

**DEPARTMENT OF
CHILDREN AND FAMILIES**

Oversight and Administration of
State Mental Health Treatment Facilities



Sherrill F. Norman, CPA
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. During the period of our audit, the following individuals served as Department Secretary:

Chad Poppell	From January 14, 2019
Rebecca Kapusta, Interim	September 7, 2018, through January 13, 2019
Mike Carroll	Through September 7, 2018

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

Please address inquiries regarding this report to Lisa Norman, CPA, Audit Manager, by e-mail at lisanorman@aud.state.fl.us or by telephone at (850) 412-2831.

This report and other reports prepared by the Auditor General are available at:

FLAuditor.gov

Printed copies of our reports may be requested by contacting us at:

State of Florida Auditor General

Claude Pepper Building, Suite G74 · 111 West Madison Street · Tallahassee, FL 32399-1450 · (850) 412-2722

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). The audit also included a follow-up on the findings noted in our report No. 2017-205. We performed selected audit procedures at: the Department and the three Department-managed facilities: Florida State Hospital (FSH), North East Florida State Hospital (NEFSH), and the North Florida Evaluation and Treatment Center (NFETC); and two contractor-managed facilities: the South Florida Evaluation and Treatment Center (SFETC) and the Treasure Coast Forensic Treatment Center (TCFTC). Our audit disclosed the following:

Department Oversight 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. A similar finding was noted in our report No. 2017-205.

Finding 2: As similarly noted in our report No. 2017-205, square footage information reported in the Florida State-Owned Lands and Records Information System for Department-managed facilities sometimes did not agree with Department records.

Finding 3: The Department did not obtain Department of Management Services approval to utilize an alternate contract source contract in procuring a pharmaceutical inventory management system for the Department-managed facilities. Additionally, the pharmaceutical inventory management system did not promote the maintenance of accurate pharmaceutical inventory data.

Administration of Department and Contracted Facilities

Finding 4: The SFETC did not ensure that controlled substances pharmacy duties were appropriately separated.

Finding 5: As similarly noted in our report No. 2017-205, FSH did not always report to the Department critical events involving clients and staff in accordance with Department and FSH procedures.

Finding 6: As similarly noted in our report No. 2017-205, FSH and NEFSH did not always comply with minimum staffing requirements.

Finding 7: NFETC and TCFTC did not always properly account for or safeguard seized contraband. A similar finding for NFETC was noted in our report No. 2017-205.

Finding 8: FSH, NEFSH, and NFETC controls still need enhancement to ensure that expenditures are accurately recorded in the Florida Accounting Information Resource Subsystem and comply with statutory prompt payment requirements.

Finding 9: As similarly noted in our report No. 2017-205, the costs for positions shared between Department-managed facilities were not allocated in a manner that accurately identified civil and forensic services costs among the facilities.

Other Facility Administrative Activities

Finding 10: Department controls over State Mental Health Treatment Facilities expenditure and procurement transactions need enhancement to ensure that such transactions comply with State law and other guidelines.

Finding 11: FSH did not monitor contractor activities related to fleet management.

Finding 12: FSH, NEFSH, and NFETC motor vehicle and fuel use controls need enhancement to ensure and demonstrate compliance with State law and the reasonableness of motor vehicle and fuel usage.

Finding 13: FSH transportation shop controls need improvement to appropriately track and account for the use of motor vehicle parts and supplies and related costs.

BACKGROUND

State law¹ 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 2017 through January 2019, the Department managed three State Mental Health Treatment Facilities (facilities) and contracted for the management of four other facilities. The Department managed Florida State Hospital (FSH), Northeast Florida State Hospital (NEFSH), and the North Florida Evaluation and Treatment Center (NFETC) and contracted for the management of the South Florida Evaluation and Treatment Center (SFETC), South Florida State Hospital (SFSH), the Treasure Coast Forensic Treatment Center (TCFTC), and the West Florida Community Care Center (WFCCC).

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 at any material stage of a criminal proceeding due to mental illness or who have been acquitted 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 Act⁴ for evaluation or treatment of mental, emotional, or behavioral disorders.

¹ Section 20.19, Florida Statutes.

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

³ Section 916.106(7), (9), and (11), Florida Statutes.

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

According to Department records, expenditures for the three Department-managed facilities during the 2018-19 fiscal year totaled approximately \$226.6 million and Department expenditures related to the four contractor-managed facilities totaled approximately \$97.6 million. Table 1 shows, by facility type, Department expenditures for the 2017-18 and 2018-19 fiscal years. Table 2 shows, for each Department-managed facility, expenditures by category for the 2018-19 fiscal year.

Table 1
Expenditures by Facility Type
For the 2017-18 and 2018-19 Fiscal Years

Type of Facility	2017-18	2018-19
Department-Managed Facilities	\$227,031,874	\$226,609,599
Contractor-Managed Facilities	78,815,821	97,623,323
Totals	<u>\$305,847,695</u>	<u>\$324,232,922</u>

Source: Department financial records.

Table 2
Department-Managed Facility Expenditures by Category
For the 2018-19 Fiscal Year

Expenditure Category	Florida State Hospital	Northeast Florida State Hospital	North Florida Evaluation and Treatment Center
Salaries and Related Expenses	\$100,232,331	\$64,469,539	\$24,745,064
Contracted Services	13,568,537	5,611,376	1,301,869
Pharmaceuticals	6,716,250	3,799,676	771,551
Food Services	1,861,475	1,336,502	354,175
Other	1,328,042	477,060	36,152
Totals	<u>\$123,706,635</u>	<u>\$75,694,153</u>	<u>\$27,208,811</u>

Source: Department financial records.

FINDINGS AND RECOMMENDATIONS

DEPARTMENT OVERSIGHT OF FACILITIES

During the period July 2017 through January 2019, the Department's Contract Oversight Unit conducted programmatic and administrative monitoring of the contractor-managed facilities. The Department assigned oversight responsibility for the Department-managed facilities to the State Mental Health Treatment Facilities (SMHTF) section and each facility had a Hospital Administrator who oversaw facility operations. In addition, the Department's Chief Hospital Administrator oversaw the operations of the Department-managed facilities.

Finding 1: Facility Licensure

State law⁵ specifies that hospitals⁶ 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 law⁷ 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 law⁸ is a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment. Pursuant to AHCA rules,⁹ licensed hospitals are subject to periodic inspections by AHCA to determine whether the hospital is operating in compliance with licensure requirements or, in lieu of a licensure inspection, a hospital is to be appropriately accredited.

In our report No. 2017-205 (Finding 1), we noted that the Department did not ensure that NFETC, TCFTC, and two FSH residential buildings were licensed by AHCA in accordance with State law. Department management at the time indicated that these facilities and residential buildings were not licensed because the physical structures did not meet the building code standards required for hospital licensure. As part of our follow-up audit procedures, we inquired of Department management and noted that, as of July 2020, the Department still had not obtained licensure for these facilities or facility buildings. As of July 2020, the bed capacities of NFETC and TCFTC were 196 and 224, respectively, and the unlicensed bed capacity at the FSH buildings was 420 beds. According to Department management, these beds were not required to be licensed because the facilities were not hospitals as defined in State law nor offered the intensive services contemplated by State law. Notwithstanding this response, the Department provides diagnostic, treatment, and therapeutic services for mental illnesses at these locations.

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 accredited by recognized accreditation organizations indicating that facility management made sufficient efforts to protect the health and safety of residents and staff, such efforts do not substitute for the assurances provided by licensure.

Recommendation: We continue to recommend that facility management continue efforts to 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

⁵ Section 395.003(1)(a), Florida Statutes.

⁶ 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.

⁷ Section 395.003(5)(a), Florida Statutes.

⁸ Part 1, Chapter 394, Florida Statutes.

⁹ AHCA Rule 59A-3.253, Florida Administrative Code.

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 “there exists no statute, case law, or rule which requires NFETC, TCFTC, and the two buildings at FSH, to be licensed as hospitals by AHCA.” Additionally, Department management indicated that “no reading of the text of Section 916.105(2), Florida Statutes, suggests the need for forensic facilities to be licensed as hospitals” and that “even the Department’s mental health ‘hospitals’ do not require licensure” because they do not meet subsection (b) of Section 395.002(12), Florida Statutes. Notwithstanding this response, nowhere in the finding do we suggest that Section 916.105(2), Florida Statutes, compels licensure of these facilities. However, as noted in the finding, our audit procedures, including observations at the facilities, indicated that clinical services, such as diagnostic, treatment, and therapeutical services, were provided to residents in beds that were not licensed by AHCA. Consequently, we find the requirements of paragraph 395.002(12)(b), Florida Statutes, to be met and, therefore, 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: Facility Property Records

Pursuant to State law,¹⁰ the Department of Environmental Protection (DEP) and the Department of Management Services (DMS) collaborated to establish the Florida State-Owned Lands and Records Information System (FL-SOLARIS) to:

- Provide 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.
- Maintain 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.

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 1 each year and the Department, Office of General Services, was 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, detailing the inventory of all State-owned facilities.

As part of our audit, we examined Department insurance and architectural drawing and blueprint records for 8 of the 514 permanent buildings located at FSH, NEFSH, and NFETC during the 2017-18 fiscal year to determine whether Department property information was correctly reported in FL-SOLARIS. As similarly noted in our report No. 2017-205 (Finding 4), building square footage recorded in FL-SOLARIS did not always agree with Department records. Specifically, our examination disclosed that the

¹⁰ Sections 216.0152(1) and 216.0153(1), Florida Statutes.

Department reported in FL-SOLARIS for the 2017-18 fiscal year a total of 163,538 square feet for 7 of the 8 buildings examined (3 at FSH, 1 at NEFSH, and 3 at the NFETC), Department insurance records for these 7 buildings reflected a total of 172,900 square feet, and Department architectural and blueprint records reflected a total of 171,239 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. Department management also indicated that a lack of communication between the staff responsible for entering information in FL-SOLARIS, including adjustments to square footage, and the staff responsible for insurance and architectural and blueprint records may have contributed to the discrepancies noted.

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 FSH, NEFSH, NFETC, and other Department-maintained properties.

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

Finding 3: Pharmaceutical Inventory Management System

Department of Health rules¹¹ require pharmacies that dispense controlled substances¹² to maintain inventory records in accordance with Federal regulations.¹³ 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 2018-19 fiscal year, the three Department-managed facilities purchased pharmaceuticals with costs totaling \$11,287,477. In our report No. 2017-205 (Finding 8), we noted that Department-managed facilities had not established and maintained appropriate inventory management controls and records to accurately account for pharmaceuticals. To improve pharmaceutical inventory management, the Department purchased, through an alternative contract source contract, three licenses for an automated pharmaceutical inventory management system in April 2018 (FSH), February 2019 (NEFSH), and March 2019 (NFETC). The annual cost of each license was \$20,188. Our examination of facility pharmacy records and interviews with facility staff disclosed that the automated pharmaceutical inventory management system was not procured in accordance with DMS rules and did not promote the maintenance of accurate pharmaceutical inventory data. Specifically, we found that:

- To facilitate the competitive procurement of commodities and contractual services, the DMS established on their Web site a list of current contracts competitively established by governmental entities (alternative contract sources) for use by State agencies. To purchase commodities or

¹¹ Department of Health, Board of Pharmacy, Rule 64B16-28.140, Florida Administrative Code.

¹² 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.

¹³ Title 21, Part 1304.04, Code of Federal Regulations.

services using alternate contract sources, State agencies must request approval from the DMS.¹⁴ As part of the DMS approval process, the DMS is to verify that the proposed purchase is within the scope of the alternate contract source agreement and that the use is cost effective and in the best interest of the State. However, the Department did not obtain DMS approval to utilize the alternative contract source contract to acquire the pharmaceutical inventory management system licenses. According to Department management, at the time of this procurement, the Department did not believe they needed to obtain DMS approval to utilize the alternative contract source contract.

- According to Department management, the licenses for the pharmaceutical inventory management system were purchased to provide the Department access to perpetual inventory data, generate refill orders, increase efficiency, and reduce overall pharmacy inventory levels. However, based on our interviews with FSH and NEFSH management and review of system reports, the system was unable to provide accurate inventory data, the re-order reports generated were not utilized due to inaccuracy, and the lack of accurate inventory records made it difficult to determine the efficiency of inventory turnover and reduce inventory levels. While SMHTF management was aware that the system was not fully functional at FSH, management proceeded with system implementation at NEFSH in February 2019 and at NFETC in March 2019.

Department management also indicated that the pharmaceutical inventory management system was selected based on ease of access and compatibility with other facility pharmaceutical drug software. However, FSH and NEFSH management indicated that the system was not compatible with their existing software for dispensing pharmaceuticals, which resulted in inaccurate perpetual inventory data. FSH and NEFSH management also indicated that the system was designed for a retail environment and not hospital use and did not have mechanisms in place to predict patient turnover.

Without DMS approval, the Department cannot demonstrate that the procurement of the pharmaceutical inventory management system was within the scope of the alternate contract source agreement, was cost effective, and in the best interest of the State. Additionally, 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.

Recommendation: We recommend that Department management strengthen controls to ensure that future procurements of goods or services using alternate contract source contracts comply with applicable DMS rules. In addition, we recommend that Department and facility management take steps to ensure that pharmaceutical records are appropriately maintained using a perpetual inventory management system that is compatible with other software, establishes appropriate reorder points, accurately accounts for pharmaceuticals, and can be used to identify and investigate discrepancies noted during physical inventory counts.

ADMINISTRATION OF FACILITIES

As part of our audit, we conducted on-site fieldwork at the three Department-managed facilities and two of the contractor-managed facilities (SFETC and TCFTC) 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

¹⁴ DMS Rule 60A-1.045(5), Florida Administrative Code.

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 4: Safeguarding of Pharmaceuticals

Each facility maintained a licensed pharmacy that was responsible for purchasing and dispensing drugs, including controlled substances such as psychotropic medications, to facility residents. Controls over pharmaceuticals are necessary to help prevent and detect the loss or theft of pharmaceuticals. 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 four facility pharmacies (pharmacies at NEFSH, NFETC, SFETC, and TCFTC) and the process for ordering, receiving, stocking, and dispensing¹⁵ pharmaceuticals. Our audit procedures disclosed that the SFETC had not appropriately separated pharmacy duties. Specifically, the SFETC pharmacist was responsible for receiving and stocking controlled substances and maintaining manual inventory records for the controlled substances. According to SFETC management, access to the controlled substances was restricted to promote the appropriate safeguarding of pharmacy drugs. However, the SFETC had not implemented compensating controls, for example, independent reconciliations of the manual inventory records to records from an electronic inventory system used to track the receipt and distribution of all pharmaceuticals, including controlled substances, to mitigate incompatible pharmacy duties.

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

Recommendation: We recommend that SFETC management ensure that pharmacy duties for controlled substances are appropriately separated. If incompatible pharmacy duties are necessary, we recommend that SFETC management establish and document effective compensating controls, such as independent reconciliations of pharmacy inventory records.

Finding 5: Incident Reporting

To protect the safety and welfare of facility residents and staff, the Department established procedures for identifying, reporting, and acting on all critical events.¹⁶ Management and staff were required to report all critical events in accordance with Department procedures and management was to take immediate steps to ensure the safety and welfare of any resident who was the victim of suspected abuse, neglect, or exploitation. Specifically:

¹⁵ We observed the process for dispensing pharmaceuticals only at the SFETC and TCFTC.

¹⁶ Department Operating Procedure No.155-25, *Incident Reporting and Processing in State Mental Health Treatment Facilities*. The Procedure 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; possession of child pornography by a resident or staff; and other major events not otherwise identified as a reportable critical event that had, or was likely to have had, a significant impact on residents, providers, or the Department.

- Individuals at any level of management were to report by telephone to the Chief Hospital Administrator or designee all escapes, elopements, or resident, staff, or nonresident deaths within 1 hour of the event.
- Level two¹⁷ resident altercations were to be reported by telephone to the Chief Hospital Administrator or designee within 2 hours of the altercation, followed by an e-mail.
- All other critical events were to be reported by telephone to the Chief Hospital Administrator or designee within 24 hours of the event.

If the Chief Hospital Administrator or designee was unavailable, the Assistant Secretary for Substance Abuse and Mental Health (SAMH) was to be called. By the next business day following the critical event, facility management was to enter critical events and resident deaths into the Facilities Incident Tracking System. In the case of a resident death, facilities were to complete a *Notification of Death* form and send the form to the SAMH program office by the next business day.

In addition to the requirements outlined in Department procedures, FSH procedures¹⁸ required a Form 611 – Critical Event Reporting (Form 611) to be completed for all critical events. FSH procedures¹⁹ also required reporting to facility management other specified incidents, such as accidents, falls, chokings, assaults, and injuries, on a FSH Resident Incident Report. According to FSH records, 4,420 Resident Incident Reports were filed during the period July 2017 through January 2019.

As part of our audit, we examined records for 40 resident incidents at the FSH, including 11 critical events, to determine whether the incidents were reported in accordance with Department and FSH procedures. As similarly noted in our report No. 2017-205 (Finding 5), our examination disclosed that:

- Although FSH records indicated that the Chief Hospital Administrator or designee was notified of the 11 critical events, FSH records did not evidence for 9 of the critical events that the notification was made by telephone. Further, FSH records for 3 of the 9 critical events (two elopements and an assault) indicated that the Chief Hospital Administrator or designee was not notified within the required time frame. Specifically, the elopements were reported 1.5 and 2 hours late and the assault was reported 5 days late.
- 8 of the 40 Resident Incident Reports were not properly completed, including 5 Reports related to critical events. Specifically, for 5 Resident Incident Reports, nursing staff did not complete, or did not accurately complete, the injury portion of the Reports in accordance with FSH procedures, including for 4 critical events. In addition, the outcome section for 2 Resident Incident Reports was not completed and another Resident Incident Report did not have the correct incident time.
- FSH staff did not complete, or did not fully complete, a Form 611 for 4 critical events.

Although we requested, Department management was unable to provide explanations for the issues noted on audit.

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

¹⁷ Department Operating Procedure No. 155-25 defined level two resident altercations as altercations with injury that required medical treatment beyond first aid.

¹⁸ FSH Operating Procedure No. 10-1.

¹⁹ FSH Operating Procedure No. 75-1.

Recommendation: We again recommend that Department and FSH management enhance controls to ensure that appropriate Department personnel are timely notified of critical events and all required reporting is completed in accordance with Department and FSH 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 can live and staff can work, Department procedures²⁰ require facilities to maintain minimum staffing coverage. The procedures specified that minimum staffing coverage was the fewest number of staff required to operate a ward, dorm, 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.

In our report No. 2017-205 (Finding 6), we noted that Department-managed facilities did not always meet minimum staffing requirements. As part of our follow-up audit procedures, we examined selected staffing coverage records for the FSH, NEFSH, NFETC, SFETC, and TCFTC for the period July 2017 through January 2019 to determine whether actual staffing coverage met the minimum requirements established by facility procedures. Our examination disclosed that:

- FSH scheduling practices did not always take into consideration specialized therapeutic observations and security escorts requiring additional staff. Our examination of 5 daily FSH staffing reports for one unit and one shift each day disclosed that the selected units were understaffed by 2 staff one day and understaffed by 3 staff another day. According to FSH management, patient needs for specialty observations may change hourly and staff are allocated within available resources.
- 3 weekly NEFSH staffing coverage reports for all units and all shifts each day indicated that 18 of the 54 shifts selected were understaffed, on average, by 3 staff per shift. In response to our audit inquiry, Department management indicated that aggressive recruiting efforts by other entities, employee absenteeism, and the lack of a shift differential for night shifts, among other factors, contributed to the staffing shortages.

Absent staffing coverage in accordance with minimum requirements, FSH and NEFSH management has reduced assurance regarding the provision of high-quality mental health care services and a safe environment in which residents can live and staff can work.

²⁰ Department Operating Procedure No. 155-29, *Management of Minimum Coverage in State Mental Health Treatment Facilities*.

Recommendation: We recommend that FSH and NEFSH management take steps to ensure compliance with established staffing minimums.

Finding 7: Control of Contraband

Department procedures²¹ for the control of contraband,²² at Department and contractor-managed facilities required that contraband found in the possession of a resident which was not in violation of the law either be secured and stored at the facility until the resident was discharged, or confiscated and liquidated by facility staff. If contraband was found to be in violation of the law, facility staff were required to immediately report the violation to local law enforcement. 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 evaluated the adequacy of FSH, NEFSH, NFETC, SFETC, and TCFTC contraband controls through inquiry of facility management, review of facility procedures, and examination of records and items related to contraband seizures. We found that:

- As similarly noted in our report No. 2017-205 (Finding 9), NFETC had not established adequate controls to ensure that the disposition of contraband was properly documented. Department procedures²³ required facility records to note the date and manner of disposition of contraband, along with the witnesses to the disposition. However, NFETC was unable to provide documentation evidencing the disposition of four contraband items identified in our audit testing, including a cigarette and a screw. According to the NFETC Security Chief, disposition documentation for these items was not maintained because the items were insignificant in nature.
- TCFTC had not established adequate controls to ensure the proper accountability for and safeguarding of seized contraband. Specifically, TCFTC procedures did not specify how to account for contraband, including its disposition. Additionally, during the period July 2017 through April 2019, TCFTC did not maintain a contraband box or logs that adequately evidenced the receipt, storage, and disposition of seized contraband. Consequently, TCFTC was unable to demonstrate that contraband was appropriately accounted for from seizure to disposition by security staff.

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

Recommendation: We recommend that NFETC and TCFTC management enhance controls to ensure the proper accountability for and safeguarding of all seized contraband items. Such controls should include procedures for 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.

²¹ Department Operating Procedure No. 155-8, *Contraband Control in the Mental Health Treatment Facilities*.

²² Department Operating Procedure No. 155-8 defined contraband as: an intoxicating beverage; a controlled substance as defined by Chapter 893, Florida Statutes, unless legally possessed pursuant to Chapter 465, Florida Statutes; a weapon as defined by Section 790.001(13), Florida Statutes, or any instrument or device customarily used or designed to be used as a dangerous weapon; any item determined by the Department and designated by Department rule or by the administrator of any facility, and designated by written institutional policies to be hazardous to the welfare of residents or the operation of the facility.

²³ Department Operating Procedure No. 175-01-01.

Finding 8: Accounting for Expenditures

State law²⁴ 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 Officer²⁵ 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 not issued within 40 days after receipt of the invoice, State law²⁶ requires the agency to pay interest to the vendor on the unpaid balance.

DFS guidance²⁷ specifies 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.

In our report No. 2017-205 (Finding 11), we noted that Department-managed facility controls did not always ensure that expenditures were appropriately coded or accounted for. As part of follow-up audit procedures, we examined Department records for 40 FSH expenditure transactions totaling \$684,370, 40 NEFSH expenditure transactions totaling \$110,468, and 40 NFETC expenditure transactions totaling \$264,672. Our examination disclosed that facility staff did not always record transaction dates in FLAIR in accordance with DFS guidance. Specifically:

- FSH staff incorrectly recorded transaction dates in FLAIR for 5 expenditure transactions totaling \$17,294. For each of the 5 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 7 days earlier to 33 days later than the transaction dates supported by FSH documentation. Notwithstanding these errors, the FSH still complied with statutory prompt payment requirements.
- NEFSH staff incorrectly recorded the transaction dates in FLAIR for 24 transactions totaling \$67,537. For 2 advance payments, NEFSH recorded actual dates rather than all zeros. For the other 22 transactions, the date NEFSH 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 1 to 93 days later than the transaction dates supported by NEFSH documentation. Had NEFSH staff correctly recorded the transaction dates, NEFSH would not have complied with statutory prompt payment requirements for 8 of the transactions. According to Department management, staff did not always date stamp invoices when received and sometimes input incorrect dates and the advance payments were processed through the State's purchasing system, which did not allow for all zeros to be recorded as the transaction date. Notwithstanding, NEFSH staff did not correct the FLAIR Transaction Date field to properly reflect the advance payments.

²⁴ Section 215.422(1), Florida Statutes.

²⁵ Pursuant to Section 20.121, the State's Chief Financial Officer is the head of the Department of Financial Services (DFS).

²⁶ Section 215.422(3)(b), Florida Statutes.

²⁷ Chief Financial Officer Memorandum No. 1 (2013-14) and, as of November 1, 2019, Chief Financial Officer Memorandum No. 18 (2019-20).

- NFETC staff incorrectly recorded the transaction dates in FLAIR for 10 expenditure transactions totaling \$48,742. For each of the 10 transactions, the date NFETC 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 1 day earlier to 91 days later than the transaction dates supported by NFETC documentation. Had NFETC staff correctly recorded the transaction date, NFETC would not have complied with statutory prompt payment requirements for 1 of the 10 transactions. In response to our audit inquiry, Department management indicated that inexperienced staff had input incorrect dates.

Without accurate transaction dates, instances of noncompliance with statutory prompt payment requirements may not be identified by the DFS and the facilities may not make required interest payments.

Recommendation: We again recommend that FSH, NEFSH, and NFETC management enhance procedures to ensure that expenditure transactions are accurately recorded in FLAIR.

Finding 9: Cost Allocation

Properly designed and executed cost allocation methodologies are essential to ensure that 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 FSH provides services to both civil and forensic clients while NEFSH provides services only to civil clients and NFETC only to forensic clients. In our report No. 2017-205 (Finding 12), we noted that Department-managed facilities did not always allocate costs in a manner that accurately identified the costs to provide civil and forensic services. As part of our follow-up audit procedures, we inquired of facility management and evaluated facility processes for allocating the costs of shared positions between the three Department-managed facilities. Our audit procedures disclosed that the Department did not allocate the costs of 23 positions shared by the Department-managed facilities. Specifically, 15 of the 23 positions were shared by the three Department-managed facilities, 5 positions were shared between NEFSH and NFETC, and 3 positions were shared between FSH and NEFSH. According to Department management, the costs associated with the positions shared between the three facilities are charged to the facility where the position is based, with 18 of the positions being based at NEFSH and 5 of the positions being based at FSH.

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

Recommendation: We recommend that Department management revise Department-managed facility cost allocation procedures to allocate the costs of shared positions between the facilities using an allocation base that reasonably associates the position costs with the facility activities that receive the benefits from which the costs are derived.

OTHER FACILITY ADMINISTRATIVE ACTIVITIES

During our audit fieldwork, the Department's Inspector General released an investigative report on October 10, 2019, sustaining allegations that the State Mental Health Treatment Facilities (SMHTF) Chief Hospital Administrator created a conflict of interest and failed to safeguard his ability to make objective, fair, and impartial decisions in relation to Department contracting actions. Additional allegations sustained against the Chief Hospital Administrator included that he had contracted staff perform repairs to a State rental vehicle and return the State rental vehicle to the rental location, failed to report an accident involving a State rental vehicle, and misused Department fleet vehicles by allowing personal use for he and his staff.

As a result of this investigation, we conducted additional audit procedures related to SMHTF expenditure and procurement transactions, monitoring of facility services contracts, and facility motor vehicle and fuel controls. As subsequently described, our audit found that Department controls need enhancement to promote the appropriate use of Department resources, including motor vehicles and fuel; the proper procurement of goods and services; and the adequate monitoring of fleet management activities.

Finding 10: SMHTF Expenditure and Procurement Transactions

To promote the appropriate expenditure of Department resources, facility management should establish controls designed to ensure that expenditures are made in accordance with State law and applicable rules and policies, are adequately supported, and represent arms-length transactions. State law²⁸ provides that a competitive solicitation process is to be used for all procurements in excess of \$35,000.

As part of our audit, we examined Department policies and procedures and Department records related to 25 SMHTF expenditure transactions, totaling \$792,506, made during the period July 2017 through September 2019. Our examination disclosed that Department policies and procedures did not require SMHTF expenditures or procurement activities to be subject to approval by management outside the SMHTF section, such as Department accounting office management, and that SMHTF expenditures did not always comply with applicable laws, rules, and policies; were not always appropriately supported; or did not always represent an arms-length transaction. Specifically, we found:

- A \$34,999 expenditure for professional medical services that was not supported by clearly defined deliverables established prior to the rendering of services or an invoice with sufficient detail identifying the extent of the services provided. According to e-mails cited in the Inspector General's report, a prospective employee asked for a signing bonus to increase her compensation. In response, a Department contractor directed her to register as a vendor in the State's procurement system and the Department issued a \$34,999 purchase order to her, \$1 less than the \$35,000 statutory threshold for competitive procurement.
- Two employee moving expense reimbursements, totaling \$6,350, were not properly authorized or documented. Pursuant to the *DFS Reference Guide for State Expenditures* (Reference Guide), the payment of employee moving expenses requires the approval of the agency head or their designee and may only be made when it is in the best interest of the State due to the exceptional or unique requirements of the position. The Reference Guide further specifies that vouchers submitted for the reimbursement of employee moving expenses must include the authorization to

²⁸ Section 287.057(1), Florida Statutes.

pay moving expenses and receipts. However, while the Department had established that certain positions were authorized to receive reimbursement for moving expenses, the two reimbursements were made to individuals in positions not authorized by the Department. Additionally, a paid receipt was not available to support one of the reimbursements totaling \$1,350.

- The Department utilized an existing contractor to purchase a \$5,039 water pump for FSH. While Department records indicated that this was an emergency purchase during a period when the FSH Purchasing Office was not processing requisitions, the Department's Headquarters Purchasing Office was not contacted to make the purchase. Department personnel indicated that the FSH Purchasing Office should have contacted the FSH Financial Services section and processed the purchase through Department-established procurement processes.
- During our evaluation of four expenditures, totaling \$45,875, that the two related purchase orders, totaling \$174,920, were not competitively procured and Department records did not otherwise evidence the basis for the purchase order amounts or exemption from statutory competitive procurement requirements. In addition, the purchase orders did not contain clearly defined deliverables.
- 14 travel payments, totaling \$8,707, to the same employee for lodging, rental car, and fuel expenses in Tallahassee, although the employee's position was headquartered in Tallahassee. According to Department management, the travel expenses did not meet Department policy and should not have been approved.

Absent effective expenditure and procurement controls, such as Department policies and procedures that require expenditures and procurement activities be approved by management outside of the SMHTF section, the risk is increased that SMHTF expenditure and procurement transactions may not comply with State law and other guidelines.

Recommendation: We recommend that Department management enhance policies and procedures to ensure that SMHTF expenditure and procurement transactions are subject to review and approval by management outside of the SMHTF section.

Finding 11: Contract Monitoring

Effective contract management requires the monitoring of contractor performance to assess compliance with contract provisions, provide a means for early detection of potential noncompliance, and facilitate timely corrective action. As part of our audit, we examined facility monitoring records for the contractor who provided environmental services for NEFSH and NFETC during the period March 2019 through September 2019 and facilities and fleet management services at FSH during the period July 2017 through September 2019. Our examination disclosed that FSH staff did not monitor contractor activities related to fleet management during the period July 2017 through September 2019 and, instead, an employee of the contractor was responsible for managing and monitoring FSH fleet activities. As of November 2019, FSH had 172 motor vehicles and related expenditures totaled \$442,490 during the period July 2017 through June 2019. According to FSH management, the contractor employee was a former State employee whose employment and duties shifted to the contractor after the contractor assumed responsibility for FSH fleet management.

Independent and effective monitoring of FSH fleet management activities provides greater assurance that contractor noncompliance with contract terms and conditions will be identified and serves as a means for early detection of potential noncompliance and timely corrective action.

Recommendation: We recommend that FSH management ensure that contractor fleet management activities are subject to independent monitoring and the results of monitoring are documented in FSH records.

Finding 12: Motor Vehicle and Fuel Controls

State law²⁹ specifies that Department motor vehicles may only be used for official State business. State law further provides³⁰ that official State business does not permit the use of a motor vehicle for commuting purposes unless such use is authorized as a perquisite by the DMS, is required by an employee after normal duty hours to perform duties of their position, or is authorized for an employee whose home is their official base of operation. Additionally, DMS rules³¹ specify that fuel purchased in any manner for State use shall be used only for official purposes.

As of November 2019, FSH had 172 motor vehicles, as of June 2019, NFETC had 13 motor vehicles, and, as of February 2019, NEFSH had 61 motor vehicles. Each facility had a fuel pump on-site for dispensing fuel and at FSH, the transportation shop, motor vehicles, and fuel pump were managed by a contractor, while the motor vehicles and fuel pump at NEFSH and NFETC were managed by facility staff.

As part of our audit, we examined the motor vehicle usage logs available for 25 facility motor vehicles³² for the months of November 2018, March 2019, and October 2019. Our examination disclosed that facility records did not always demonstrate the reasonableness of motor vehicle usage. Specifically:

- FSH was unable to provide for our examination 3 motor vehicle usage logs related to 3 vehicles and NEFSH was unable to provide 6 motor vehicle usage logs related to 5 vehicles.
- 8 motor vehicle usage logs pertaining to 4 motor vehicles assigned to FSH indicated that employees used the vehicles for commuting, and in certain instances, personal purposes. These motor vehicles were driven a total of 10,081 miles during November 2018 and March 2019 (the vehicles were not driven in October 2019). However, Department records did not clearly evidence the authorization for the employees to utilize the motor vehicles for commuting purposes. In response to our audit inquiry regarding the personal use of State vehicles, Department management indicated that, when the Department became aware of the personal use, the staff were informed that it was not allowed and should cease immediately.

Additionally, the facilities did not periodically reconcile fuel inventory records to actual fuel usage records and stores to ensure that fuel was used only for official purposes. Specifically, we noted that:

- FSH records did not permit a reconciliation of fuel usage to actual fuel stores. While FSH contractor staff indicated that they took physical stick readings once a month to determine whether the readings corresponded to FSH fuel records, no documentation of the results of these procedures was maintained.
- At NEFSH, although management indicated that monthly fuel logs were kept, NEFSH was unable to provide monthly fuel readings for the period April 2019 through June 2019, which prohibited a reconciliation to monthly fuel pump logs.

²⁹ Section 287.17(1), Florida Statutes.

³⁰ Section 287.17(3)(a), Florida Statutes.

³¹ DMS Rule 60B-1.013, Florida Administrative Code.

³² 15 FSH motor vehicles, 6 NEFSH motor vehicles, and 4 NFETC motor vehicles.

- While NFETC maintained records of fuel usage, purchases, and fuel measurements, NFETC did not reconcile actual fuel stores to the fuel usage reported on the Vehicle Maintenance Monthly Cost report. Our comparison of the measured fuel inventory records to the fuel usage records found differences ranging from a monthly overage of 136 gallons to a monthly shortage totaling 84 gallons during the period April through July 2019.

Absent effective controls and complete motor vehicle and fuel use records, including authorization for any commuting use and routine monitoring of fuel consumption, there is an increased risk of noncompliance with State law and that loss, theft, or unauthorized use of facility fuel could occur and not be promptly detected.

Recommendation: We recommend that facility management enhance motor vehicle and fuel use controls to ensure facility records demonstrate compliance with State law and that fuel is only used for official purposes.

Finding 13: FSH Transportation Shop Controls

As previously noted, FSH utilizes a contractor to operate the FSH transportation shop. Controls over the operation of the transportation shop are necessary to, among other things, promote the appropriate use of FSH resources, help prevent and detect the loss or theft of vehicle parts and supplies, and ensure that maintenance costs are appropriately identified for each motor vehicle.

As part of our audit, we inquired of contractor personnel, reviewed records from the transportation shop's work order system, and observed selected transportation shop parts and supplies. Our audit procedures disclosed that the work order system did not identify all parts used for each job, nor did it include the costs of each item used. Additionally, we attempted to trace 28 supply items, such as tires and batteries, delivered to the transportation shop during the period July 2017 through October 2019 to a work order to determine whether the items were utilized on FSH vehicles. However, 9 of the 28 items could not be traced to a work order and FSH records did not otherwise evidence that the items were used on FSH vehicles.

Although we requested, Department management was unable to provide explanations for the issues noted on audit. Adequate controls to appropriately track and account for motor vehicle parts and supplies would promote the appropriate use of FSH resources and help to prevent or timely detect loss or theft, should it occur.

Recommendation: We recommend that FSH management ensure that the transportation shop contractor accounts for the use of all parts and supplies and related costs.

PRIOR AUDIT FOLLOW-UP

Except as discussed in the preceding paragraphs, the Department had taken corrective actions for the findings included in our report No. 2017-205.

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 January 2019 through April 2020 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.

This operational audit of the Department of Children and Families (Department) focused on the oversight and administration of State Mental Health Treatment Facilities (facilities). 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 other 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 determine whether management had corrected, or was in the process of correcting, all deficiencies disclosed in our report No. 2017-205.
- 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 obtain an understanding of Department controls for the oversight and administration of the facilities.
- Performed inquiries of Department personnel and inspected documents and records to determine whether Department management had adequately designed and implemented controls, including policies and procedures, for the facilities.
- Inquired of Department management to determine whether the Department had obtained appropriate licenses to operate Florida State Hospital (FSH), Northeast Florida State Hospital (NEFSH), and the North Florida Evaluation and Treatment Center (NFETC).
- Reviewed Department procedures governing the operation of Department-managed facilities, including the processes for reviewing and approving facility procedures and providing facility management minimum staffing coverage guidelines, to determine whether the Department had established adequate and consistent procedures for the operation and staffing of Department-managed facilities.
- Reviewed Department procedures and examined Department records 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 residents was met and that the facilities complied with applicable laws, rules, and Department procedures.
- From the population of the ten monitoring reports issued during the period July 2017 through January 2019 related to the four contractor-managed facilities, examined five selected monitoring reports to determine whether all key contract requirements were subject to monitoring and whether adequate supervisory review of monitoring activities was properly documented.
- From the population of 514 permanent buildings located at FSH, NEFSH, and NFETC during the 2017-18 fiscal year, examined Department insurance and architectural and blueprint records for 8 selected buildings to determine whether Department property information was correctly reported in FL-SOLARIS.
- From the population of 79,294 expenditure transactions, totaling \$63,839,110, made by the Department-managed facilities during the period July 2017 through January 2019, examined Department records for 120 selected expenditure transactions, totaling \$1,059,510, 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 and examined:
 - 40 FSH expenditure transactions, totaling \$684,370, from the population of 45,706 FSH expenditure transactions totaling \$39,634,925.
 - 40 NEFSH expenditure transactions, totaling \$110,468, from the population of 25,194 NEFSH expenditure transactions totaling \$19,393,796.
 - 40 NFETC expenditure transactions, totaling \$264,672, from the population of 8,394 NFETC expenditure transactions totaling \$4,810,389.

- Examined documentation related to the staffing of the three Department-managed facilities and two contractor-managed facilities during the period July 2017 through January 2019 to determine whether actual staffing levels met the minimum requirements established by facility procedures. Our examination included:
 - For the FSH, documentation for one shift for one unit during a 5-day period.
 - For the NEFSH, documentation for 54 shifts in a 3-week period.
 - For the NFETC, documentation for 567 shifts in a 3-week period.
 - For the South Florida Evaluation and Treatment Center (SFETC), documentation for one shift per day for 10 days.
 - For the Treasure Coast Forensic Treatment Center (TCFTC), documentation for one shift per day for 5 days.
- Performed inquiries, observations, and inspections of documents and records related to pharmaceutical inventory management at the three Department-managed facilities and two contractor-managed facilities (SFETC and TCFTC) 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.
- Examined facility pharmacy records and interviewed facility staff to determine whether the Department procured the licenses for a pharmaceutical inventory management system at FSH, NEFSH, and NFETC in accordance with applicable State laws and Department of Management Services rules, and to determine whether the system promoted the maintenance of accurate pharmaceutical inventory data.
- Performed inquiries, observations, inspections of documents and records related to contraband items at the three Department-managed facilities and two contractor-managed facilities (SFETC and TCFTC) to determine whether the facilities had adequately designed and implemented controls to ensure: the adequate safeguarding of contraband items seized from employees, visitors, and residents; 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; the contraband item was returned upon the resident 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 2017 through January 2019 to determine whether seized items were accounted for and disposed of in accordance with Department procedures. Specifically, we examined records and items related to:
 - 5 of 32 seizures listed in NEFSH records and 5 seizures selected from contraband storage.
 - 5 of 110 seizures listed in NFETC records and 5 seizures selected from contraband storage.
 - 10 of 149 seizures listed in SFETC records and 3 seizures selected from contraband storage.
- Observed six distributions of pharmaceuticals to facility residents to determine whether the facilities had established and maintained appropriate inventory management controls to accurately account for pharmaceuticals distributed. Specifically:
 - At the SFETC, we observed three pharmaceuticals distributions during the period April 30, 2019, through May 2, 2019.
 - At the TCFTC, we observed three pharmaceuticals distributions during the period May 21, 2019, through May 22, 2019.
- From the population of 154 resident complaints filed at the SFETC and 146 resident complaints filed at the TCFTC during the period July 2017 through January 2019, examined documentation

for 10 selected complaints from the SEFTC and 20 selected complaints from the TCFTC to determine whether the facilities investigated and resolved resident complaints in accordance with established procedures. In addition, performed inquiries, observations, and inspections of documents and records related to resident complaints to determine whether facility management had established appropriate procedures for reporting, investigating, resolving, and following up on resident complaints.

- Evaluated staff qualifications and the training of facility employees to determine whether staffing and training was sufficient to protect employee and resident safety. Specifically, we selected and examined:
 - Staff qualifications and training documentation for 6 of the 544 SFETC employees for the period July 2017 through January 2019.
 - Staff qualifications and training documentation for 6 of the 204 TCFTC employees for the period July 2017 through January 2019.
- From the population of 20,021 incidents reported during the period July 2017 through January 2019 by two Department-managed facilities (FSH and NEFSH) and two contractor-managed facilities (SFETC and TCFTC), examined facility records related to 140 selected incidents to determine whether the incidents were reviewed by appropriate management, reported to the appropriate authority, and all required forms were appropriately completed and within the required time frame. Specifically, we selected and examined:
 - 40 FSH incident reports from the population of 4,420 incident reports.
 - 40 NEFSH incident reports from the population of 12,630 incident reports.
 - 40 SFETC incident reports from the population of 2,091 incident reports.
 - 20 TCFTC incident reports from the population of 880 incident reports.
- From the population of 1,445 workers' compensation claims reported by the FSH, NEFSH, SFETC, and TCFTC for injuries occurring during the period July 2017 through January 2019, examined 75 selected workers' compensation claims to determine whether incidents identified by Department policy were properly reported by the facilities. Specifically, we selected and examined:
 - 25 of 809 workers' compensation claims reported by the FSH.
 - 25 of 504 workers' compensation claims reported by the NEFSH.
 - 20 of 92 workers' compensation claims reported by the SFETC.
 - 5 of 40 workers' compensation claims reported by the TCFTC.
- From the population of 45,706 expenditure transactions, totaling \$39,634,925, made by the FSH during the period July 2017 through January 2019, examined records for 20 selected transactions, totaling \$808,081, to determine whether expenditures were appropriately allocated between civil and forensic services.
- Inquired of Department personnel and reviewed the mutual aid agreements and call logs for the FSH fire department to determine whether other governmental entity costs were appropriately accounted for in Department records.
- Inquired of Department personnel and reviewed Department property records to determine whether the Department had enhanced procedures to properly account for Department-owned canines in accordance with applicable rules and other guidelines.
- As a follow-up to the Office of Inspector General's (OIG's) report No. 2019-0001, dated October 10, 2019, regarding the Chief Hospital Administrator for the State Mental Health Treatment facilities, we:

- Conducted interviews with applicable Department and facility staff to determine whether other areas of concern should be examined as part of our audit, obtained the current status of the OIG report recommendations, and obtained an understanding of internal controls over motor vehicles and procurement.
- From FSH purchasing and warehouse records, selected 28 supply items that were sent to the transportation shop during the period July 2017 through October 2019, and attempted to trace the items to work orders and vehicle cost and maintenance records or physically observed the items to determine whether the items were used on a FSH vehicle and related costs were appropriately accounted for.
- Examined Department records for 25 selected expenditure transactions, totaling \$792,506, made during the period July 2019 through September 2019 and related to matters disclosed in the OIG report to determine whether the expenditures were properly authorized and supported; complied with applicable laws, rules, and policies; and represented arms-length transactions.
- Examined facility procurement, payment, and monitoring records for the contractor that provided environmental services for the three Department-managed facilities during the period July 2017 through September 2019 and facilities and fleet management services at the FSH to determine whether the contracts for each facility were appropriately procured or renewed in accordance with applicable laws, rules, and policies and whether costs were appropriately charged, invoices properly approved, and the contracts were monitored.
- From the population of 55 payments, totaling \$224,417, made during the period July 2017 through September 2019 related to matters disclosed in the OIG report, examined Department records for 15 selected payments, totaling \$37,591, to determine whether the purchase orders associated with the selected payments appeared to circumvent competitive procurement laws and rules and whether the payments appeared appropriate.
- Reviewed documentation for four motor vehicles assigned to Department employees for commuting purposes to determine whether the assignments were properly approved in accordance with State law. Additionally, for 25 of 172 motor vehicles at FSH, NEFSH, and NFETC, obtained motor vehicle usage logs for November 2018, March 2019, and October 2019 to determine whether motor vehicles were used solely for State business and whether motor vehicle usage appeared reasonable.
- Conducted interviews of facility staff at FSH, NEFSH, and NFETC to gain an understanding of the procedures used for maintaining fuel inventory records and reconciling inventory records to fuel usage and purchases. Compared fuel inventory records to fuel usage records at FSH for the period January 2019 through April 2019 and NFETC for the period April 2019 through July 2019 to determine whether facility records supported that fuel was used only for official purposes.
- 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.

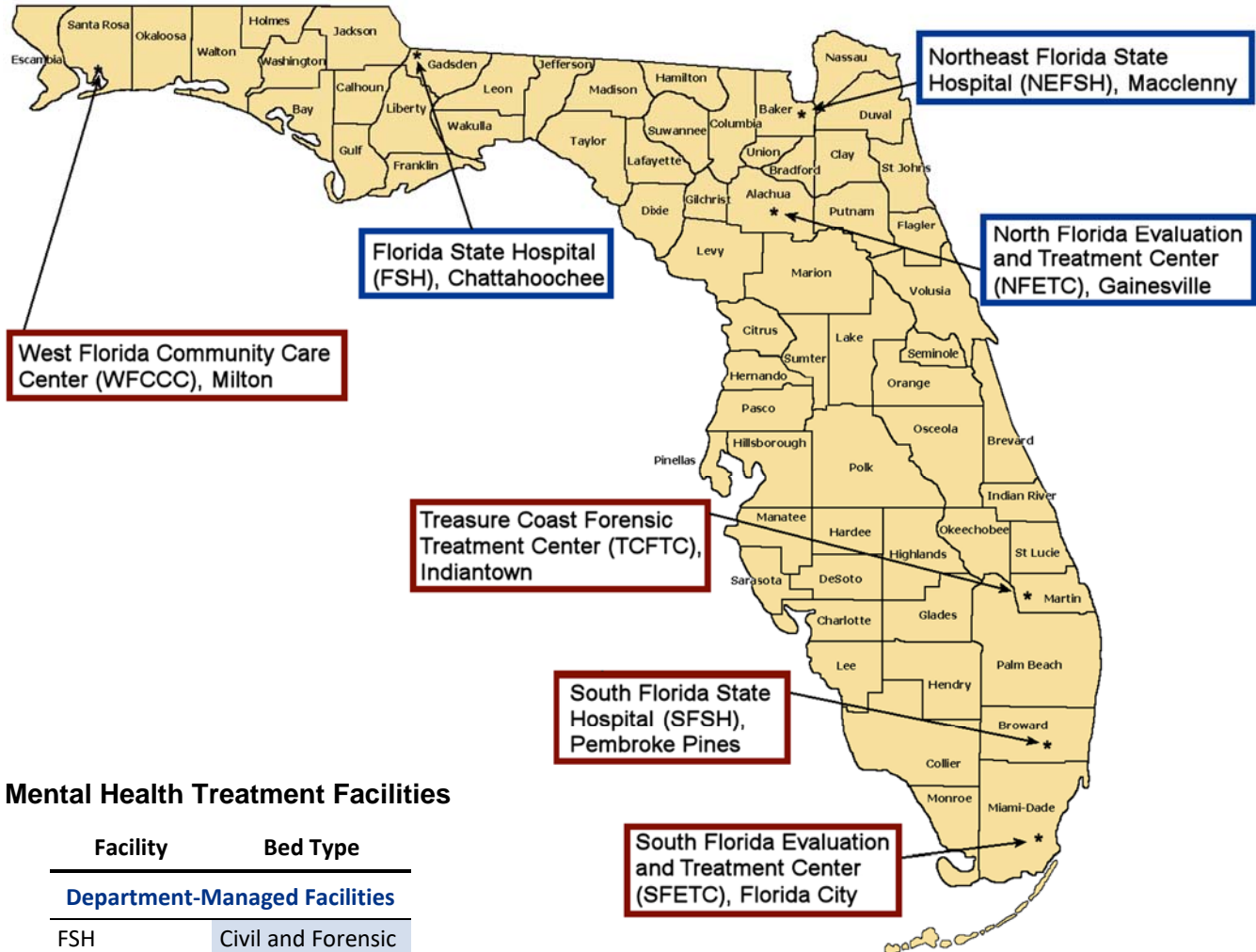
A handwritten signature in blue ink that reads "Sherrill F. Norman". The signature is fluid and cursive, with the first name being the most prominent.

Sherrill F. Norman, CPA
Auditor General

EXHIBIT A

MENTAL HEALTH TREATMENT FACILITIES

JULY 2017 THROUGH JANUARY 2019



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.

MANAGEMENT'S RESPONSE³³



State of Florida
Department of Children and Families

Ron DeSantis
Governor

Chad Poppell
Secretary

October 9, 2020

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

Dear Sherrill Norman:

This letter is in response to the preliminary and tentative audit findings and recommendations for the State Mental Health Treatment Facilities issued to the Department of Children and Families (DCF) on September 2, 2020. The findings and recommendations are related to an operational audit of the oversight and administration of the state mental health treatment facilities (SMHTFs). The five public and private SMHTFs included in the audit are North Florida Evaluation and Treatment Center (NFETC), Northeast Florida State Hospital (NEFSH), Florida State Hospital (FSH), South Florida Evaluation and Treatment Center (SFETC), and Treasure Coast Forensic Treatment Center (TCFTC).

Information regarding DCF's ongoing SMHTF improvement initiatives is included below. An action plan that addresses the audit 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 Agency for Health Care Administration (AHCA) licenses all but two of the Department's mental health facilities (North Florida Evaluation and Treatment Center and Treasure Coast Forensic Treatment Center) and two buildings (one civil and one forensic) located at Florida State Hospital (FSH), as hospitals. This licensing framework has been in place for some time spanning multiple administrations.

Section 916.105(2), Florida Statutes, charges the Department with establishing and maintaining "separate and secure forensic facilities and programs for the treatment...of defendants who have been charged with a felony and who have been found to be incompetent to proceed due to their mental illness, intellectual disability,...," and discusses the balance between providing security at these commitment facilities for forensic clients as well as insuring that their rights are protected. It is clear the

1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

Mission: 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

³³ Management's Action Plan refers to an attachment that is not included in this report but may be a public record that can be obtained from the Department.

Legislature intended forensic clients to be held and treated in separate environments from both civil clients as well as the communities where these facilities are located. NFETC, TCFTC, and the forensic units at FSH fit these requirements and adhere to the provisions of this statute. However, no reading of the text of Section 916.105(2), Florida Statutes, suggests the need for forensic facilities to be licensed as hospitals.

Although the Department does have mental health treatment facilities that are licensed as hospitals, those facilities are notably different from the Department's forensic facilities, in both population and the level of medical care provided. The Department's licensed facilities are designed and staffed to accept psychiatric clients with co-morbid medical conditions and chronic medical needs (i.e. diabetes, hypertension, etc.).

Even the Department's mental health "hospitals" do not require licensure. Section 395.002(12), Florida Statutes, defines a "hospital" as any establishment which:

- (a) 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; **AND**
- (b) 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, except that a critical access hospital, as defined in s. 408.07, shall not be required to make available treatment facilities for surgery, obstetrical care, or similar services as long as it maintains its critical access hospital designation and shall be required to make such facilities available only if it ceases to be designated as a critical access hospital.

While the Department's mental health "hospitals" may meet subsection (a) of section 395.002(12), Florida Statutes, they do not meet subsection (b). The Department's facilities do not provide treatment facilities for surgery or obstetric care, or other definitive medical treatment of similar extent. Nor do the mental health "hospitals" meet the definition of "critical access hospital" found in section 408.07(15), Fla. Stat. Because the mental health "hospitals" do not meet the definition of a hospital requiring licensure under statute, then no license is required under Chapter 395, Florida Statutes. See Section 395.003, Florida Statutes.

Succinctly and conclusively, there exists no statute, case law, or rule which requires NFETC, TCFTC, and the two buildings at FSH, to be licensed as hospitals by AHCA. These forensic facilities are not hospitals as defined by Florida Statutes, as they do not offer medical treatment or health care, other than what is required for managing minor health concerns of the clients. In fact, and specifically, local specialists and licensed hospitals handle serious or acute medical issues for those clients requiring more significant medical treatment.

As illustrated above, the Department is not opposed to regulatory oversight and high standards for its treatment facilities. We are in initial discussions with ACHA on a future regulatory framework since the existing licensing standards are not statutorily required and are not practically applied in all settings. The primary gaps center around the physical structures (e.g., adding a bathroom to every room) would require a significant investment that would not directly lead to higher levels of care.

Finding 2: Square footage information reported in the Florida State-Owned Lands and Records Information System for department-managed facilities sometimes did not agree with department records.

Department Design and Construction staff have coordinated with General Services staff handling insurance issues in FLAIR to ensure that square footages in SOLARIS match those in FLAIR. Design and Construction staff will continue to work with facility managers to ensure any square footage changes are properly recorded in SOLARIS and FLAIR.

Finding 3: The Department did not obtain Department of Management Services approval to utilize an alternate contract source contract in procuring a pharmaceutical inventory management system for the Department-managed facilities. Additionally, the pharmaceutical inventory management system did not promote the maintenance of accurate pharmaceutical inventory data.

Procurement activity has been realigned to DCF Headquarters to ensure all guidelines are followed and enforced. The current pharmaceutical inventory management system, Cardinal Inventory Management (CIM), does not integrate with the facilities' pharmacy software; therefore, facility staff conduct manual audits as recommended by the CIM software. Additionally, DCF is in discussions with Cardinal Health to modify the current CIM system software to accommodate facilities' pharmacy software and has requested Cardinal provide a plan for a solution within the next 30 days.

Finding 4: The South Florida Evaluation and Treatment Center (SFETC) did not ensure that controlled substances pharmacy duties were appropriately separated.

Protocols for the processing of controlled substances at SFETC have been revised to address this issue. See attached action plan for additional details.

Finding 5: Florida State Hospital (FSH) did not always report to the Department critical events involving clients and staff in accordance with Department and Florida State Hospital procedures.

DCF and FSH will develop enhanced controls to ensure timely notification of critical events. Additional training of key staff has begun at FSH. See attached action plan for additional details.

Finding 6: Florida State Hospital (FSH) and Northeast Florida State Hospital (NEFSH) did not always comply with minimum staffing requirements.

DCF will work with the facilities to comply with minimum staffing requirements. See attached action plan for additional details.

Finding 7: North Florida Evaluation & Treatment Center (NFETC) and Treasure Coast Forensic Treatment Center (TCFTC) did not always properly account for or safeguard seized contraband.

Steps to address this issue have been taken at NFETC and TCFTC. See attached action plan for additional details.

Finding 8: FSH, NEFSH, and NFETC controls still need enhancement to ensure that expenditures are accurately recorded in the Florida Accounting Information Resource Subsystem and comply with statutory prompt payment requirements.

Steps to address this issue have been taken. Quarterly training is now done with the SMHTF accounts payable staff. Part of this training is identifying and utilizing the correction transaction date for all disbursements.

Finding 9: The costs for positions shared between Department-managed facilities were not allocated in a manner that accurately identified civil and forensic services costs among the facilities.

Time studies for shared positions are completed and submitted to the SMHTF Revenue Manager and included in the Centers for Medicare & Medicaid cost report. DCF is currently consulting with the Administrative Services Budget Office to develop cost allocations for shared positions.

Finding 10: Department controls over State Mental Health Treatment Facilities (SMHTF) expenditure and procurement transactions need enhancement to ensure that such transactions comply with State law and other guidelines.

SMHTF procurement has been realigned to DCF Headquarters. This will ensure that all purchasing guidelines are followed and enforced. In addition, all purchase orders over \$50K will be routed through DCF Headquarters Legal for approval.

Finding 11: Florida State Hospital (FSH) did not monitor contractor activities related to fleet management.

FSH Master Vehicle Log is maintained by Aramark Transportation Department and will be submitted to the FSH Contract Management Office monthly for review and oversight.

Finding 12: FSH, NEFSH, and NFETC motor vehicle and fuel use controls need enhancement to ensure and demonstrate compliance with State law and the reasonableness of motor vehicle and fuel usage.

Facility processes are being modified to address this issue. See attached action plan for details.

Finding 13: Florida State Hospital (FSH) transportation shop controls need improvement to appropriately track and account for the use of motor vehicle parts and supplies and related costs.

Facility processes are being modified to address this issue. See attached action plan for details.

Thank you for the opportunity to provide feedback.

Sincerely,



Chad Poppell
Secretary

Enclosure

cc: Melinda Miguel, Chief Inspector General, Executive Office of the Governor
David Mica, Chief of Staff, Department of Children and Families
Rodney E. Moore, Assistant Secretary for Substance Abuse & Mental Health,
Department of Children and Families
Jacqueline Young, Policy and Programs Director, Department of Children and
Families
Wendy Scott, Acting Chief Hospital Administrator
Keith Parks, Inspector General, Department of Children and Families
Steven Meredith, Director of Auditing, Department of Children and Families
Lisa Norman, Audit Manager, Office of the Auditor General
Kathy DuBose, Staff Director, Joint Legislative Committee
Javier Enriquez, General Counsel, Department of Children and Families

Action Plan in Response to Preliminary Auditor General Findings Dated September 2, 2020
Department of Children and Families
Oversight and Administration of State Mental Health Treatment Facilities

Finding	Recommendation	Owner	Action Steps	Anticipated Completion	Status
<p>1. The Department did not ensure that all Facilities were licensed by the Agency for Health Care Administration in accordance with State law. A similar finding was noted in the 2017 AG audit, report no. 2017-205.</p>	<p>a. Facility Management continue efforts to 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.</p>	<p>Bob Gibson (NFETC) Chris Mattingly (FSH) Roland Pelier (TCFTC)</p>	<ul style="list-style-type: none"> FSH, NFETC and TCFTC are inspected annually by AHCA and the State Fire Marshall for Life Safety issues. 		<p>Complete DCF submitted a Legislative Budget Request for \$1 million dollars for the planning and design of a new 500 bed forensic treatment center. The issue was not included in the Governor's recommendations to the Legislature. The department does not agree with the finding/recommendation in this case. It is the department's position, and DCF General Counsel concurs, that neither statute, case law nor rule exists which requires TCFTC or NFETC to be licensed as a hospital by AHCA. This forensic facility is not a "hospital" as defined by 395.002(12), F.S., and does not offer medical treatment other than what is required for minor health concerns. Serious or acute medical issues are handled by local specialists or hospitals. Also see attachment "AHCA Licensing Memo 2019".</p>
	<p>b. Department management, in consultation with the Legislature, evaluate the licensure needs for FSH, NEFTC and TCFTC.</p>	<p>Wendy Scott Jackie Young Matt Howard Perry Dollinger</p>			
<p>2. As similarly noted in the 2017 AG audit, report no. 2017-205, the square footage information reported in the Florida State-Owned Lands and Records</p>	<p>Department management establish policies and procedures for maintaining facility data in FL-SOLARIS and ensure that facility information reported in FL-SOLARIS,</p>	<p>Wendy Scott Perry Dollinger Chris Mattingly (FSH)</p>	<ul style="list-style-type: none"> DCF Design and Construction staff have coordinated with General Services staff handling insurance issues in FLAIR to ensure that square footages in SOLARIS match those in FLAIR. Design and Construction staff will continue to work with facility 		<p>Complete</p>

Action Plan in Response to Preliminary Auditor General Findings Dated September 2, 2020
Department of Children and Families
Oversight and Administration of State Mental Health Treatment Facilities

Finding	Recommendation	Owner	Action Steps	Anticipated Completion	Status
Information System for the Department-managed facilities sometimes did not agree with Department records.	and any adjustments to reported information, is supported by Department records.	Bob Gibson (NFETC) Linda Williams (NEFSH) General Services	managers to ensure any square footage changes are properly recorded in SOLARIS and FLAIR.		
3. The Department did not obtain Department of Management Services approval to utilize an alternate contract source contract in procuring a pharmaceutical inventory management system for the Department-managed facilities.	<p>a. Department management strengthen controls to ensure that future procurements of goods or services using alternate contract source contracts comply with applicable DMS rules.</p> <p>b. Department and facility management take steps to ensure that pharmaceutical records are appropriately maintained using a perpetual inventory management system that is</p> <ul style="list-style-type: none"> o compatible with other software o establishes appropriate reorder points o accurately accounts for pharmaceuticals o can be used to identify and investigate discrepancies noted during physical inventory counts. 	D Nielson	<ul style="list-style-type: none"> • Procurement activity has been realigned to DCF HQ. This will ensure that all property guidelines are followed and enforced. 		Complete
Additionally, the pharmaceutical inventory management system did not promote the maintenance of accurate pharmaceutical inventory data.		Wendy Scott Rodney Moore Chris Mattingly (FSH) Bob Gibson (NFETC) Linda Williams (NEFSH)	<ul style="list-style-type: none"> • The Department-managed facilities utilize the Cardinal Inventory Management (CIM) system for pharmaceutical management. CIM software is not compatible with the facilities' pharmacy software to identify what specific product is dispensed. Facilities conduct manual audits as per CIM recommendations. • DCF is in discussions with Cardinal Health to modify the current CIM system software to accommodate facilities' pharmacy software and has requested Cardinal provide a plan for a solution within the next 30 days. 	Ongoing	<p>NEETC: Since June 2019, the CIM supports reorder points and accounts for pharmaceuticals. Touch Point sends information to the CIM system, allowing a technician to audit activity and associated discrepancies. The pharmacists manually produce daily audit reports. Physical counts in Touch Point machines by the technicians are entered in the CIM System for updates. The perpetual inventory integrates physical counts from machines on buildings with stock in the pharmacy. Regarding controlled</p>

Action Plan in Response to Preliminary Auditor General Findings Dated September 2, 2020
 Department of Children and Families
 Oversight and Administration of State Mental Health Treatment Facilities

Finding	Recommendation	Owner	Action Steps	Anticipated Completion	Status
					<p>substances, any discrepancy is investigated daily with Nursing providing timely reasons.</p> <p>NEFSH: Cardinal Health services pharmacies (hospitals & retail) throughout the country and yet it just developed Cardinal Inventory Management (CIM) for hospital setting for the first time when DCF IT spearheaded this project in 2019. After CIM installation, NEFSH has been performing random auditing as suggested by the software 100% of the times (250 audits per week). NEFSH also use the software suggested reorder point as a guide to daily ordering. Accurate count of pharmaceuticals is crucial, but it takes manpower to manage it and this takes away pharmacy clinical duties to take care patients. CIM is not able to integrate with the pharmacy software to identify what specific NDC product is dispensed.</p> <p>FSH continues to utilize the CIM to manage pharmaceutical inventory. The pharmacy department conducts audit weekly to</p>

Action Plan in Response to Preliminary Auditor General Findings Dated September 2, 2020
Department of Children and Families
Oversight and Administration of State Mental Health Treatment Facilities

Finding	Recommendation	Owner	Action Steps	Anticipated Completion	Status
<p>4. The South Florida Evaluation and Treatment Center (SFETC) did not ensure that controlled substances pharmacy duties were appropriately separated.</p>	<p>a. SFETC management ensure that pharmacy duties for controlled substances are appropriately separated.</p> <p>b. If incompatible pharmacy duties are necessary, we recommend that SFETC management establish and document effective compensating controls, such as independent reconciliations of pharmacy inventory records.</p>	<p>Frank Schwartz (SFETC)</p>	<ul style="list-style-type: none"> • Changes to the Pharmacy's protocols for the processing of controlled substances were initiated shortly after the AG's audit, in response to the preliminary verbal report provided during the exit interview. • A more detailed inventory process was implemented to include the following additional steps/checks: <ol style="list-style-type: none"> 1. Pharmacy Technician 1 will order the controlled substances. 2. Pharmacy Technician 2 will receive the order upon delivery. 3. The main Pharmacist will check the invoice against the quantity sent from vendor (Amerisource). 4. The per diem Pharmacist will perform the perpetual inventory. • SFETC Internal Policy MM 300-08 Management of Controlled Medications will be updated accordingly to reflect the new protocol. 	<p>10/30/20</p>	<p>validate perpetual count. Corrections are entered manually to the SIMS system by the pharmacy technician. Pharmacy Director, Dr. McElvin, regularly communicates with CIMS management to address their system failures. These issues are addressed to the IT team. Dr. McElvin last communicated with CIMS in August and was told that all development enhancements were placed on hold due to Covid 19 and they would be meeting within the next two weeks to prioritize.</p> <p>Pending revision of the internal policy to reflect updated processes for pharmacy inventory of controlled substances.</p>

Action Plan in Response to Preliminary Auditor General Findings Dated September 2, 2020
 Department of Children and Families
 Oversight and Administration of State Mental Health Treatment Facilities

Finding	Recommendation	Owner	Action Steps	Anticipated Completion	Status
<p>5. As similarly noted in the 2017 AG audit, report no. 2017-205, Florida State Hospital (FSH) did not always report to the Department critical events involving clients and staff in accordance with Department and Florida State Hospital procedures.</p>	<p>Department and FSH management enhance controls to ensure that appropriate Department personnel are timely notified of critical events and all required reporting is completed in accordance with Department and FSH procedures.</p>	<p>Chris Mattingly (FSH)</p>	<ul style="list-style-type: none"> FSH Quality Improvement Department is in the process of analyzing the critical event reporting discrepancies and will provide a summary report to facility management for use in developing enhanced controls to ensure timely notification of critical events. An Administrator on Duty (AOD) training manual was created and distributed to all AOD staff to include night weekend Critical Event reporting. AOD training was provided to all AODs based on this manual. This training will be provided to all AODs added to the rotation moving forward. 	<p>10/10/2020</p>	<p>Complete</p> <p>Complete</p>
<p>6. As similarly noted in the 2017 AG audit, report no. 2017-205, Florida State Hospital (FSH) and Northeast Florida State Hospital (NEFSH) did not always comply with minimum staffing requirements.</p>	<p>FSH and NEFSH management take steps to ensure compliance with established staffing minimums.</p>	<p>Chris Mattingly (FSH) Linda Williams (NEFSH)</p>	<ul style="list-style-type: none"> NEFSH has changed New Employee Orientation from bi-weekly to weekly to expedite getting new employees trained and on the living areas. Starting in November 2019 staffing numbers have been added to the morning meeting that is attended by NEFSH Managers and Administrative Staff. FSH: To maximize staffing resources, FSH Assistant Hospital Administrators are assessing bed utilization to consider consolidation of dorms as census permits. FSH Human Resources Business Partner will develop a recruitment plan for filling critical positions. 	<p>Ongoing</p>	<p>Complete</p> <p>Due to the Covid 19 pandemic FSH is experiencing critical staff shortages. CARES funds are being utilized to obtain supplemental temporary staffing from an employment agency (direct care, nursing, medical). Many Rehabilitation Therapy staff have been reassigned to residential areas to meet staffing minimums.</p>

Action Plan in Response to Preliminary Auditor General Findings Dated September 2, 2020
 Department of Children and Families
 Oversight and Administration of State Mental Health Treatment Facilities

Finding	Recommendation	Owner	Action Steps	Anticipated Completion	Status
<p>7. North Florida Evaluation & Treatment Center (NFETC) and Treasure Coast Forensic Treatment Center (TCFTC) did not always properly account for or safeguard seized contraband. As similarly noted in the 2017 AG audit, report no. 2017-205.</p>	<p>NFSTC and TCFTC management enhance controls to ensure the proper accountability for and safeguarding of all seized contraband items. Such controls should include procedures for staff to maintain records</p> <ul style="list-style-type: none"> o describing the contraband o evidencing date the contraband was seized o date and manner of disposition o identifying the witnesses to the disposal. 	<p>Bob Gibson (NFETC) Roland Peltier (TCFTC)</p>	<ul style="list-style-type: none"> ▪ NFETC: Contraband form revised to include the two signatures, OA I and OA II review at beginning of each month and disposition the contraband. Contraband forms kept on file by OA II. • TCFTC: A secured cabinet was purchased to store items determined to be contraband. This cabinet is maintained within a secured area. An updated contraband tracking log has also been developed and the TCFTC Contraband policy has been revised to reflect record keeping procedures as outlined in the recommendations section. 		<p>Completed</p> <p>Completed</p>
<p>8. FSH, NEFSH, and NFETC controls still need enhancement to ensure that expenditures are accurately recorded in the Florida Accounting Information Resource Subsystem and comply with statutory prompt payment requirements.</p>	<p>FSH, NEFSH, and NFETC management enhance procedures to ensure that expenditure transactions are accurately recorded in FLAIR.</p>	<p>Diana Nielsen</p>	<ul style="list-style-type: none"> • Quarterly training is now done with the SMHTF accounts payable staff. Part of this training is identifying and utilizing the correction transaction date for all disbursements. 	<p>Ongoing</p>	<p>Completed</p>
<p>9. As similarly noted in the 2017 AG audit, report no. 2017-205, the Department managed facilities were not allocated in a manner that accurately identified civil and forensic services costs among the facilities.</p>	<p>Department management revise Department-managed facility cost allocation procedures to allocate the costs of shared positions between the facilities using an allocation base that reasonably associates the position costs with the facility activities that receive the benefits from which the costs are derived.</p>	<p>D. Nielson</p>	<ul style="list-style-type: none"> • Time studies are completed for shared positions within the SMHTF. These time studies are submitted to the SMHTF Revenue Manager and included in the Centers for Medicare & Medicaid Cost Report. • Cost allocations for shared positions have not been developed. We are currently consulting with the Administrative Services Budget Office to see what options are available. 	<p>Ongoing</p> <p>12/31/2020</p>	<p>Complete</p>

Action Plan in Response to Preliminary Auditor General Findings Dated September 2, 2020
 Department of Children and Families
 Oversight and Administration of State Mental Health Treatment Facilities

Finding	Recommendation	Owner	Action Steps	Anticipated Completion	Status
10. Department controls over State Mental Health Treatment Facilities (SMHTF) expenditure and procurement transactions need enhancement to ensure that such transactions comply with State law and other guidelines.	Department management enhance policies and procedures to ensure that SMHTF expenditure and procurement transactions are subject to review and approval by management outside of the SMHTF section.	Wendy Scott Rodney Moore	<ul style="list-style-type: none"> All procurement activity has been realigned to Headquarters. This will ensure that all purchasing guidelines are followed and enforced. In addition, all purchase orders over \$50K are routed through Headquarters Legal for approval. 		Complete
11. Florida State Hospital did not monitor contractor activities related to fleet management.	FSH management ensure that contractor fleet management activities are subject to independent monitoring and the results of monitoring are documented in FSH records.	Chris Mattingly (FSH)	<ul style="list-style-type: none"> The Master Vehicle Log sheet containing vehicle tag number, in-service hours, vehicle assignment and maintenance information is maintained by Aramark Transportation Department and will be submitted to the FSH Contract Management Office monthly for review and oversight. 	10/14/2020	
12. FSH, NEFSH, and NFETC motor vehicle and fuel use controls need enhancement to ensure and demonstrate compliance with State law and the reasonableness of motor vehicle and fuel usage.	Facility management enhance motor vehicle and fuel use controls to ensure facility records demonstrate compliance with State law and that fuel is only used for official purposes.	Chris Mattingly (FSH) Bob Gibson (NFETC) Linda Williams (NEFSH)	<ul style="list-style-type: none"> NEFSH has redesigned the vehicle logs. Financial Services reviews the receipts, vehicle logs and matches the logs with receipts. Vehicle logs are reviewed monthly by a Property Administrator. The automotive department does a monthly fuel audit separate from the monthly review of the vehicle logs. These measures were implemented to ensure continued compliance with State Law. NFETC: The vehicle fuel pump is secured 24/7 and only accessible by either Vehicle Mechanic or one of two Maintenance supervisors. Pump key and fuel dispense logbook are kept secured in supervisor's office and not accessible after hours. The fuel dispense logbook is maintained upon each operation of the fuel pump regarding beginning and ending dispense numbers with quantities dispensed. This log is reviewed monthly by facility Maintenance Supervisor as well as reported to MHTF Property Administrator. 		Complete Complete

Action Plan in Response to Preliminary Auditor General Findings Dated September 2, 2020
 Department of Children and Families
 Oversight and Administration of State Mental Health Treatment Facilities

Finding	Recommendation	Owner	Action Steps	Anticipated Completion	Status
13. Florida State Hospital (FSH) transportation shop controls need improvement to appropriately track and account for the use of motor vehicle parts and supplies and related costs.	FSH management ensure that the transportation shop contractor accounts for the use of all parts and supplies and related costs.	Chris Mattingly (FSH)	<ul style="list-style-type: none"> FSH: The missing vehicle logs were stored in the Transportation Department Building 1066. The roof structure of this building was heavily damaged during Hurricane Michael and several boxes of mileage logs were destroyed. Forms destruction documentation was completed. To ensure this does not reoccur, plans are underway to establish a process to scan mileage logs to a network location monthly. FSH Director of Facility Operations met with Aramark District Manager to develop a plan to track parts for individual repairs. Preliminary work points to a single PO per repair job. Further discussion is planned with Finance and Purchasing. 	10/30/2020	