basis. Pursuant to the provisions of Section 11.45, Florida Statutes, I have directed that this report be prepared to present the results of our operational audit.

Sherrill F. Norman, CPA
Auditor General

EXHIBIT A

STATE MENTAL HEALTH TREATMENT FACILITIES

JULY 2014 THROUGH JANUARY 2016



Department of Children and Families
Mental Health Treatment Facilities

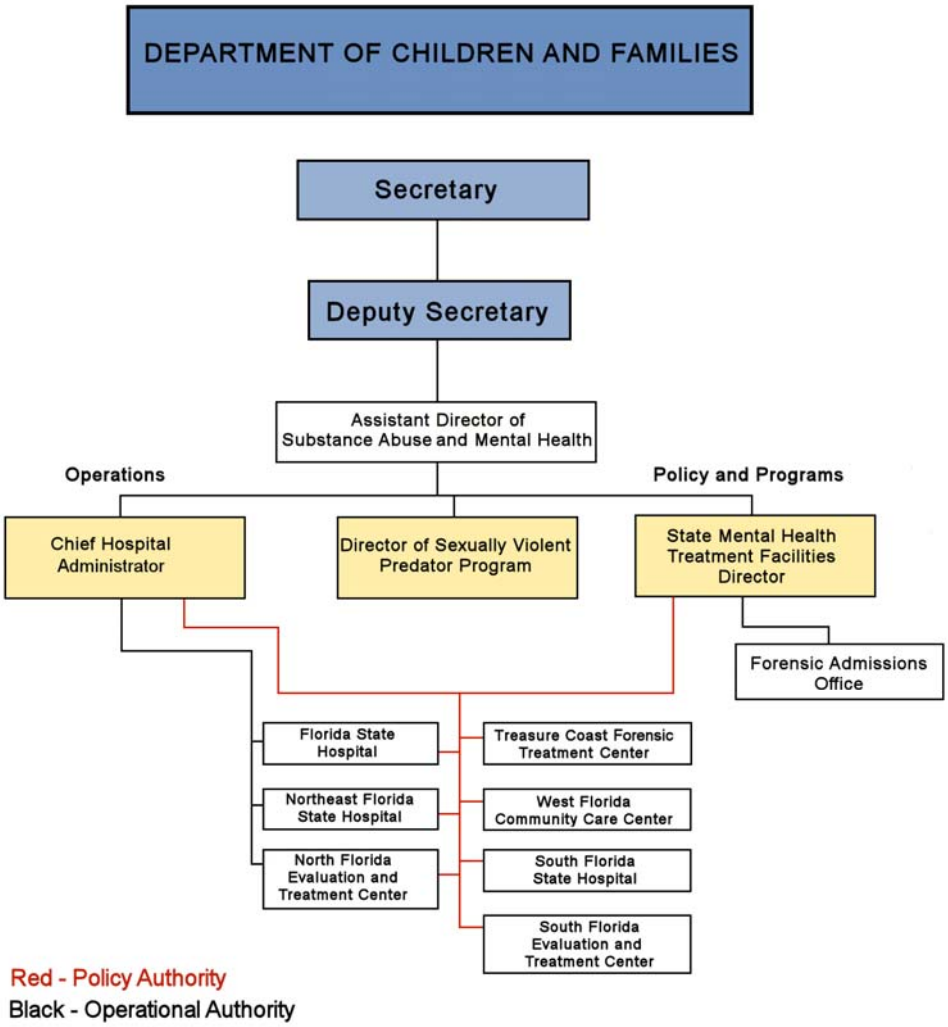
Facility	Bed Type
Department-managed Facilities	
FSH	Civil and Forensic
NEFSH	Civil
NFETC	Forensic
Contractor-managed Facilities	
SFETC	Forensic
SFSH	Civil
TCFTC	Forensic
WFCCC	Civil

Source: Department records.

EXHIBIT B

MENTAL HEALTH PROGRAM ORGANIZATIONAL CHART

SEPTEMBER 2016



Source: Audit procedure results.

State of Florida
Department of Children and Families

Rick Scott
Governor

Mike Carroll
Secretary

May 23, 2017

Sherrill F. Norman, CPA
Auditor General, State of Florida
Claude Denson Pepper Building, Suite G74
111 West Madison Street
Tallahassee, FL 32399-1450

RE: Response to Preliminary and Tentative Audit Findings on State Mental Health Treatment Facilities

Dear Ms. Norman:

This letter is in response to the preliminary and tentative audit findings and recommendations issued to the Department of Children and Families (DCF) on April 13. The findings and recommendations were related to an operational audit of the oversight and administration of the state mental health treatment facilities (MHTFs). Six public and private state mental health treatment facilities, South Florida Evaluation and Treatment Center (SFETC), South Florida State Hospital (SFSH), Treasure Coast Forensic Treatment Center (TCFTC), North Florida Evaluation and Treatment Center (NFETC), Northeast Florida State Hospital (NEFSH), and Florida State Hospital (FSH), were included in the audit, in addition to the Florida Civil Commitment Center; however, the primary operational focus was on the state-operated treatment facilities.

In 2014, DCF undertook an extensive analysis of the state behavioral health services system, including the state-operated MHTFs, to review staffing levels, operations, work culture, and infrastructure needs. As a result of this comprehensive assessment, the department continues to make improvements in safety and performance at the three state-operated facilities.

Information regarding DCF's ongoing MHTFs improvement initiatives is included below. An action plan that addresses the Auditor General's findings is attached for more details.

Finding 1: The Department did not ensure that all Facilities were licensed by the Agency for Health Care Administration in accordance with State law.

The buildings that house two forensic-only facilities (NFETC and TCFTC), as well as the 435 beds at FSH referenced in the AG findings, were not designed or required to be used as hospitals per Chapter 394 regarding forensic psychiatric treatment. All clinical services are delivered to residents who are in AHCA-licensed beds as required by law. All three state-operated facilities are accredited by the Commission on Accreditation of Rehabilitation Facilities and TCFTC is accredited by the Joint Commission. DCF has sought legislative funding to address the facilities' physical plant deficiencies and will continue to look for improvements that

can be made with current resources and facilities. For example, construction costs to build a facility for AHCA licensure at NFETC are estimated at approximately $45 million. The construction costs to renovate FSH's non-licensed buildings is approximately $21 million and the new construction cost is approximately $35 million.

Finding 2: The Department's oversight of Department-managed Facilities needs enhancement to ensure that the standard of care for all clients is met and the Facilities comply with State law, Department rules, and Department procedures.

In 2016, DCF began implementation of the one hospital approach to improve and standardize operations, services, core processes, and performance measurement systems across the three state-operated facilities. As part of the one hospital approach, a new reporting structure for facility operations was established with the appointment of a Chief Hospital Administrator. Under the leadership of the Chief Hospital Administrator, all hospitals are moving towards a clinical organizational model and unified policies and procedures, quality reviews, financial management, employee classifications, job descriptions, and pay equity.

The Chief Hospital Administrator is also hiring a Chief Medical Executive Director to oversee all psychiatric, medical, pharmacy, and dietary functions of the facilities. Quality reviews have been scheduled at each state-operated facility to establish periodic monitoring of facilities' compliance with statutes and DCF policies and priorities.

Finding 3: The Department's monitoring of contractor-managed Facilities and the SVPP Facility was not always adequate to ensure that all key contract requirements were subject to monitoring or that adequate supervisory review of monitoring efforts was documented.

DCF will enhance its monitoring of contracted facilities to ensure that all key contract requirements are reviewed on a regular basis. Specifically, the Chief Medical Executive Director hired by the Chief Hospital Administrator will participate in onsite monitoring of contracted facilities. See attached action plan for additional details.

Finding 4: The Department did not always ensure that square footage information for Department-managed Facilities was accurately reported in the Florida State-Owned Lands and Records Information System.

DCF will work with the facilities to establish policies and procedures for maintaining facility data in the Florida State-Owned Lands and Records Information System. See attached action plan for additional details.

Finding 5: Department-managed Facilities staff did not always prepare required incident reports or report to the Department critical events involving clients and staff in accordance with Department procedures.

The one hospital approach's streamlined administrative structure is addressing incident reporting issues; specifically, the consistent application of policies and practice regarding

incident reports. Procedures for incident reporting have been enhanced and now also include a weekly call with department leadership regarding any level two assaults. The Facility Incident Tracking System (FITS) was brought online in all public and private facilities in 2016 to provide electronic notification when critical incidents occur at any facility. Further, an agency-wide review of various incident reporting mechanisms and procedures is underway.

Finding 6: Department-managed Facility procedures did not specify the factors to be considered in determining minimum staffing coverage or how frequently minimum staffing levels should be evaluated and updated. Additionally, Department-managed Facilities did not always meet minimum staffing requirements.

In 2015, DCF hired a consultant to analyze the staffing needs of state-operated MHTFs. The consultant concluded that there are no national standards for minimum staffing of psychiatric facilities. However, DCF is in the process of updating the facility staffing policy to allow for consideration of additional factors when determining minimum facility staffing requirements.

Finding 7: Department-managed Facilities did not always ensure that pharmaceuticals were properly secured or that pharmacy duties were appropriately separated.

The issue identified in this finding has been resolved. Additionally, pharmaceutical practice will continue to be monitored as part of ongoing quality assurance activities, including adding a pharmacist to the quality review team. See attached action plan for additional details.

Finding 8: Department-managed Facility controls for accurately and appropriately accounting for pharmaceuticals need enhancement.

The Finance Director, who reports to the Chief Hospital Administrator, is in the process of establishing purchasing controls to ensure compliance with state law and will also oversee pharmaceutical operations. This additional pharmacy oversight will improve accountability. DCF recently purchased automated medication carts to aid in the accuracy and accountability of resident medication administration at the three state-operated facilities.

Finding 9: Department-managed Facilities did not always properly account for or safeguard seized contraband.

DCF is revising the contraband policy and will ensure that state-operated facilities comply with its requirements.

Finding 10: Department-managed Facilities did not always ensure that expenditures were authorized by State law, adequately supported, properly calculated, or subject to appropriate approval.

DCF has addressed all of the issues identified in this finding and will ensure future compliance of financial management. See attached action plan for additional details.

Finding 11: Department-managed Facility controls did not always ensure that expenditures were appropriately coded or accounted for.

DCF has addressed all of the issues identified in this finding and will ensure future compliance of financial management. See attached action plan for additional details.

Finding 12: Department-managed Facilities did not always allocate costs in a manner that accurately identified the costs to provide civil and forensic services.

DCF is developing cost allocation plans to address these issues and is also working with a consultant to ensure costs are captured accurately for reporting purposes. See attached action plan for additional details.

Finding 13: Florida State Hospital and North East Florida State Hospital controls for appropriately accounting for tracking and detection canines need enhancement.

Procedures to more appropriately manage the administrative function of the tracking and detection canines are under development. DCF is also researching best practices to guide to practice improvements.

In closing, DCF has worked aggressively over the last two years and continues to make improvements on safety and performance at the state-operated MHTFs to achieve the best outcomes for residents committed to the state's care. DCF has developed a four-year plan that strategizes actions and initiatives through 2020 to continue to advance treatment and service delivery. The improvements to the state's substance abuse and mental health system of care, including the oversight and operation of all state mental health treatment facilities, will continue to be among the agency's top priorities.

Thank you for the opportunity to provide feedback.

Sincerely,

Mike Carroll
Secretary

ACTION PLAN IN RESPONSE TO PRELIMINARY AND TENTATIVE FINDINGS

DEPARTMENT OF CHILDREN AND FAMILIES,
OVERSIGHT AND ADMINISTRATION OF
STATE MENTAL HEALTH TREATMENT FACILITIES

Finding	Recommendation	Owner	Action Steps	Anticipated Completion
1. The Department did not ensure that all Facilities were licensed by the Agency for Health Care Administration in accordance with State law.	a. Facility management continue efforts to protect the health and safety of residents and staff. b. Facility Management take appropriate actions to comply with the applicable standards of safety and quality established by State and Federal regulations. c. Department management, in consultation with the Legislature, evaluate the licensure needs for Florida State Hospital (FSH), Northeast Florida State Hospital (NEFSH), North Florida Evaluation and Treatment Center (NFETC).	M. Morgan John Bryant Bob Quam Matt Howard Wendy Scott	➢ Monthly Quality and Safety Inspections (Environmental, Infection Control, and Safety) of each unit to ensure compliance with applicable State and Federal standards of safety and quality. ➢ The Department has identified physical plant modernization as a targeted milestone, which is regularly addressed as part of a Priority of Effort Plan to Modernize and Enhance State Mental Health Treatment Facilities. ➢ Toured FSH to assess facility structure and building needs. ➢ Schedule a meeting with the DCF Secretary, SAMH Assistant Secretary, and General Services to begin formalizing plans for physical plant modernization.	On-going 2019/2020 3/20/2017 5/31/2017
2. The Department's oversight of Department-managed Facilities needs enhancement to ensure that the standard of care for all clients is met and the Facilities comply with State law, Department rules, and Department procedures.	a. To ensure the establishment of adequate and consistent procedures, we recommend that Department management review and approve all Department-managed facility	Bob Quam	➢ Quality reviews have been scheduled at each state-operated facility as part of Department action to establish periodic monitoring of Facilities. ➢ The FSH review is scheduled during the week of July 29, 2017; the NEFSH review is scheduled during the week of September 18, 2017; and the NFETC review for October 9, 2017.	7/31/2017

ACTION PLAN IN RESPONSE TO PRELIMINARY AND TENTATIVE FINDINGS

DEPARTMENT OF CHILDREN AND FAMILIES,
OVERSIGHT AND ADMINISTRATION OF
STATE MENTAL HEALTH TREATMENT FACILITIES

Finding	Recommendation	Owner	Action Steps	Anticipated Completion
	procedures.		➢ Department management review and approve all Department-managed Facility procedures. ➢ FSH will add designated Department manager to email list at process point of final policy review for all FSH operating policies and procedures.	
	b. Department management establish procedures for conducting periodic monitoring of Department-managed Facilities to ensure that the Facilities operate in accordance with State law, Department rules, and Department procedures.	Wendy Scott	➢ Develop review process plan and review protocol with Chief Hospital Administrator and Hospital Administrators ➢ Determine Department level Quality Improvement Team Subject Matter Experts (SME) within existing resources. ➢ Expand/Develop review tools for key leadership areas of focus. ➢ Identify facility representatives for key leadership areas of focus. ➢ Provide first wave of training for facility reviewers ➢ Conduct reviews of each publicly funded SMHTF ➢ Determine resource needs for expanding scope of reviews and for the provision of technical assistance associated with CAP and subsequent assessment of improvements and submit legislative budget request.	Completed Completed 5/31/2017 Completed 07/14/17; 12/31/2017; 8/7/2018

ACTION PLAN IN RESPONSE TO PRELIMINARY AND TENTATIVE FINDINGS

DEPARTMENT OF CHILDREN AND FAMILIES,
OVERSIGHT AND ADMINISTRATION OF
STATE MENTAL HEALTH TREATMENT FACILITIES

Finding	Recommendation	Owner	Action Steps	Anticipated Completion
3. The Department's monitoring of contractor-managed Facilities and the SVPP Facility was not always adequate to ensure that all key contract requirements were subject to monitoring or that adequate supervisory review of monitoring efforts was documented.	a. Department management enhance procedures for monitoring contractor-managed Facilities and the SVPP Facility to ensure that the monitoring scope includes all key contract requirements.	Dineen Cicco	➢ The Department will enhance its monitoring of contracted Facilities to ensure that all key contract requirements are reviewed on a regular basis as follows: • For medical, dental, and pharmacy standards, the Department has already implemented recommendations noted in the report. The Office of Mental Health Treatment Facilities will hire a Chief Medical Executive Director responsible, in part, for evaluation of contract compliance related to medical, dietary, and clinical pharmacy services for three contracted mental health treatment Facilities, including SFSH, TCFTC and SFETC. During FY 16-17, the Nurse Consultant conducted a preliminary review of SFETC and TCFTC. Beginning FY 17-18, the Chief Medical Executive Director will conduct reviews on all three Facilities. • The SVPP facility is contractually-required to provide health related services in accordance with the National Commission on Correctional Health Care, Standards for Health Services in Prisons, and the same standards applicable to state correctional facilities. The Department explored using the	2017/2018

ACTION PLAN IN RESPONSE TO PRELIMINARY AND TENTATIVE FINDINGS

DEPARTMENT OF CHILDREN AND FAMILIES,
OVERSIGHT AND ADMINISTRATION OF
STATE MENTAL HEALTH TREATMENT FACILITIES

Finding	Recommendation	Owner	Action Steps	Anticipated Completion
			Correctional Medical Authority (CMA), a statutorily established entity to conduct monitoring in compliance with correctional healthcare standards. However, CMA has reported it is unable to conduct reviews in the SVPP facility, due to its limited authority under law. Instead, beginning FY 17-18, the Department will contract with consulting agencies or individuals experienced in monitoring prison healthcare standards to participate in SVPP facility monitoring. • For incident reporting, the FY 16-17 contract manager monitoring included incident reporting compliance at TCFTC, SFETC, SFSH and the SVPP facility during annual on-site reviews. Beginning FY 17-18, the Contract Oversight Unit (COU) will add this domain to its core monitoring scope for these Facilities.	
	b. Department management should ensure that adequate supervisory review of Facility monitoring efforts is documented in Department records.	Dineen Cicco	For supervisory review, the Office of Substance Abuse and Mental Health contract monitoring processes have been revised to include documentation of supervisory reviews in the contract file. Contract files now include documentation of approval by the Contract Manager supervisor and appropriate program leadership for monitoring plans, tools, and reports. The COU will review its methods for performing and documenting quality	2017/2018

ACTION PLAN IN RESPONSE TO PRELIMINARY AND TENTATIVE FINDINGS

DEPARTMENT OF CHILDREN AND FAMILIES,
OVERSIGHT AND ADMINISTRATION OF
STATE MENTAL HEALTH TREATMENT FACILITIES

Finding	Recommendation	Owner	Action Steps	Anticipated Completion
			assurance.	
4. The Department did not always ensure that square footage information for Department-managed Facilities was accurately reported in the Florida State-Owned Lands and Records Information System.	Department management establish policies and procedures for maintaining facility data in FL-SOLARIS and ensure that facility information reported in FL-SOLARIS is supported by Department records.	Bob Quam B. Williams, C.Jerris (NEFSH) Linda Williams (FSH)	➢ The Program Office will work with the Facilities to establish policies and procedures for maintaining facility data in FL-SOLARIS. ➢ NEFSH - All building information is currently being updated and recorded. It will be entered in the database when completed. ➢ FSH – Property Administrator will contact the Department of Environmental Protection to request access to SOLARIS in order to monitor and maintain accurate information concerning Florida State Hospital buildings. ➢ FSH Property Administrator will communicate with the Office of Design and Construction to investigate the reported record discrepancy regarding FSH building square footage. Property Administrator will ensure the accurate information is on file in the FSH Property Management Office.	TBD 7/31/17 Completed Completed
5. Department-managed Facilities staff did not always prepare required incident reports or report to the Department critical events involving clients and staff in accordance with Department procedures.	a. Department management enhance controls to ensure that incident forms are properly completed for all incidents in accordance with Department procedures.	Wendy Scott	➢ Generate monthly facility compliance reports to track the timeliness of incident reporting by each public and private SMHTF. Provide data to Chief Hospital Administrator and contract managers for corrective action plan, if needed. ➢ Conduct annual on-site monitoring at all SMHTFs related to incident reporting and compliance with DCFOP 155-25. On-site	6/1/17 6/30/18

ACTION PLAN IN RESPONSE TO PRELIMINARY AND TENTATIVE FINDINGS

DEPARTMENT OF CHILDREN AND FAMILIES,
OVERSIGHT AND ADMINISTRATION OF
STATE MENTAL HEALTH TREATMENT FACILITIES

Finding	Recommendation	Owner	Action Steps	Anticipated Completion
			reviews will include researching facility workers compensation claims, travel logs and transportation logs to identify possible events that require reporting per policy. Incident log reviews and chart reviews will also be compared with information in FITS. ➢ Conduct remote reviews of facility internal incident reporting systems to ensure congruence with FITS data.	9/30/17
	b. Facility management enhance controls to ensure that incident forms are properly completed for all incidents in accordance with Facility procedures.	Marvin Bailey A. Johnson (NEFSH)	➢ Facilities will ensure compliance with Children and Families Operating Procedure 155-25 (Incident Reporting and Processing in State Mental Health Treatment Facilities) by following the steps below for Level II assaults: • Email notification is required immediately following phone call notification. • Identify the specific Department personnel and notify. • All critical incidents and level II assaults are to be reported into FITS (Facility Incident Tracking System) by the end of the next business day.	Completed
	c. Facility management ensure that the appropriate Department personnel are timely notified of critical events in accordance with	M. Morgan	➢ Facilities will ensure compliance with Children and Families Operating Procedure 155-25 (Incident Reporting and Processing in State Mental Health Treatment Facilities) by following the steps below for Level II assaults:	Completed

ACTION PLAN IN RESPONSE TO PRELIMINARY AND TENTATIVE FINDINGS

DEPARTMENT OF CHILDREN AND FAMILIES,
OVERSIGHT AND ADMINISTRATION OF
STATE MENTAL HEALTH TREATMENT FACILITIES

Finding	Recommendation	Owner	Action Steps	Anticipated Completion
	Department procedures.		• Email notification is required immediately following phone call notification. • Identify the specific Department personnel and notify. • All critical incidents and level II assaults are to be reported into FITS (Facility Incident Tracking System) by the end of the next business day.	
6. Department-managed Facility procedures did not specify the factors to be considered in determining minimum staffing coverage or how frequently minimum staffing levels should be evaluated and updated. Additionally, Department-managed Facilities did not always meet minimum staffing requirements.	a. Department management revise Department staffing procedures to provide Facility management with guidelines to consider when developing minimum staffing coverage and to identify the circumstances that would necessitate a review of minimum staffing levels.	Wendy Scott	➢ Develop guidelines for consideration when establishing minimum staffing requirements and identify circumstances when staffing levels should be reviewed and revised DCFOP 155-29 to reflect guidelines.	6/30/17 7/31/17
	b. Facility management enhance procedures to specify the factors to be considered in determining minimum staffing, require periodic evaluation of staffing requirements, and take steps to ensure	M. Morgan Bob Gibson Marvin Bailey	➢ Facility management will work with Department management to establish guidelines to consider when determining minimum staffing coverage and to identify the circumstances that would necessitate a review of minimum staffing levels. ➢ Revise facility procedure to include specific factors to be considered in determining minimum staffing in alignment	TBD

ACTION PLAN IN RESPONSE TO PRELIMINARY AND TENTATIVE FINDINGS

DEPARTMENT OF CHILDREN AND FAMILIES,
OVERSIGHT AND ADMINISTRATION OF
STATE MENTAL HEALTH TREATMENT FACILITIES

Finding	Recommendation	Owner	Action Steps	Anticipated Completion
	compliance with established staffing minimums.		with DCFOP 155-29, Management of Minimum Coverage in State Mental Health Facilities. The facility procedure will address the frequency of periodic evaluation of minimum coverage and steps to ensure compliance.	
7. Department-managed Facilities did not always ensure that pharmaceuticals were properly secured or that pharmacy duties were appropriately separated.	Facility management ensure that pharmaceuticals are properly secured and that ordering, receiving, and stocking duties for pharmaceuticals are appropriately separated.	T Pham, DOP Dr. Tonja McElvin, DOP	➢ NEFSH - Establish duty assignments in the Pharmacy that clearly separate the functions of ordering, receiving, and stocking of pharmaceuticals. ➢ FSH - The Pharmacy Inventory and Drug Control Policy (Administrative Services Policy 150-1) was updated to address recommendations and staff were trained. ➢ FSH - A monitoring form was created for compliance with the emergency narcotic room keys being stored in the controlled substance box.	Completed Completed Completed
8. Department-managed Facility controls for accurately and appropriately accounting for pharmaceuticals need enhancement.	a. Facility management take steps to maintain pharmaceutical records using a perpetual inventory system that establishes appropriate reorder points, accurately accounts for pharmaceuticals, and can be used to identify and investigate discrepancies noted during physical inventory counts.	T Pham, DOP Dr. Tonja McElvin, DOP	➢ NEFSH - The Pharmacy will work with Health Care Systems (HCS) to assist on identifying and investigating discrepancies. A rolling inventory system is currently in development by HCS, Inc. for State Hospitals. NEFSH will convert to this system. ➢ FSH has already begun working with Health Care Systems (HCS), on the replacement of the Medics system for HCS to assist in identifying and investigating discrepancies.	7/1/17 7/1/17

ACTION PLAN IN RESPONSE TO PRELIMINARY AND TENTATIVE FINDINGS

DEPARTMENT OF CHILDREN AND FAMILIES,
OVERSIGHT AND ADMINISTRATION OF
STATE MENTAL HEALTH TREATMENT FACILITIES

Finding	Recommendation	Owner	Action Steps	Anticipated Completion
	b. FSH management ensure that physical inventory counts are periodically performed in accordance with established procedures, differences between physical inventory counts and inventory records are appropriately investigated prior to adjusting inventory records, and all adjustments to inventory records are properly documented and approved.	Bill Jones Dr. Tonja McElvin, DOP	➢ FSH has approved the purchase order for the implementation of the Electronic Medication Administration (E-MAR) system that will allow the ePharmacy processes to work. ➢ NFETC and FSH are using the ePharmacy processes developed at NEFSH as proof-of-concept and working with the vendor for implementation. ➢ FSH will conduct a quarterly inventory for three quarters of each year and hire a company to take a total inventory each June.	7/1/17 7/1/17 7/1/17
9. Department-managed Facilities did not always properly account for or safeguard seized contraband.	Facility management enhance procedures to ensure the proper accountability for and safeguarding of all seized contraband items. Such procedures should require Facility staff to maintain records describing the contraband, evidencing the date the contraband was seized and the date and manner of disposition, and identifying the witnesses to the disposal.	Wendy Scott Bob Quam	➢ Revise Department policy, DCFOP 155-8: Contraband Control in the State Mental Health Treatment Facilities to include requirements related to the proper accountability of seized contraband items including maintaining records describing the contraband, date seized, date and manner disposed, and witness thereof. ➢ Chief Hospital Administrator ensure state-operated Facilities have procedures and systems in place to comply with new provisions in DCFOP 155-8. ➢ Contract managers ensure contracted Facilities comply with new provisions during next cycle of contract reviews.	7/31/17 10/31/17 6/30/18

ACTION PLAN IN RESPONSE TO PRELIMINARY AND TENTATIVE FINDINGS

DEPARTMENT OF CHILDREN AND FAMILIES,
OVERSIGHT AND ADMINISTRATION OF
STATE MENTAL HEALTH TREATMENT FACILITIES

Finding	Recommendation	Owner	Action Steps	Anticipated Completion
10. Department-managed Facilities did not always ensure that expenditures were authorized by State law, adequately supported, properly calculated, or subject to appropriate approval.	a. Facility management ensure that expenditure transactions are authorized by State law, adequately documented, and properly calculated.	Diana Nielsen Bill Jones	➢ NEFSH will use funds properly in prescribed categories. Use of tokens by residents will be tracked and reconciled. ➢ FSH - The Financial Service Director will review all purchase orders for compliance with State statutes and the DFS policies and guidelines. ➢ Random vouchers will be reviewed quarterly by the Disbursement Supervisor for compliance. Errors will be reported to the Financial Services Director.	Completed Completed 7/1/17
	b. Facility management ensure that purchasing duties are appropriately separated.	Diana Nielsen Bill Jones	➢ Management has reviewed and adjusted duties in the Department to ensure proper separation.	Completed
11. Department-managed Facility controls did not always ensure that expenditures were appropriately coded or accounted for.	a. Facility management enhance procedures to ensure that expenditure transactions are accurately recorded in FLAIR.	Diana Nielsen Bill Jones Anita Bradley	➢ NEFSH/NFETC Accounting Staff provided refresher training in the appropriate use of transaction dates. Quality checks will be done to ensure accurate dates are being used. ➢ FSH – A review of DCF Policy regarding expenditure transactions will be done in monthly meetings with accounting staff. ➢ Random vouchers will be pulled quarterly to check for errors and report findings to the Financial Services Director.	Completed Completed 7/1/17
	b. FSH management enhance controls to ensure that expenditure transactions are appropriately recorded in FLAIR, paid from the	Bill Jones	➢ FSH – Revised process to require the Financial Services Director to approve all purchase orders to ensure compliance with Florida Statute and the DFS policies and guidelines.	Completed

ACTION PLAN IN RESPONSE TO PRELIMINARY AND TENTATIVE FINDINGS

DEPARTMENT OF CHILDREN AND FAMILIES,
OVERSIGHT AND ADMINISTRATION OF
STATE MENTAL HEALTH TREATMENT FACILITIES

Finding	Recommendation	Owner	Action Steps	Anticipated Completion
	appropriate funding sources, and, as applicable, recorded in Department property records.			
12. Department-managed Facilities did not always allocate costs in a manner that accurately identified the costs to provide civil and forensic services.	a. FSH management ensure that expenditure amounts are appropriately allocated between civil and forensic services and the basis for allocations is documented in FSH records.	Bill Jones	➢ Develop a team to address allocations in accordance with Forensic and Civil cost drivers. Both the Budget and Expenditures will be allocated between Forensic and Civil Program Components based upon the cost drivers.	7/1/17
	b. NEFSH and NFETC management develop a methodology to appropriately allocate the costs associated with administrative support provided by NEFSH to NFETC.	Diana Nielsen	➢ The Facilities and Headquarters staff will develop a cost allocation method for any shared positions or services within NEFSH and NFETC. ➢ NEFSH is consulting with Public Consulting Group, Inc. who submits the Facilities' annual Medicare/Medicaid Cost Report to ensure costs are captured in the correct cost centers for reporting purposes.	5/5/17 (Ongoing)
13. Florida State Hospital and Northeast Florida State Hospital controls for appropriately accounting for tracking and detection canines need enhancement.	a. FSH and NEFSH management establish procedures to account for the receipt, management, use, and retirement of tracking and detection canines.	Diana Nielsen Bryan Croft	➢ Canine program and procedures will be revised to address receipt, management, use, and retirement of tracking and detection canines.	7/31/17
	b. FSH and NEFSH management enhance	Diana Nielsen Bryan Croft	➢ All tracking and detection canines will become FSH property and will be entered	7/31/17

ACTION PLAN IN RESPONSE TO PRELIMINARY AND TENTATIVE FINDINGS

DEPARTMENT OF CHILDREN AND FAMILIES,
OVERSIGHT AND ADMINISTRATION OF
STATE MENTAL HEALTH TREATMENT FACILITIES

Finding	Recommendation	Owner	Action Steps	Anticipated Completion
	tangible personal property controls to ensure that Department property records include all tracking and detection canines in accordance with DFS rules, all canine retirements are appropriately authorized and documented, and Department resources are not used to train canines that will not serve an authorized public purpose.		into the property inventory system. ➢ FSH canine area will be upgraded, kennels repaired, and the canine grounds fenced in.	