STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

INTEROFFICE MEMORANDUM

DATE: June 30, 2016

TO: Christina K. Daly, Secretary
Melinda M. Miguel, Chief Inspector General, Executive Office of the Governor

FROM: Robert A. Munson, Inspector General

SUBJECT: Final Report - #A-1516DJJ-006, *Audit of Psychotropic Medication Oversight*

Please find the enclosed copy of our final audit report *Audit of Psychotropic Medication Oversight*. The Bureau of Internal Audit will conduct a follow-up review to determine the status of corrective actions taken to address the reported findings.

We would like to thank the Offices of Residential Services and Detention Services for the assistance extended to our staff during the audit process. Please feel free to contact Michael Yu, Audit Director, at 850-717-2468 if you have any questions.

RM/my/kn

Attachment

Cc: Timothy Niermann, Deputy Secretary
Fred Schuknecht, Chief of Staff
Laura Moneyham, Assistant Secretary, Residential Services
Dixie Fosler, Assistant Secretary, Detention Services
Sherrill F. Norman, Auditor General
Kathy DuBose, Director, Legislative Auditing Committee

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Audit of Psychotropic Medication Oversight
Report Number A-1516DJJ-006
June 30, 2016

By

The Office of the Inspector General
Bureau of Internal Audit

Robert A. Munson
Inspector General

Michael Yu, CIA, CIG
Director of Auditing

Kelly Neel
Auditor-in-Charge

Karen Miller
Auditor

Christina K. Daly, Secretary

Office of Inspector General
Bureau of Internal Audit
Audit of Psychotropic Medication Oversight
Audit No. A-1516DJJ-006

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EXECUTIVE SUMMARY

The Department of Juvenile Justice (Department), Office of the Inspector General, Bureau of Internal Audit has performed an Audit of Psychotropic Medication Oversight. The audit objectives were to provide reasonable assurances that psychotropic medication oversight complies with Florida Statute, Florida Administrative Code, and Department policy and procedure; and determine if adequate internal controls are in place to ensure the effectiveness and safety in prescription, procurement, storage, administration, and monitoring of psychotropic medication. The audit scope was from July 1, 2014 through December 31, 2015, and related activities through the end of fieldwork. We selected a 10% sample of residential programs and detention facilities for review, consisting of non-secure, high-risk, male, female, and six private providers under contract with the Department.

The audit disclosed that, in general, residential commitment programs and detention facilities had policies and procedures in place that complied with Florida Statute, Florida Administrative Code, and Department policy and procedures regarding psychotropic medication. In addition, our review indicated programs and facilities had internal controls in place to ensure the effectiveness and safety in prescribing, procuring, storing, administering, and monitoring psychotropic medication. However, we noted the following deficiencies in one or more programs/facilities:

- Facility operating procedures and treatment protocol review by doctors and nurses was not documented;
- A nurse was not following Florida Administrative Code by pre-pouring psychotropic medication for non-licensed staff to administer to youth;
- A current Board of Pharmacy Permit was unavailable and a Pharmacy Consultant had not been designated;
- A Designated Mental Health Clinician Authority was not licensed,
- Quality Improvement Meetings were not being held;
- Medical and mental health staff résumés were not maintained in the health care provider agreement file;
- An individualized mental health treatment plan was not completed within 30 days of admission;
- Documents were missing from youths' individual health care records; and
- Policies were non-specific for training non-licensed staff in assisting youth with self-administration of medication.

We recommend the Department implement processes to enhance oversight of medical and mental health procedures pertaining to psychotropic medication in residential programs and detention facilities.

Audit of Psychotropic Medication Oversight
Audit # A-1516DJJ-006

INTRODUCTION

The Office of the Inspector General, Bureau of Internal Audit conducted an audit of psychotropic medication oversight in residential commitment programs and detention facilities from July 1, 2014 through December 31, 2015, and related activities through the end of fieldwork. This audit was initiated based on our Fiscal Year 2015-2016 Audit Plan and conducted in accordance with the *International Standards for the Professional Practice of Internal Auditing*, published by the Institute of Internal Auditors.

Background

The Offices of Residential and Detention Services oversee the Department of Juvenile Justice (Department) development and management of behavioral health, mental health, substance abuse, and sex offender treatment services. Treatment services are designed to increase public safety, strengthen families, and turn around the lives of troubled youth. The Office of Health Services oversees treatment services for the Department by providing clinical technical assistance, administrative rule and policy development, contract enhancement, standardization and monitoring, staff training and support, and quality assurance standards for health and mental health/substance abuse services. The Bureau of Monitoring and Quality Improvement monitors and evaluates each facility/program annually.

There are currently fifty-six (56) residential commitment programs operated by nine private providers contracted with the Department. Additionally, the Department operates twenty-one (21) secure detention centers in twenty-one (21) counties. Over sixty-five percent (65%) of youth in the Department's care have a mental illness or substance abuse issue. Additionally, a significant number of youth have experienced severe childhood trauma (physical, sexual, and emotional abuse) which influences their behavior and treatment needs. All issues must be addressed through assessments, evaluations, crisis intervention, and treatment services.

Objectives, Scope, and Methodology

The objectives of this audit were to provide with reasonable assurances that psychotropic medication oversight is in compliance with Florida Statutes, Florida Administrative Codes, and Department policies and procedures; and determine if adequate internal controls are in place to ensure the effectiveness and safety in the prescription, procurement, storage, administration, and monitoring of psychotropic medications. The scope of the audit included the oversight of psychotropic medications in residential programs and detention facilities from July 1, 2014 through December 31, 2015, and related activities through the end of fieldwork.

To achieve the audit objectives we:

- reviewed applicable statutes and rules;
- reviewed Department policies and procedures;

- selected a sample of residential programs and detention facilities for review;
- reviewed the sample program's and facilities' processes for prescribing, procuring, storing, administering, and monitoring psychotropic medications;
- interviewed program and facility management, staff, and youth;
- interviewed therapists, psychiatrists, and nurses;
- reviewed youth's individual health care records, staff training files, and licenses for medical and mental health professionals;
- reviewed Central Communications Center reports;
- reviewed Bureau of Monitoring and Quality Improvement Program Reports; and
- conducted other activities deemed necessary.

We visited and conducted audit procedures for the following programs and facilities:

- Juvenile Unit for Specialized Treatment (JUST), a non-secure male program in Sumatra provided by Twin Oaks Juvenile Development, Inc.;
- Okaloosa Youth Development Center Borderline Developmental Disability and Developmental Disability High-risk Program, a high-risk male program in Crestview provided by Gulf Coast Youth Services;
- Kissimmee Youth Academy, a high-risk male program in Kissimmee provided by Eckerd Kids;
- Melbourne Center for Personal Growth, a non-secure male program in Melbourne provided by AMIkids, Inc.;
- Lake Academy, a non-secure female program in Tampa provided by G4S Youth Services, LLC;
- St. Johns Youth Academy, a high-risk male program in St. Augustine provided by Sequel TSI of Florida, Inc.;
- Hillsborough Juvenile Detention Center West, a 93 bed secure facility in Tampa provided by the Department; and
- Duval Regional Juvenile Detention Center, a 100 bed secure facility in Jacksonville, provided by the Department.

We used judgmental sampling to improve the overall efficiency of the audit. Errors or irregularities could have occurred, but not detected, because of inherent limitations associated with judgmental sampling. As such, projection of the auditors' conclusions based on our sampling method may be different from that reached if all residential commitment programs and detention facilities were subject to the audit procedures applied during the audit process.

RESULTS OF AUDIT

The audit revealed policies and procedures were in place for prescribing, procuring, storing, administering, and monitoring psychotropic medications and internal control processes were generally in compliance with applicable laws and regulations. However, we noted areas for improvement.

Details of Findings and Recommendations

Finding 1: Facility Operating Procedures (FOPs) and treatment protocol review was not documented.

According to Florida Administrative Code (F.A.C.) 63M-2.0035, the DHA, the Psychiatrist, and the Dentist, must sign and date all of their respective written treatment protocols, each time a new protocol is developed and/or an existing one is changed. Additionally, an annual review of FOPs and treatment protocols is required and shall be demonstrated by the signature and date of the DHA and Facility Superintendent. Nursing staff are required to review, sign, and date a cover page listing all FOPs, treatment protocols, and other procedures. Any changes made during the year to existing FOPs, treatment protocols or other procedures, must be reviewed, signed, and dated by the nurses on the individual documents.

Our review of six residential commitment programs and two detention facilities indicated that one program had implemented treatment protocols that were not signed by the DHA, psychiatrist, dentist, or program director. The implemented treatment protocols appeared to have been reviewed by the registered nurse, which was demonstrated by the nurse's signature on a cover page listing all the treatment protocols.

Our review also indicated that one program did not require nurses to review, sign, and date a cover page signifying review of all FOPs.

Annual review of FOPs, treatment protocols, and other procedures is critical to standardization, quality control, performance management, and replication.

We recommend the Department ensure residential programs and detention facilities follow F.A.C. 63M-2.0035 and implement a measure for ensuring the DHA, program director or facility superintendent, and nursing staff are documenting their annual review and approval of FOPs, treatment protocols, and other procedures.

Finding 2: The registered nurse was not following Florida Administrative Code by pre-pouring medicine before administering to youth.

According to F.A.C. 63M-2.030, a prescription medication shall not be removed from its original packaging or prescription container and placed in another container for subsequent administration until the time of medication administration. Additionally, the same staff shall prepare and administer medication. Further, in accordance with F.A.C. 63M-2.031 non-licensed staff assisting youth in the self-administration of medication are required to identify and verify medications together with the youth by checking the prescription label and comparing it to the Medication Administration Record (MAR).

In one residential program, when the nurse was not going to be on site, she pre-poured medications from their pharmacy labeled blister packs for non-licensed staff to administer to youth. Through individual interviews with the registered nurse and non-licensed staff trained to administer medication, it was determined that the registered nurse was preparing youth medications in advance for evening disbursement to youth. Specifically, all interviewees stated

that when the registered nurse is not expected to be on-site, prescribed medications are removed from their pharmacy labeled blister packs in advance, placed into a clear cup with the youth's name written on the bottom, and placed on a tray for the non-licensed staff to disperse to the youth during med pass.

No Central Communication Center (CCC) complaints relating to medication errors for this program were filed within the audit scope. Additionally, the program provider advised they have contracted with medical consultant Kathy Bingham for medical oversight, although no medical oversight had been provided to the program at the time of the site visit.

Medication administration oversight is critical to ensuring the safety of youth in the Department's care. Removing medication in advance from its original packaging for non-licensed staff to administer to youth is in violation of Florida Administrative Code. We recommend the Department ensure residential and detention nurses and non-licensed staff trained in medication administration dispense medications to youth in accordance with Florida Administrative Code and Facility Operating Procedures.

Finding 3: A current Board of Pharmacy Permit was unavailable for review and a Consultant Pharmacist had not been designated.

According to F.A.C. 63M-2.021, all detention and residential facilities are required to obtain and maintain the appropriate Board of Pharmacy permits/licenses required by F.A.C. 64B16-28. More specifically, according to F.A.C. 64B16-28.501, facilities holding a Class I, a Class II, or a Modified Class II Institutional permit, must designate a consultant pharmacist of record to ensure compliance with the laws and rules governing the permit. The Board of Pharmacy must be notified in writing within 10 days of any change in the consultant pharmacist of record. The consultant pharmacist of record must conduct Drug Regimen Reviews as required by Federal or State law, inspect the facility and prepare a written report to be filed at the permitted facility at least monthly. In addition, the consultant pharmacist of record must monitor monthly the facility system for providing medication administration records and physician order sheets to ensure that the most current record of medications is available for the monthly Drug Regimen Reviews.

In one residential program, it was noted that the pharmacy permit and consultant pharmacist license maintained at the program were not current. In fact, the program provider changed two months prior to our site visit and the existing contracts with the pharmacy and consultant pharmacist were ended when the provider changed. At the time of our site visit, a contract had been implemented between the current program provider and a pharmacy, although a pharmacy permit was not available for review. However, the program provider had not yet established a contract with a licensed consultant pharmacist.

The lack of a valid pharmacy permit and licensed consultant pharmacist could impact a facility's ability to dispense and store medications. In turn, the safety of youth in the custody of the Department may be adversely affected.

We recommend the Department implement processes to ensure residential programs maintain current board of pharmacy permits and consultant pharmacist licenses.

Finding 4: The Designated Mental Health Clinician Authority (DMHCA) in one program was not a licensed mental health professional.

Pursuant to F.A.C. 63N-1.0035, each facility with an operating capacity of 100 or more youths, each facility providing Department of Juvenile Justice (DJJ) Specialized Treatment Services and every detention Center shall employ or contract with a single Licensed Mental Health Professional to act as the DMHCA for the facility or program. If the facility or program contracts with an agency or corporate entity, rather than a single Licensed Mental Health Professional, then a single Licensed Mental Health Professional within the agency or corporate entity shall be identified as the DMHCA for the facility or program. Each facility that does not meet any of the previously listed criteria shall identify either a DMHCA or a Clinical Coordinator to be responsible for coordinating and verifying implementation of necessary and appropriate Mental Health and Substance Abuse Treatment services in the facility/program.

During our visit to one residential program, the provider was unable to furnish auditors with a license for the program's DMHCA. In consultation with the Department's Quality Improvement team members, located on-site for an annual compliance review, it was determined the DMHCA was not licensed.

Subsequent to our site visit, the residential program's facility administrator advised that the DMHCA had resigned and the licensed assistant clinical director is currently serving as the acting DMHCA.

Proper DMHCA licensing is critical to the coordination and implementation of mental health and substance abuse services for youth placed in the Department's care.

We recommend the Department implement processes to ensure appropriate medical and clinical professionals maintain current licenses.

Finding 5: Quality Improvement meetings were not being held in one program.

According to F.A.C. 63M-2.0039, all facilities and programs are required to implement a method of identifying and solving potential and actual problems in health care delivery to committed youth. Meetings are to be held no less than quarterly, including participants from all disciplines that provide or oversee the provision of physical and mental health care, programming/ operations, and behavior management.

At the time of our site visit, seven of the eight facilities/programs reviewed, demonstrated monthly meetings were held to address health care related issues. One residential program was not holding meetings to identify and solve potential and actual problems in their health care delivery.

Quality Improvement meetings are critical to identify and solve potential and actual problems in health care delivery to youth. The lack of quality improvement meetings could impact youth care. Subsequent to our visit, the program advised they would hold their first monthly Quality Improvement meeting on May 25, 2016, and continue to hold meetings on the last Wednesday of every month at 10:00 a.m.

We recommend the Department implement measures to ensure quality improvement meetings regarding health care delivery to youth are held at least quarterly to identify and solve potential and actual problems.

Finding 6: Medical and mental health staff résumés were not maintained in the health care provider service agreement files at the programs/facilities.

According to F.A.C. 63M-2.0037, the facility Superintendent, Program Director or designee are responsible for verification of credentials prior to contract execution for all health care providers at the facility. Additionally, a copy of the following documentation shall be maintained in the health care provider's service agreement file at the facility and at the respective regional office: a current license, a résumé, and current Basic, Advanced, or Pediatric Advanced Cardiac Life Support Certification that includes training on the automated external defibrillator.

Our review disclosed that three out of eight programs/facilities visited did not maintain résumés on site in the health care provider's service agreement file. However, programs/facilities did maintain, on site, copies of current licenses and current certifications for Basic, Advanced, or Pediatric Advanced Cardiac Life Support that included training on the automated external defibrillator.

The programs/facilities that did not maintain résumés on site for health care providers advised that résumés were maintained offsite at the program provider's human resource/personnel office. Although auditors requested résumés for all health care providers, some were not located and made available for review.

We recommend the Department implement processes to ensure all documentation required to be in the health care provider's service agreement file is maintained at the program/facility.

Finding 7: An individualized mental health treatment plan was not completed within 30 days of admission date.

Pursuant to F.A.C. 63N-1.0072, an Individualized Mental Health Treatment Plan is required when a youth enters on-going mental health treatment, including treatment with psychotropic medication. In Department residential commitment programs or day treatment programs designated for Specialized Treatment Services, the Individualized Mental Health Treatment Plan must be developed within 30 days of the youth's admission, by the multidisciplinary treatment team and the youth with mental health treatment needs.

In one residential program, a youth admitted to the program on two psychotropic medications did not have his individualized mental health treatment plan completed until two and a half months after his admission date.

The main purpose of an Individualized Mental Health Treatment Plan is to establish the written goals and objectives of mental health treatment and structure the focus of a youth's ongoing mental health treatment, including treatment with psychotropic medication. The lack of such plans could delay youth in receiving necessary mental health treatment and delay their timely exit from a program.

We recommend the Department establish measures to ensure Individualized Mental Health Treatment Plans are developed in a timely manner.

Finding 8: Documents were missing from the Individual Health Care Records (IHCR).

According to F.A.C. 63N-1.0076, Individualized Mental Health Treatment Plans must be reviewed and updated by the Mental Health Clinical Staff Person, treatment team, and youth every 30 days. Pursuant to F.A.C. 63N-1.0084, records of Mental Health Treatment Services shall be maintained in a progress note or treatment note in the youth's Active Mental Health and Substance Abuse Treatment file or in the Mental Health section of the youth's IHCR. Further, F.A.C. 63N-1.0085 mandates that psychotropic medication shall be only one component of the therapeutic program and additional treatment modalities such as individual, group, and family therapy, behavioral therapy, substance abuse counseling, and psychosocial skills training shall be utilized in conjunction with the use of psychotropic medication.

In one residential program, a youth's updated mental health treatment plans were missing from his IHCR for two consecutive months and could not be provided because the therapist was no longer employed with the program.

In another program, two of the six youth's IHCRs were missing Mental Health or Substance Abuse Treatment Services records; while four of six youth's IHCRs were missing Progress Notes/Treatment Notes, including evidence of additional treatment modalities.

The IHCR provides documentation pertaining to the health and mental health care youth receive while in the custody of the Department. This record also facilitates effective communication among the various providers who treat a youth while he or she resides in the program/facility.

We recommend the Department ensure Individual Health Care Records at programs/facilities comply with Florida Administrative Code.

Finding 9: Facility Operating Procedures (FOPs) were non-specific for training non-licensed staff to assist youth with self-administration of medication.

According to F.A.C. 63M-2.031, each program/facility shall implement training of non-licensed staff members to provide medications to youth for self-administration only when there is no licensed health care professional staff on-site. The training is to be conducted by a registered nurse or higher licensure level; and the registered nurse must supervise the trained staff member by periodically performing direct observation of skills, inspecting the Medication Administration Records (MARs), and the required documentation assigned to the staff member.

Our review disclosed that six programs/facilities minimally addressed training of non-licensed staff to assist youth with self-administration of medication in their Medication Administration FOP. At the remaining sites, it was determined that one facility maintained licensed nurses on-site until 9:00 p.m., ensuring non-licensed staff did not have to assist youth with self-administration of medications; and one program had nursing staff on duty 24 hours per day, seven days per week.

In the programs/facilities where non-licensed staff assisted youth with self-administration of medication, the following was noted in their FOPs:

- one facility's FOP stated non-licensed staff are trained annually;
- one program's FOP stated the non-licensed staff will be trained by the registered nurse or Licensed Practical Nurse;
- one program's FOP indicated non-licensed staff will be trained by licensed medical staff and the names of the trained, non-licensed staff approved to access the medication storage area will be posted on-site;
- one program's FOP specified the title/position of non-licensed staff to be trained, along with the areas to be covered in training by the licensed nurse;
- one program's FOP stated only designated, trained individuals will assist youth with self-administration of medication, including procedural steps for staff to follow when administering medications; a Quality Assurance form recently implemented to document evaluation of non-licensed staff was provided; and
- one program's FOP provided the areas non-licensed staff will be trained in by the Nurse/Supervisor, included that initial training would be a minimum of 2 hours, with an annual refresher training of no less than 1 hour, and stipulated proof of training would be maintained in the individual's training records.

Interviews conducted with registered nurses, program directors, facility superintendents, and trained non-licensed staff indicated that non-licensed staff have received training. However, due to changes in providers and staff turnover, non-licensed staff could not always state how often training to assist youth with self-administration of medication occurred. Additionally, most non-licensed staff maintained that they were supervised by other supervisors or licensed care workers/counselors when assisting youth with self-administration of medication. They further stated the nurse only observed them during training through mock scenarios.

A review of individual training records substantiated that training occurred. However, facilities/programs had no records indicating direct observation/periodic evaluations of non-licensed staff assisting youth with self-administration of medication by a registered nurse.

FOPs are designed to define what the program/facility intends to do, on a consistent basis. We recommend the Department ensure programs/facilities implement an FOP for training non-licensed staff to assisting youth with self-administration or medication in accordance with Florida Administrative codes.

APPENDIX

MANAGEMENT RESPONSE

STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

INTEROFFICE MEMORANDUM

DATE: June 22, 2016

TO: Michael Yu, Audit Director

FROM: Dixie Fosler, Asst. Secretary, Detention Services

SUBJECT: Bureau of Internal Audit Report Response

Detention Services has reviewed the Audit of Psychotropic Medication Oversight draft report findings and offers the following response:

Finding 6: We concur with the Auditor's findings. Detention Services has instructed all Superintendents to maintain a file at the facility that includes the license, resume and current Basic, Advanced, or Pediatric Advanced Cardiac Life Support Certification that includes training on the automated external defibrillator for all health care providers at their facility.

Finding 9: We concur with the Auditor's findings. Detention Services has submitted draft medical protocols for our facilities to the Office of Health Services for their review and comment. Once approved, these protocols addressing training for non-licensed staff to assist youth with self-administration of medication will be established in all twenty-one (21) detention centers.

Cc: Tim Niermann, Deputy Secretary

STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

INTEROFFICE MEMORANDUM

DATE: **June 30, 2016**

TO: Robert A. Munson, Inspector General
Michael Yu, Audit Director

FROM: Laura Moneyham, Assistant Secretary for Residential Services

SUBJECT: Responses to Draft Report - Audit No. A-1516DJJ-006, Audit of Psychotropic Medication Oversight

We have reviewed the above-referenced draft report of audit findings, regarding psychotropic medication oversight in the 10% sample of residential programs reviewed for compliance with Florida Statute, Florida Administrative Code, and department policies and procedures from July 1, 2014, to December 31, 2015.

Attached please find our responses to Findings 1 through 9, as they relate to the programs that were sampled.

LKM/lpb

Attachment

Cc: Christina K. Daly, Secretary
Timothy Niermann, Deputy Secretary
Fred Schuknecht, Chief of Staff
Kirk Mauro, Chief Medical Director

Office of Residential Services
June 30, 2016

Responses to Draft Report Audit No. A-1516DJJ-006
"Audit of Psychotropic Medication Oversight"
(July 1, 2014 to December 31, 2015)

Finding 1: Facility Operating Procedures (FOPs) and treatment protocol review was not documented.

CENTRAL REGION:

Kissimmee Youth Academy

Deficiency

- At the time of the audit, the program had implemented treatment protocols that were not signed by the DHA, psychiatrist, dentist, or program director.

Corrective Action

- The Department will verify that the Provider is in compliance with F.A.C. 63M-2 ensuring all required parties are documenting their annual review and approval of FOPs, treatment protocols and other procedures by June 29, 2016.

NORTH REGION:

Okaloosa Youth Development Center (OYDC)
Borderline Developmental Disability and
Developmental Disability (BDD/DD) Program

Deficiency

- OYDC BDD/DD, at the time of the audit, did not require nurses to review, sign, and date a cover page specifying review of all FOPs.

Corrective Action

- All RNs have reviewed Section 8 Health Services of the Facility's Operating Procedure (FOP) and have signed and dated a cover page indicating their review of the FOPs within this section.

Finding 2: The registered nurse was not following Florida Administrative Code by pre-pouring medicine before administering to youth.

CENTRAL REGION:

Kissimmee Youth Academy

Deficiency

- The audit revealed that when the nurse was not going to be on-site, she pre-poured medications from the pharmacy-labeled blister packs for non-licensed staff to administer to youth.

Corrective Action

- At the time of the audit, this program was a newly initiated contract. During the post-operational review for this program, the deficiency was identified as critical. Immediate action was taken by the DJJ Office of Health Services (OHS) Registered Nursing Consultant for Residential Services Christine Gurk who contacted OHS-HQ and was instructed to destroy the medication.
    - The medication was destroyed and documented.
    - A place to maintain the key to the medication cart was established so staff had access to the key in order to give evening medication.

- During the follow-up site visit conducted by Christine Gurk, RN, there were no pre-poured medications.
- The nurse who was pre-pouring medications is no longer employed at the facility.

Finding 3: A current Board of Pharmacy Permit was unavailable for review and a Consultant Pharmacist had not been designated.

CENTRAL REGION:

Kissimmee Youth Academy

Deficiency

- The Pharmacy Permit and Consultant Pharmacist license maintained at the program were not current. In fact, the program provider changed two months prior to our site visit and the existing contracts with the pharmacy and consultant pharmacist were ended when the provider changed. At the time of our site visit, a contract had been implemented between the current program provider and a pharmacy, although a pharmacy permit was not available for review. However, the program provider had not yet established a contract with a licensed consultant pharmacist.

Corrective Action

- The deficiency was also noted as critical during the post-operational review conducted by Shared Services and OHS.
  - Technical assistance was provided by OHS staff. Pharmacy consultant, Jack Whitecage was on-site May 10, 2016.
  - Monitoring will occur to ensure consultant is on site monthly.
  - There is a pharmacy manual in place at the facility. The modified Class II B permit has been issued by the Department of Health and the facility has received the temporary notice pending the certificate.

Finding 4: The Designated Mental Health Clinician Authority (DMHCA) in one program was not a licensed mental health professional.

NORTH REGION:

Saint John's Youth Academy

Deficiency

- The provider was unable to furnish auditors with a license for the program's DMHCA. In consultation with the Department's Quality Improvement team members, located on-site for an annual compliance review, it was determined the DMHCA was not licensed.

Corrective Action

- A copy of the license from the Department of Health was obtained that shows the practitioner was a Licensed Mental Health Counselor, effective 3/14/2015 through 3/31/2017.

Finding 5: Quality Improvement meetings were not being held in one program.

CENTRAL REGION:

Kissimmee Youth Academy

Deficiency

- One residential program was not holding meetings to identify and solve potential and actual problems in their health care delivery system.

Corrective Action

- The provider noted the first Quality Improvement Meeting to be conducted on May 25, 2016 and to conduct meetings on the last Wednesday of each month.
    - The Department will request copies of documentation for the Quality Improvement Meetings for May and June 2016, to be submitted to the Department by July 9, 2016.

Finding 6: Medical and mental health staff résumés were not maintained in the health care provider service agreement files at the programs/facilities.

CENTRAL REGION:

Melbourne Center for Personal Growth (MCPG)

Deficiency

- Program did not maintain on-site copies of résumés or service agreements for health care providers.

Corrective Action

- According to Cedric Cliatt, MCPG executive director, the auditors were provided a copy of the résumé for the AMIkids, Inc. registered nurse resume during the audit.
    - It was explained that Circles of Care and Brevard Health Alliances are sub-contractors with which AMIkids, Inc. contracts for the services of the doctor, psychiatrist, and mental health staff.
    - The sub-contractors' personnel files are not located at MCPG.
    - However, Cedric Cliatt will request résumés for the files from the sub-contractors to be completed by July 9, 2016.

NORTH REGION:

OYDC BDD/DD Program

Deficiency

- OYDC BDD/DD, at the time of the audit, maintained the health and mental health providers' résumés in the program's corporate human resources office, but did not maintain a copy on-site at the program in the provider's service agreement file.

Corrective Action

- Résumés for DHA Stephen A. Schwartz, MD, and Psychiatrist Jordan C. Iserman, MD, continue to be maintained in the provider's service agreement file located at the program's corporate human resources office.
    - Copies of the résumés have been included in the provider's service agreement file located on-site at the program as required.

Finding 7: An individualized mental health treatment plan was not completed within 30 days of admission date.

NORTH REGION:

Saint John's Youth Academy

Deficiency

- A youth admitted to the program on two psychotropic medications did not have his individualized mental health treatment plan completed until two and a half months after his admission date.

Corrective Action

- The youth's individualized mental health treatment plan is in place with short-term and long-term objectives, pertaining to taking his medication as prescribed and learning effective ways to cope with symptoms related to his mental health diagnosis.
    - The youth's Medication Administration Record (MAR) includes a section in which all persons who administer medications to that youth legibly write their name and initials, and credentials (if applicable).
    - Youth will also sign and print if non-licensed staff assisted with the self-administration of medication.

Finding 8: Documents were missing from the Individual Health Care Records (IHCR).

CENTRAL REGION:

Kissimmee Youth Academy

Deficiency

- Two of the six youths' IHCRs were missing Mental Health or Substance Abuse Treatment Services records; while four of the six youths' IHCRs were missing Progress Noates/Treatment Notes, including evidence of additional treatment modalities.

Corrective Action

- This deficiency also was noted as critical during the post-operational review conducted by Shared Services and OHS.
    - Technical assistance was provided to the program by OHS on April 25, 2016.
    - During the follow-up site visit conducted by Christine Gurk. a review of medical files indicated that they are in accurate order and improvements were noted on documentation.
    - Additional training was provided by OHS for proper documentation and accuracy of documentation.
    - There is still a need for improvement and to ensure accurate medical grades are assigned.

Finding 9: Facility Operating Procedures (FOPs) were non-specific for training non-licensed staff to assist youth with self-administration of medication.

The Office Of Residential Services will work with OHS to provide training to our contracted programs at the region's program directors' meetings to ensure that their policy for training non-licensed staff to assist youth with self-administration of medication is in adherence with Florida Administrative Codes and the department's policies and procedures.