FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

Office of Inspector General

Annual Report

Fiscal Year 2001-2002

Secretary
Jerry Regier

Acting Inspector General
Dr. Samara H. Navarro

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

Jeb Bush
Governor

Jerry Regier
Secretary

September 23, 2002

Dear Reader,

As the Acting Inspector General, it is my pleasure to present the *Fiscal year 2001-2002 Office of Inspector General Annual Report*. The information in this report provides a detailed accounting of last year's accomplishments and work efforts completed by the following offices: Investigations, Internal Audit, Appeal Hearings, and Quality Control. As you will notice, the accomplishments are numerous.

The end of the Fiscal year brought several internal changes. Former Inspector General Guiseppe A. "Joe" Betta retired after serving the Department for more than four years following a distinguished career with the Marine Corps. The Department will greatly miss his unrelenting efforts to promote ethical employee behavior and his desire to ensure accountability within Department programs. Chief of Investigations Dawn E. Case left the Department after more than 16 years of service in the inspector general office. The Department will miss her knowledge, professionalism, and management capabilities. We wish her success in her new role as the Director of Investigations in the Governor's Office of the Chief Inspector General. On behalf of the entire office staff, we extend a wholehearted "thanks" to Joe and Dawn for their loyalty and unrelenting efforts to promote integrity and accountability within the Department of Children and Families.

As the Acting Inspector General, I have been impressed with the professionalism, commitment, and desire for excellence exhibited by Office of Inspector General staff. By legislative mandate, and on a daily basis, the Office identifies and seeks resolution to findings of wrongdoing, program deficiencies, and challenges to Department decisions. Despite the trying circumstances, inspector general staff continue to operate professionally and effectively, even in the face of recent position cuts and increased workloads. I encourage you to review the contents of the attached report, and I am confident that you too will appreciate the role and accomplishments of the Office of Inspector General during Fiscal year 2001-2002.

If I may be of assistance, feel free to contact me at (850) 488-1225.

Sincerely,

Samara H. Navarro

Dr. Samara H. Navarro
Acting Inspector General

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Questions regarding the contents of this report may be directed to the Office of Inspector General, 1317 Winewood Boulevard, Tallahassee, Florida, 32399-0700, telephone (850) 488-1225.

Executive Summary

In accordance with Section 20.055, Florida Statutes (F.S.), the Office of Inspector General serves as the central point for coordination of activities that promote accountability, integrity, and efficiency within the Department. The Office investigates and reviews employee and provider compliance to many rules and regulations enacted to ensure accountability in programs and appropriate conduct amongst Department employees. In keeping with the mission of the Office, several summary highlights are shown for Fiscal Year 2001-2002.

Investigations

- Reviewed, assessed, and responded to 1551 control assignments resulting in 895 in-depth reviews of complaints and 2235 allegations of wrongdoing, responded to 194 public records requests, and tracked 343 incidents and criminal arrests
- Opened 126 inspector general investigations and completed 108
- Conducted 3801 personnel reference checks for Department managers

Internal Audit

- Issued eight reports, six in response to allegations. Provided audit assistance for a review issued by the General Counsel and assisted in an investigation on the Department of Education issued by the Chief Inspector General
- Received an Office of Auditor General Quality Assurance review of the Internal Audit function. A July 24, 2002, report stated the system of quality control provided reasonable assurance of compliance with applicable professional auditing standards, Office of Inspector General policies and procedures, and Section 20.055, F.S.
- Coordinated 95 external audit liaison activities for the Office of the Auditor General, Office of Program Policy Analysis and Governmental Accountability, and Federal agency requests for responses and information regarding audits and reviews
- Prepared a Department-wide Risk Assessment and Annual Audit Plan
- Participated in a multi-agency audit of Purchasing cards

Appeal Hearings

- Completed 5539 Department fair hearings and 602 fair hearings for other agencies, representing a 13 percent increase over the previous year
- Completed 712 disqualification hearings for Temporary Assistance for Needy Families or Food Stamp benefits

Quality Control

- Identified a 9.8 percent error rate for Food Stamps program, 44 percent were agency errors, and 56 percent were client errors
- Current Food Stamp error rate is 10.44 percent (through May)
- Identified a 6.23 percent error rate for Temporary Assistance for Needy Families program, 53.4 percent were agency errors and 46.6 were client errors

Specific measurable accomplishments can be found within the text of this report.

Section A: Introduction

The mission of the Office of Inspector General is to provide management with independent support and assistance to improve agency efficiency and effectiveness and to detect fraud, waste, abuse, and error in agency operations. This report, as mandated by Section 20.055, Florida Statutes, summarizes the Office of Inspector General activities for Fiscal Year 2001-2002.

Statutory Requirements

The Office of Inspector General is established in each state agency to provide a central point of coordination and responsibility for promoting accountability, integrity, and efficiency in government. The statute requires the inspector general to be appointed by, report to, and be under the general supervision of the agency head. The Office of Inspector General is organizationally located within the Office of the Secretary and the Inspector General reports directly to the Secretary.

The Office of Inspector General is statutorily charged with the following duties and responsibilities:

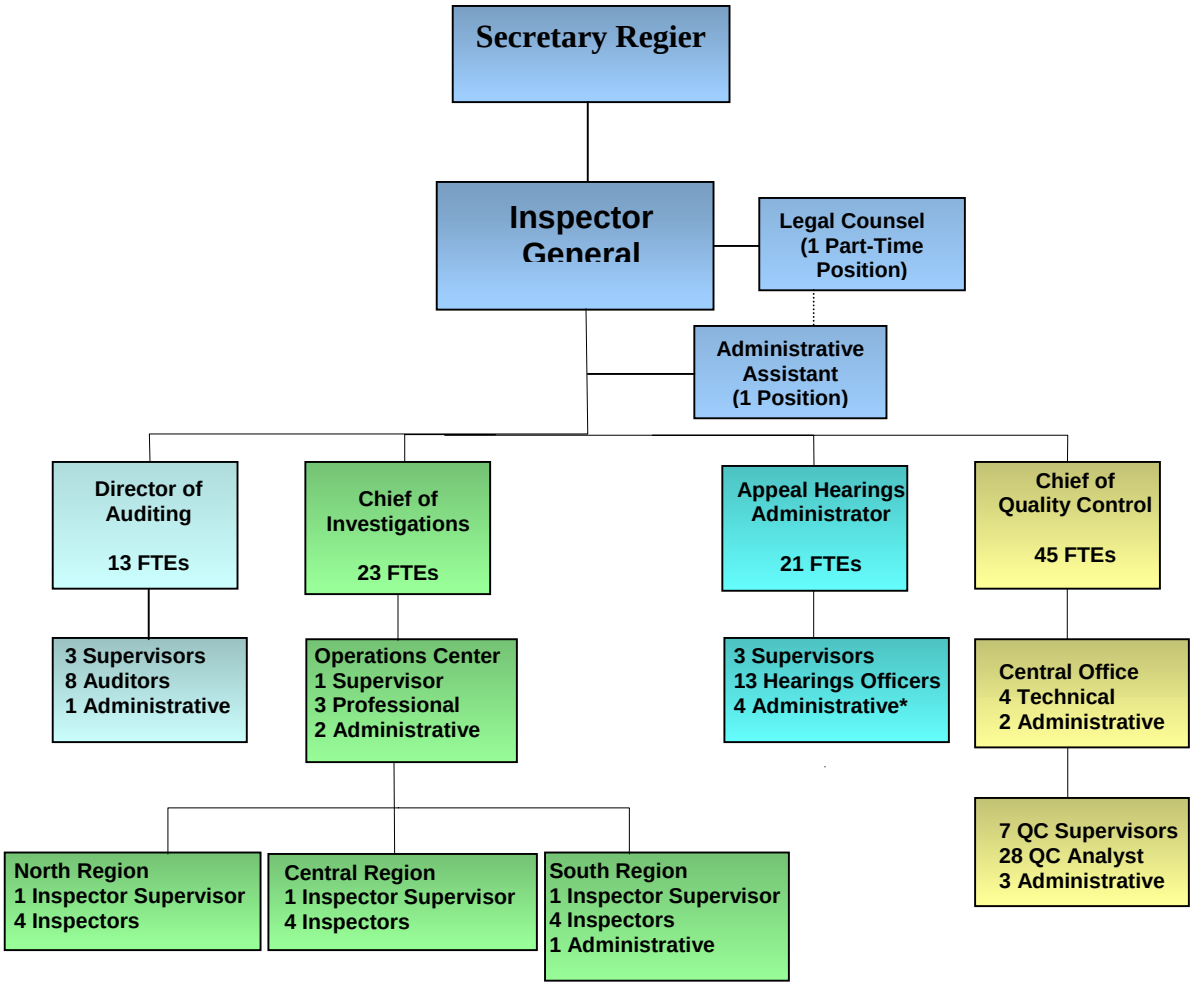
- Advises in development of performance measures, standards, and procedures for evaluation of programs.
- Assesses the reliability and validity of information provided on performance measures and standards, and makes recommendations as needed.
- Reviews actions taken to improve program performance and makes recommendations for improvement.
- Directs, supervises, and coordinates audits, investigations, and management reviews.
- Conducts, supervises, and coordinates activities that promote economy and efficiency and prevent or detect fraud, waste, and abuse.
- Keeps agency heads informed about fraud, abuses, and deficiencies and recommends corrective measures.
- Ensures effective coordination and cooperation between the Auditor General, Federal auditors, and other governmental bodies.
- Reviews rules relating to programs and operations and makes recommendations regarding impact.
- Ensures appropriate balance between audit, investigative, and other accountability activities.

Resource Management

Office of Inspector General units are located throughout the State. This positions staff to:

- Extend management's presence.
- Maximize administrative and logistical resource sharing among personnel in Investigations, Internal Audit, Quality Control, and Appeal Hearings.
- Enhance the potential for synergism among personnel through co-location and consolidation.

Office of Inspector General Organizational Alignment



* One Appeal Hearings administrative position is funded by Economic Self-Sufficiency

Figure A.1
Source: Office of Inspector General

Section B: Office of Investigations

The Office of Investigations is supervised by the Chief of Investigations who reports directly to the Inspector General. The office has 23 full-time positions.

Primary responsibilities include receiving, responding to, and investigating complaints involving employee and contract provider wrongdoing. Every complaint is assessed for investigative need and tracked through resolution, regardless of magnitude or severity.

During the assessment phase, complaints are screened to determine if the facts suggest possible misconduct by a Department or contract employee. Eighty-six percent of the complaints received represent management-related issues, and are referred to the appropriate entity for review and resolution.

If warranted, the office conducts an official investigation. When completed, the findings are reported to the Secretary, applicable district, regional or program entity, and the Governor's office, along with recommendations. The office also monitors corrective actions.

To ensure a timely response to the correspondence control assignments (1551 in Fiscal Year 2001-2002), the office is structured into the functional areas of intake and investigations.

Operations Center

The Operations Center reviews, assesses, and responds to correspondence and complaints. Each assignment is reviewed, given a tracking number, and entered into an automated tracking system. Complaints are screened for thoroughness and sufficiency before they are forwarded to managers for review or investigation.

The Operations Center evaluates each allegation received and determines whether an official investigation is warranted. If so, the complaint is assigned to the appropriate regional office and an investigation is initiated. Complaints involving management issues are forwarded to Department managers for review and action. In such cases, the manager is asked to provide a written summary of the findings and the corrective actions taken.

Correspondence assignments for the fiscal year were as follows:

- assigned for internal investigation -- 12%
- referred to a Department manager for review and response -- 61%
- referred to another agency for handling (i.e., law enforcement, Department of Health, etc.) -- 7%
- handled by Operations Center staff -- 20%

Each response was reviewed for sufficiency to ensure the complainant's concerns were adequately addressed and to determine if additional activity was warranted.

The Operations Center also completed **3,801** personnel reference checks; **194** public records requests; analyzed and disseminated statistical information; and received and tracked through resolution **343** serious incidents or criminal arrest information on Department and contract provider employees.

Assignments Received by Type
Fiscal Year 2001-2002

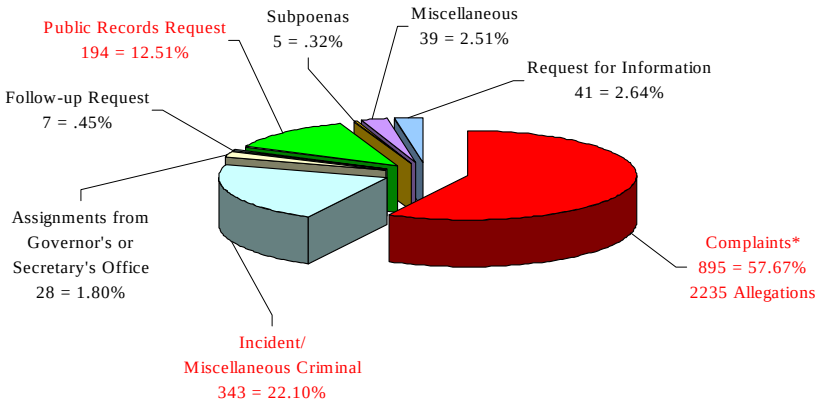


Figure B.1
*Contains Whistle-blower, Request for investigations, and Get Lean Hot Line.
Majority were Complaints, Incidents/Miscellaneous Criminal, and Public Records Requests.
Source: Office of Investigations

Complaints Received
4-Year Comparison

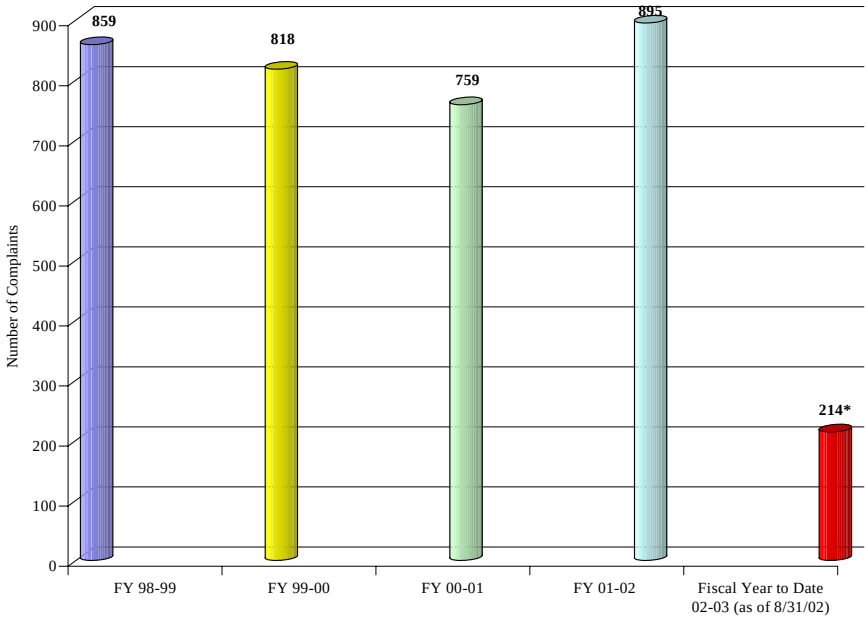


Figure B.2
*FY 02-03 Projected = 35% increase
Source: Office of Investigations

Requests for Employee Reference Checks
Fiscal Year 2001-2002

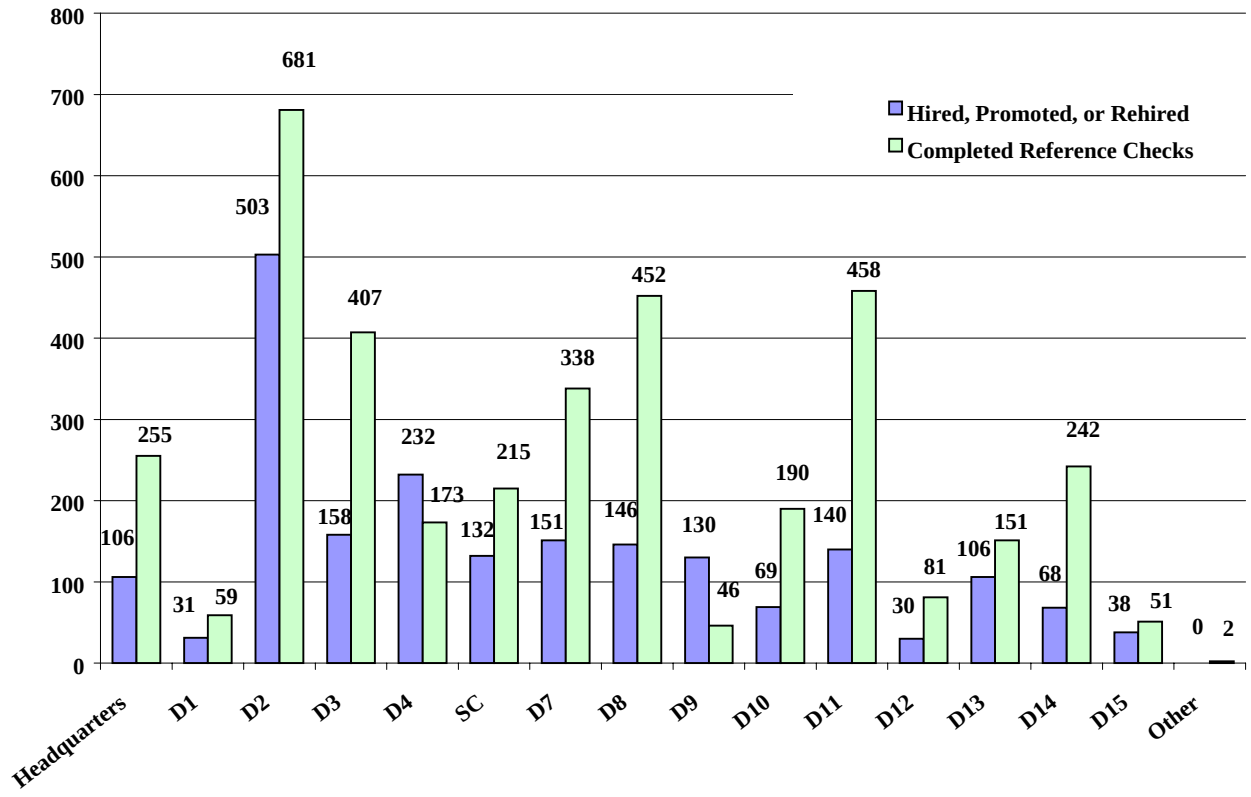
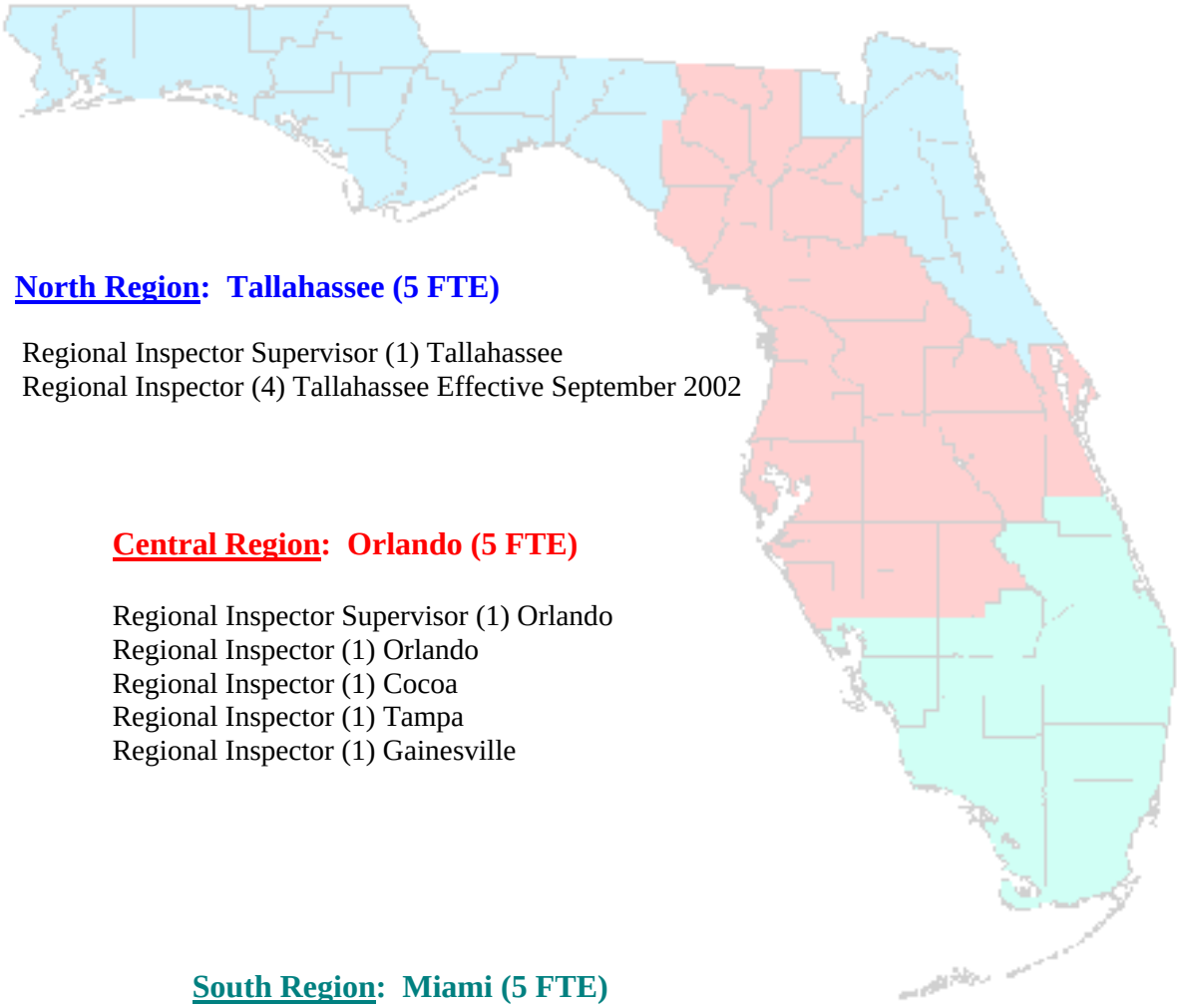


Figure: B.3
(Compares the number of personnel hired, promoted, or rehired against the number of reference checks conducted)
Source: Office of Investigations

Regional Office Staffing
Fiscal year 2001-2002



North Region: Tallahassee (5 FTE)

Regional Inspector Supervisor (1) Tallahassee
Regional Inspector (4) Tallahassee Effective September 2002

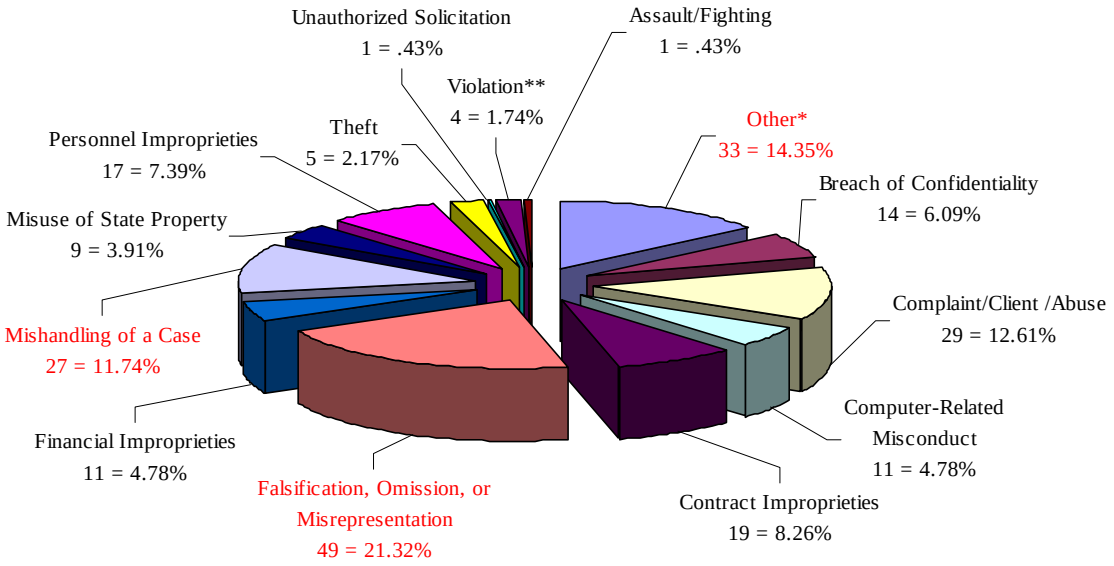
Central Region: Orlando (5 FTE)

Regional Inspector Supervisor (1) Orlando
Regional Inspector (1) Orlando
Regional Inspector (1) Cocoa
Regional Inspector (1) Tampa
Regional Inspector (1) Gainesville

South Region: Miami (5 FTE)

Regional Inspector Supervisor (1) Ft. Lauderdale effective July 2002
Administrative Assistant (1) Ft. Lauderdale effective July 2002
Regional Inspector (2) West Palm Beach
Regional Inspector (2) Ft. Lauderdale

Inspector General
Investigations by Allegation
Fiscal Year 2001-2002



Investigations Opened = 126
Total Cases Closed = 108
Total Allegations Closed = 230

Figure B.4
* Other: includes gambling, excessive absenteeism from work, and drug or alcohol related offenses.
** Violation: includes violations of ethics standards, sexual harassment, and civil rights violations.
Source: Office of Investigations

Investigations Highlights

The following summaries represent a broad spectrum of investigations. A complete listing of all investigations closed by district or region is provided after these summaries.

Allegation -- Case #2000-0072

Employees of a contract provider agency failed to report incidents of alleged child-on-child sexual abuse to the Abuse Hotline, the district, or the Office of Attorney General. Also, the provider failed to provide the Office of Attorney General complete records of the incidents after being subpoenaed.

Investigative Findings:

Information obtained did not support the allegation that the provider failed to report the incident.

The findings supported the allegation that the provider failed to provide the Office of Attorney General with complete records of the incidents after being subpoenaed.

It was also noted that one early services intervention caseworker did not visit a client as often as required.

Inspector General Recommendation:

District administration should, with the assistance of the Office of General Counsel, consider developing guidelines to assist providers in addressing child-on-child sexual abuse.

The provider should update its employee handbook and reference the correct statutes regarding the reporting of child abuse and clearly state employees' responsibilities to report suspected or actual abuse, neglect, or abandonment to the Abuse Hotline.

The provider should review records retention practices.

District and Provider Response:

The district sent a memo to staff ensuring they review the provider's incidence files.

The district indicated that all required client visits were not made since the counselor had been promoted to supervisor and was, therefore, handling an uncovered caseload. At the time (1998), standards allowed for missed visits to be justified due to vacant positions.

Sexual abuse training (the differences between juvenile sexual abuse and juvenile sexual activity) and to whom incident reports or occurrences should be reported was provided to Department staff.

The provider implemented written policies and trained staff on the procedures for identifying and reporting abuse.

Allegation -- Case #2000-0091

Contract provider staff did not properly chart and monitor medications given to clients of a group home.

A report of neglect was made to the Abuse Hotline alleging an open sore on an

adult client, inadequate care provided by staff at a group home, and staff falsification of client records regarding a client's symptoms and treatment.

Provider staff did not receive required in-service training and were instructed to sign their names in attendance when no training was given.

The facility billed for services and treatment not provided to the client.

Investigative Findings:

Administrative staff acknowledged there had been medication errors.

The following discrepancies were identified:

- unauthorized individuals had access to medical information on residents;
- services could not be verified based on invoices; and,
- deficiencies in record-keeping were noted.

Information obtained did not support the remaining allegations.

Inspector General Recommendation:

District staff should review deficiencies identified and monitor the contract provider who must ensure compliance with established protocols and corrective actions. Coercive action, as permitted by the contract between the provider and the Department, should be employed where necessary.

District and Provider Response:

The district increased monitoring at the group home and funded additional staff. Staff from adult services and developmental disabilities will work together to assure information is passed between the two programs.

The provider conducted training in over-sight, medication administration, and other nursing-related issues. Provider record keeping was reorganized to assure required information is available and kept confidential.

Nurses were freed from responsibilities other than nursing.

Allegation -- Case #2000-0098

A protective investigator failed to conduct a thorough and accurate protective investigation and the protective investigator supervisor failed to properly review the investigation and improperly closed the investigation as unfounded.

Investigative Findings:

The allegations were not supported. According to a review of the investigative case file by the Adult Services Program Office, policies and procedures were followed.

Although the investigation was conducted according to policies and procedures, after reviewing the file, the inspector and supervisor stated that additional steps should have been taken.

Inspector General Recommendation:

This was a complicated case involving multiple issues and agencies. The Office of Inspector General relied heavily upon Department program experts to determine that all policies and procedures were followed.

The Chief Medical Officer, in conjunction with Adult Services, should consider developing a universal set of standards and guidelines to be used when asking for medical consultation. Department employees must ensure that those asked to provide consultation are qualified to conduct the tasked review.

District Response:

The district developed an operating procedure addressing the chain of custody of all adult protective investigator files and a format for requesting medical consultation and providing feedback. Supervisors will review and approve requests.

Adult protective investigators were given refresher training on evidence collection and labeling and storage of photographs. Adult Services at Central Office and the Chief Medical Officer developed a universal set of standards and guidelines for medical services and included qualifications for medical consultants.

Allegation -- Case #2001-0013

A family services counselor failed to conduct a fair and adequate child abuse investigation, failed to comply with Florida Statutes, failed to immediately provide copies of the Child Protection Team medical reports concerning the complainant's children upon request, and improperly used medical terminology in a shelter petition. A file containing personal information regarding a foster parent was left at the complainant's residence.

Investigative Findings:

The counselor failed to comply with Section 39.301(5)(a), Florida Statutes. The complainant was not advised of her right to legal counsel. The counselor disputed the complainant's allegation that she failed to advise the complainant of other requirements under the listed statute.

The family support worker admitted inadvertently leaving the foster care file at the complainant's residence. The counselor admitted she was informed about the incident; however, she did not retrieve the file.

The other allegations were not supported.

Inspector General Recommendation:

The regional director should take the appropriate corrective action.

Regional Director Response:

The counselor also failed to provide the parents the Rights and Responsibilities Pamphlet 175-32 in accordance with Children and Families Operating Procedure (CFOP) 175-21, Investigative Response.

Each protective investigator will be given a copy of and sign acknowledgement that they received, reviewed, and understand the requirements in Children and Families Operating Procedure 175-21.

The support worker was given a documented counseling memo regarding leaving the confidential file at the parent's home. The counselor was given a written reprimand for failing to retrieve the file.

Allegation -- Case #2001-0014

Confidential abuse reports were obtained for personal use and released to unauthorized persons and the media.

Investigative Findings:

A family services counselor supervisor admitted violating the Security Agreement by writing her passwords on a slip of paper next to her computer and by allowing others to access the Client Information System using her security access.

A family services counselor, when confronted with the log-in times, admitted accessing and printing the Florida Abuse Hotline Information System (FAHIS) report and giving a copy of the report with the sheriff's report to her supervisor. The counselor also admitted she did not lock her office door after hours.

The program operations administrator stated staff could look at and print any Florida Abuse Hotline Information System report with or without reason and reports downloaded for personal viewing, but not needed for any reason, should be shredded when no longer needed.

A family services counselor read Florida Abuse Hotline Information System reports out of curiosity and discussed the reports with union representatives.

The parking lot level door release lever was secured with a plastic tie strap in a permanent position of unlock.

Inspector General Recommendation:

District administration should take appropriate corrective action.

Department policy and procedures, as outlined in Children and Families Pamphlet 60-1, Standards for Disciplinary Action to be Applied (27), were violated by management. Department employees do not have carte blanche authority to review confidential FAHIS records. The district administrator should review the program operations administrator's statement with district legal staff to determine what action to take.

District management should review and take action, if required, concerning the counselor's statement admitting to reading Florida Abuse Hotline Information System reports out of curiosity and sharing the information with union representatives.

Management should review and act on the security of the building.

District Response:

The family services counselor resigned in lieu of dismissal and the other counselor was given a written reprimand. The family services counselor supervisor was suspended for 10 working days. The program operations administrator indicated that her statement to the inspector was misinterpreted. She stated that when she said her staff could pull up any case at any time, she meant that they had the ability to do so. The administrator understands the policy and has advised her staff of such.

The building manager installed alarms on doors to preclude the doors being propped open. Anyone wishing to enter the building after hours must have a key.

Allegation -- Case #2001-0016

An abuse report was made to the Abuse Hotline and neither the alleged victim, the reporter, nor law enforcement were interviewed, contacted, or involved in the

investigation. A provider family services counselor did not thoroughly investigate allegations of abuse and documented false information in the abuse report.

Investigative Findings:

A quality assurance review indicated the abuse investigation was not conducted timely or thoroughly by Department or contract provider staff.

Inspector General and Quality Assurance Recommendation:

The district should:

- Take corrective action as deemed appropriate.
- Notify the licensing office, as well as the local advocacy committee, concerning the allegations regarding the foster home.
- Carefully assess the foster home, individually interview each child in the home, and determine the foster parents' abilities to appropriately handle difficult children and child-on-child incidents.
- Consider further training to remind staff of the basic responsibilities in protective investigative casework.
- Review a sampling of the counselor's cases to ensure investigations are thorough.

District and Provider Response:

Department and provider counselors are no longer working with the Department or the provider. The other counselor was new, inexperienced, and carried too large a workload.

District Operating Procedure (DOP) 215-6, Event Reporting, was revised to ensure appropriate parties are notified when abuse reports are received on foster homes and distributed to staff.

DOP 175-5, Child Abuse, Neglect, and Abandonment Investigations in Institutional Cases, was approved and implemented. The procedure establishes a process for formal staffing of all abuse reports involving substitute care settings.

An institutional staffing was held on the foster home. At the time of the incident, more children were placed in the home than the license permitted. It was recommended that the home not exceed the licensed capacity.

The service center established a specialized institutional counselor to work closely with the licensing unit responsible for investigating all abuse reports involving foster homes, emergency shelters, residential group care, and childcare facilities.

Weekly meetings are held at the service center with all investigative staff to discuss issues and areas of concern.

Allegation -- Case #2001-0018

Department computer equipment was used to view pornographic internet web sites by a distributed computer systems administrator.

Investigative Findings:

Due to conflicting information obtained, the allegation was not supported.

The inspector was unable to determine, with certainty, who accessed the sites. The

office shared a common password.

Inspector General Recommendation:

The district administrator, in consultation with legal and human resources, should take corrective action.

Also, when an employee is asked to view a pornographic web site for an investigation, or for any official purpose, there should be a witness. The precise date, time, persons, and web site address should be documented.

District Response:

The following measures were taken:

- Common password was eliminated.
- Management systems staff working hours were changed to 8:00 a.m. to 5:00 p.m., eliminating the perception that misuse is free to occur before or after staff are on duty.
- The administrator was counseled to avoid situations that create the perception of misuse and staff were counseled to immediately report suspicions of misuse.
- The district implemented an operating procedure that any time an employee has reason to suspect misuse of Department computers, the employee immediately tells a district executive management team member. Then a team member and one witness will investigate the computer misuse.

Allegation -- Case #2001-0021

A family services counselor supervisor acted inappropriately with a client at a juvenile offender correction facility. The counselor was permanently suspended from visiting a contract provider development center for improper conduct.

Investigative Findings:

The information obtained did not support all of the allegations and the counselor denied any inappropriate behavior. However, the supervisor was permanently suspended from visiting a provider development center for inappropriate conduct, taking contraband into the facility, and transporting a client without authorization.

The supervisor admitted failing to make subordinates complete required client visits, failing to document visits in protective services files, and failing to ensure subordinates documented visits.

The supervisor also submitted inaccurate vicinity mileage trip logs and inaccurate attendance and leave records.

Inspector General Recommendation:

The district administrator should take appropriate corrective action.

District Response:

The supervisor was terminated and the Department requested reimbursement for travel expenses.

Allegation -- Case #2001-0026

A protective investigation file contained inaccurate information in the Caregiver Home Study on the client's grandmother and on the client's great aunt and uncle.

Investigative Findings:

The information obtained did not support or refute the allegation that some of the information in the Caregiver Home Study on the client's grandmother was inaccurate. The information supported the allegation that some of the information in the Caregiver Home Study on the client's great aunt and uncle was inaccurate.

Inspector General Recommendation:

The district administrator should take appropriate action.

District and Provider Response:

The family services counselor was given a documented conference concerning documenting factual information and timely returning telephone messages. The counselor and family services counselor supervisor attended Customer Relations training.

Allegation -- Case #2001-0034

Service Center employees failed to conduct thorough and accurate abuse report investigations and wrote false information in an abuse report. Management was aware of wrongdoing and failed to take appropriate action.

Investigative Findings:

Employees failed to conduct thorough and accurate abuse report investigations. However, due to conflicting statements, the information obtained did not support the allegation that employees wrote false information in an abuse report.

This investigation was conducted simultaneously with a whistle-blower investigation alleging that staff falsified child abuse records and intentionally removed documents from those records to interfere with the provider's ability to comply with its contractual obligations.

Although the findings did not prove intentional falsification or removal of documents, management admitted 40 percent of cases referred to the contract provider for closure had to be recreated and contained only a Florida Abuse Hotline Information System printout.

The contract provider alleged certain cases were not thoroughly investigated by district staff and a Quality Assurance review supported most of the concerns.

Interviews with provider staff identified a few cases where management requested or expected provider staff to complete investigative activity outside the parameters of the contract.

Inspector General Recommendation:

The district administrator should:

- Review the Quality Assurance review findings and ensure investigative activity and follow-up services are provided.
- Review the findings of the Inspector General investigation and take corrective action.
- Conduct a review of open cases to ensure the quality of casework improved as management directed.
- Provide appropriate training to family services counselors on deficiencies.

District Response:

The district identified many of the issues prior to the investigation and initiated corrective action.

- Two factors combined to create serious deficiencies in staff work: a substantial turnover of staff and an increase in abuse reports.
- Staff were under the assumption that the provider would address many backlogged cases allowing the district to focus on incoming reports with the limited resources available.
- Actions were taken on Quality Assurance review findings. A Quality Assurance follow-up review reflected significant improvement in casework quality and the work atmosphere.
- Held weekly meetings with staff to provide updates, clarification, and technical assistance.
- Implemented a Family Safety Quality Assurance plan to improve overall quality of casework.

Allegation -- Case #2001-0040

Inadequate direct care staffing at a state hospital endangered residents. Management was aware of and covered up the problem.

Investigative Findings:

According to the Chief of Mental Health Facilities, the Department has no specific policy on staffing, nor is there a state or federal policy regarding staffing levels at mental health facilities.

A 2001 Agency for Health Care Administration survey did not cite related deficiencies. An on-site resident advocate received concerns of staffing shortages, but has been unable to support them. A representative of the local advocacy council had no information to support administration's attempt to cover problems related to staff shortages.

Inspector General Recommendation:

Hospital administration provided reports demonstrating continuous efforts to improve quality of resident care and staff retention.

District or Hospital Response:

None

Allegation -- Case #2001-0041

The owner/operator of a childcare facility failed to make a child abuse report concerning an employee. A family services counselor accepted a bribe from the owner/operator of a childcare facility in exchange for not documenting noncompliance inspection items.

Investigative Findings:

The owner/operator of a childcare facility failed to make an abuse report as required. None of the childcare employees who were aware of the abuse reported the incident.

- The counselor only interviewed the owner/operator of the childcare facility who provided inaccurate information concerning child abuse.

- Several employees with accurate information were available and were not interviewed.

Information obtained did not support the bribery allegation.

Inspector General Recommendation:

The district administration should:

- Consider changing the licensing inspection system by periodically rotating the geographical areas assigned to licensing representatives who conduct inspections.
- Determine if the individual responsible for the abuse/safety incident is currently employed by another childcare facility. If so, take appropriate action.
- Ensure district and contract provider employees are fully aware of the mandatory reporting requirements for suspected child abuse, neglect, and abandonment mandated by Section 39.201, Florida Statutes.

District Response:

The district:

- Determined that the individual responsible for the abuse/safety incident is no longer employed as a child care worker.
- Reassigned caseloads and will reassign them annually.
- Reviewed the Inspector General's report with all day care licensing staff. The importance and mandate of abuse reporting was discussed with staff.
- A letter was sent to all day care center operators explaining the responsibility to report abuse, neglect, or threatened harm to any child in their care.

Allegation -- Case #2001-0044

A contract provider inappropriately paid for Department employees' meals, travel, and other expenses.

District staff showed bias against one provider and favoritism toward another in the awarding and selection of contracts and services.

A conflict of interest existed when a state employee served on the board of directors for a provider.

District staff denied a provider the opportunity to obtain appropriate certification resulting in the provider's loss of its Medicaid provider number.

Investigative Findings:

Department employees admitted accepting meals paid for by the provider. A contract provider paid for contract-related meetings, travel, and other Department employees' expenses. It was believed that the provider would be reimbursed under contract. However, the State Comptroller Accounting Services said the travel charges were not allowable in the contract documentation and the Department must pay for them from other accounts.

All other allegations were not supported. Although specific contracts and services were not shown favoritism, there was the perception that favoritism occurred.

Inspector General Recommendation:

Legal staff should review current contracts to determine if there are any

conflicts of interest and correct the problem if necessary.

The district should:

- Comply with Children and Families Operating Procedure 75-02, Contract Management System for Contractual Services.
- Place contracts up for competitive bids and ensure proper documentation of reasons for applying the Florida Statutes' competitive bid exemption.
- Assign a person within the Contract Performance Unit to conduct alcohol, drug abuse, and mental health program monitoring.

District Response:

The district administrator was counseled and the two district program managers were given a final counseling.

Department employees reimbursed the provider for the meals.

Allegation -- Case #2001-0055

A systems programming administrator showed favoritism toward a provider, acted inappropriately, and failed to reject a contractor's Request for Proposal for fatal criteria when the proposal was first reviewed.

Investigative Findings:

Although information obtained does not support that the administrator showed favoritism toward a specific contractor, the administrator's actions gave the impression he had a friendship with the contractor's representatives.

Inspector General Recommendation:

Management should consider implementing a procedure where the review of fatal criteria is conducted by two individuals. This would minimize the chance or perception of favoritism.

Recommend management take action as deemed appropriate to address the issue.

Management Response:

Pending.

Allegation -- Case #2001-0057

A family services specialist used the State's SunCom telephone system, her Department assigned cellular telephone, and computer for personal use.

Investigative Findings:

The information obtained supports the allegations.

Inspector General Recommendation:

District management should:

- Take appropriate corrective action and recoup any unpaid monies for unauthorized personal phone calls.
- Review the actions of the district staff who had knowledge of the counselor's conduct and failed to act.
- Review telephone policies and ensure employees clearly understand them.
- Determine whether the counselor's allegation of widespread misuse and of being singled out for retaliation is true.

District Response:

The counselor received a 5-day suspension for unauthorized use of State property, equipment, or personnel. The counselor made financial restitution.

The district implemented:

- Quarterly training classes on the procedures and responsibilities of using telephone equipment.
- Review of Department of Management Services SunCom Long Distance Reports.
- Revision of the cellular user agreements by the General Services Manager to include rules and regulations regarding the use of the Department cellular phone to include employee reimbursement for personal emergency calls.
- Revision of the Certification and Approval Statement Form by the Fiscal Office to include the cost per minute for personal calls.

Allegation -- Case #2001-0059

The contract provider failed to hire and train staff in accordance with their contract. Provider counselors failed to maintain appropriate documentation required by the contract to verify that services were provided. The provider billed the Department for case management units not allowed by the contract, and double-billed for units of service provided to Department clients.

Investigative Findings:

During an unannounced site visit to the provider, violations to the contract were identified:

- The provider hired five part-time counselors instead of two full-time counselors as required.
- The provider did not provide the mandatory training to its counselors.
- At least one counselor did not meet the work experience level as required.
- The documentation for verification of services provided was either incomplete or not contained in the client files reviewed.
- A limit of 14 files reflected numerous non-compliance items as required by the Department's contract.
- Backup documentation submitted with the provider's invoices contained double the number of units billed compared to documentation in the client files.
- Overlaps in billing occurred when the provider submitted the same client names for payment of services that were previously paid for by the Department to the provider for settlement of services provided July 1, 2000 through September 18, 2000.

Inspector General Recommendation:

The investigation reviewed what district staff obtained during a monitoring of the contract.

Although additional investigative activity was not conducted, the monitoring identified where the provider failed to comply with contract requirements. Additional review is needed to obtain a full accounting of the deficiencies. The district should:

- Conduct a complete audit of the contract to determine the extent of non-compliance by the provider and

the extent of monies that should be recouped.

- Review its practice of paying for services without receiving proper documentation to verify that the services were actually provided.
- Take corrective action.

District Response:

The district took the following actions:

- Conducted Contract Manager Re-certification.
- Reviewed requirements of invoice review/approval procedures.
- Developed document-tracking forms to be used by contract managers to assist them in their awareness of required document submission.
- Counseled staff regarding the accurate completion of invoice review and approval.
- Conducted a record of counseling with the employee for failure to require complete documentation and placed the counseling in the employee's personnel file.
- Conducted an audit of the services rendered by the provider. Identified overpayments.

Allegation -- Case #2001-0074 Preliminary

A contracted Certified Behavioral Analyst billed the Department for services not rendered, falsified clients' parents' signatures on service visit logs, and falsified clients' progress data and clients' treatment notes in at least one and possibly three districts.

Investigative Findings:

The information obtained was presented to the Florida Department of Law Enforcement (FDLE) Economic Crimes Unit which opened an investigation of possible fraud. The FDLE Special Agent said that because the analyst cancelled his contract with the district and refused payment for alleged fraudulent billing, combined with the very limited memory of Department clients who were interviewed, a criminal case against the analyst could not be filed.

The Special Agent said information obtained in the intelligence investigation would be forwarded to regulatory agencies for appropriate regulatory action against the analyst due to the alleged fraudulent activity.

Inspector General Recommendation:

Since the allegations were investigated by FDLE, no action was required.

A copy of the report was sent to the district managers for their information and review of applicable contracts as deemed appropriate. The districts should:

- Conduct periodic, unannounced visits with clients to monitor provider activity and verify the accuracy of services reported by providers.
- Develop an informational handout for clients, explaining the services to be rendered and the notification procedures for reporting when services are not received.

District response:

The provider contract was terminated.

Where necessary, additional staff were hired to expand existing quality assurance capabilities.

Additional information about reporting inconsistencies or problems with services or contract providers was added to existing informational forms that families receive when services begin.

Allegation -- Case #2001-0100 Whistle-Blower

The following allegations were made under the Whistle-Blower Act:

- The administrator and nursing staff dispensed the wrong medication to residents.
- A health care administrator is drug dependent, is having an on-going relationship with a staff member, and is mismanaging the medical department.
- Overtime is being charged to the Department in violation of the contract.
- The contract provider retaliated against an employee after advising executive staff of concerns and no action was taken to correct the concerns.

Investigative Findings:

A wrong prescription was issued, narcotic medications were not accounted for, and no disciplinary process was in place to deal with medication errors.

Information did not support the other allegations. Names of employees who could provide specific information were provided; however, most of the individuals interviewed did not have direct knowledge of the allegations.

There is a perception of drug abuse and mismanagement of the medical department. Findings related to the Pharmacotherapy Systems and the lack of expertise available to conduct an effective review of the facility's medical department.

Inspector General Recommendation:

The Mental Health Program Office should request a review of the medical department by an appropriately skilled management review team to ensure standards compliance.

The Department should review the need for a formal drug testing policy to be in a contractual language and should clarify, in contractual language, when reimbursement for overtime is permissible and require adequate documentation to support reimbursement.

District and Provider Response:

Prior to the Inspector General's investigation, the contract provider's Quality Improvement Director reviewed policies, procedures, and practices pertaining to medication management and errors. The following were reported:

- Identified a medication management issue -- the "wasting" of medications.
  - Corrected current procedure to be consistent with national standards.
  - Oversight responsibility for the procedure, "wasting" medications, assigned to the charge or supervising nurse.

- Corrective supervision administered to involved staff.

The contract provider implemented enhancements to the medical unit and medical management.

Allegation -- Case #2001-0106

The removal of the client from the former non-relative caregivers' home and a reinvestigation of former non-relative caregivers' child were unjustified acts of retaliation.

The written Motion for Foster Care Placement prepared by a senior attorney contained incorrect information. A family services counselor lied to the Court during the foster care placement hearing.

District employees refused to accept an affidavit submitted by the client's mother to surrender her parental rights by mistakenly labeling the affidavit as "conditional."

A family services counselor wrongfully followed the client and the client's father during an unsupervised visitation. District employees did not attempt to locate the client's father before placing the client with non-relatives.

Investigative Findings:

Alleged retaliation was not supported. However, due to the timing of Department and law enforcement actions, there was a perception of retaliation.

Prior to and during the time the client was placed in the complainant's home, it is hard to find instances when proper operating procedures were followed, sound judgement exercised, or appropriate action taken.

- The Motion for Foster Care Placement contained incorrect information.
- District employees did not attempt to locate the child's father before placing the child with non-relatives.
- The father should have been notified and a party to the court proceedings.

Information obtained did not support the other allegations.

Inspector General Recommendation:

The Quality Assurance review was forwarded to the district administrator under separate cover.

The district administrator should take corrective action. In addition, the district administrator should ensure a detailed written history of the client and the client's maternal family, and other background information provided is maintained with the client's case file.

District Response:

No disciplinary action was taken. Three district staff left the agency prior to this case situation coming to light.

The district took the following actions:

- The child protective investigator and attorneys were all inexperienced staff and were counseled.
- The family services counselor and the supervisor took appropriate action in removing the child.
- Service area managers were advised of the deficiencies on the part of their staff and took action to re-emphasize

the importance of adhering to policy and procedures.

- District Chief Legal Counsel and Child Welfare Legal Services Senior Attorney were advised of the need to remind attorneys the petitions and motions must reflect investigative findings, not allegations.
- Historical information provided on the family was made part of the child's case file.

Allegation -- Case #2001-0107 Case Review

From August 2000 through October 2001, the Office of Inspector General (OIG) received more than 100 allegations and questions from the complainant centering on dissatisfaction with the Department's intervention regarding an infant the complainant planned to privately adopt. Allegations of wrongdoing and alleged mishandling were reported. The allegations were summarized into eight broad allegations, within each allegation were multiple questions and sub-allegations, all of which were fully addressed.

Investigative Findings:

According to Inspector General Legal Counsel, the findings support the allegation that the district exceeded its authority.

The findings did not support the allegation that laws were violated relative to the Department's initial intervention.

The findings, however, support the allegation that district staff misused their authority when they placed an infant on "hold" status, but did not seek a judicial review within 24-hours as required by Chapter 39, Florida Statutes. It was not questioned that the Department had the authority to shelter an infant deemed at risk, nor was it suggested that the involved players did not have the best interest of the child in mind. However, the handling of the case caused concern considering that district staff:

- Generated the sequence of events that resulted in Department involvement.
- Failed to consider the wishes of the parents and other involved parties.
- Were hesitant to respond to the complainant's allegations that the proposed placement might not be suitable for the child and a sibling.
- Did not comply with legal time frames regarding sheltering and other matters.

The less than forthright responses from the involved family services counselor supervisor were of major concern.

Inspector General Recommendation:

The district should provide the complainant a copy of the home study completed on her home and the safety assessment instrument since she is entitled to the information.

The Family Safety Program Office should:

- Conduct a review of the district's Family Safety protective services, foster care, and adoptions programs to ensure they are adhering to standard policies and procedures regarding emergency removal of children and termination of parental rights. Based

on the findings, appropriate corrective measures should be requested.

- Review current policies and procedures regarding adoptions applications to ensure consistent and uniform eligibility criteria are being used across the state, and that appeals are occurring as required in Florida Administrative Code 65-16.008.
- Review, with the Office of General Counsel, existing policy guidelines to ensure that the indefinite "holding" of children who are being sheltered is prohibited and that statutory time frames regarding sheltering of children are adhered to.
- The suitability of paternal grandparents' home regarding placement of the older sibling has not been resolved. This issue should be closely examined by the district to assure that the concerns identified by the complainant, the infant's biological father, and the Guardian Ad Litem have been addressed.

The district should:

- Attempt to reconcile the discrepancies identified regarding the small volume of protective services casework notes now available versus the reported voluminous amount of notes taken as described by the complainant and the child protective investigator.
- Provide the complainant with all information requested and entitled to receive, as a complainant and as the adoptive parent of the involved child.

Appropriate offices and staff should review the Inspector General's report in its entirety to determine if personnel actions or corrective actions are appropriate and evaluate the need for statewide applicability.

District and Program Office Response:

The program office responded. The district was under a corrective action plan and that a district review would be completed in January 2003. The district maintains it acted appropriately, but could not account for the actions of the former supervisor assigned to the case. The supervisor was terminated prior to completion of the investigation.

Allegation -- Case #2001-0121

A family services counselor released information identifying the reporter of an abuse report to a parent of the alleged victim.

Investigative Findings:

Limited information obtained did not support the allegation. Attempts by the inspector to obtain additional information from the complainant were unsuccessful. The counselor and the alleged victim's parent denied that the counselor released information identifying the reporter.

Inspector General Recommendation:

None.

District Response:

None.

Allegation -- Case #2002-0011

A senior human services program specialist behaved inappropriately and violated Department policies and

regulations as the instructor in a training class.

The district administrator and a program administrator failed to act upon complaints made by a former employee.

A public assistance specialist was processed as resigned from the Department without an official resignation.

Investigative Findings:

Trainees played computer games during training while waiting on others to complete their assignments. Trainees said they accessed an Internet news site; however, it could not be determined whether the class was asked to access the site or it occurred during class hours or a break. Although the incidents described by the complainant were confirmed by the trainer and seven trainees in the class, when viewed in perspective, they were not inappropriate or violations of Department policies or regulations.

The other allegations were not supported.

Inspector General Recommendation:

Concerns raised should be viewed as one trainee's evaluation of the course and lessons learned should be applied to future training courses.

District Response:

The program administrator addressed the deficiencies identified.

Allegation -- Case #2002-0013 Case Review

Since 1997, the Department has been extensively involved with this family due to multiple abuse investigations in two districts. The Office of Inspector General conducted three investigations, requested a Quality Assurance review, and separately responded to six complaints regarding two district's handling of the complainant's case. The intent of the Case Review was to provide a "final look" at the Protective Services case to determine if the Department, including the Office of Inspector General, responded adequately to the complainant's concerns and bring a final closure to the case.

Investigative Findings:

Although prior Office of Inspector General reviews and investigations did not technically support most of the complainant's allegations, enough errors and omissions were identified to warrant further Office of Inspector General involvement. The following issues, while not inclusive, were identified as problematic:

- The involvement of a family services counselor and her direct supervisor relative to misinformation provided to the State Attorney's Office, resulted in the complainant's arrest.
- Key witnesses were not interviewed by the Office of Inspector General in a previous investigation.
- District employees made "questionable child safety decisions" regarding the complainant's children's placement.

- The district administrator submitted a corrective action plan; however, the steps were too broad, making it difficult to determine if appropriate actions were taken to prevent recurrence.
- District administrator responses were inconsistent regarding:
  - Delay in providing information the complainant needed to support his case in court, but did not receive until after the hearing.
  - Assignment of district employees to the case who were subjects of the complainant's complaints.
- Emails between senior managers indicated the Department mishandled the complainant's dependency case in its earliest stages.
- Employees of two districts did not attempt to facilitate court-ordered supervised visitation between the complainant and his children.
- In a prior Office of Inspector General investigation, the complainant submitted allegations of unethical and unprofessional behavior by a family services counselor supervisor, which were never addressed by the Office of Inspector General.

Inspector General Recommendation:

The district administrator should critique the decision making process that led to the recommendation of placement of the children.

The Office of Quality Assurance will be asked to review the district's corrective action plan to determine if it addressed the deficiencies noted in the quality assurance report.

The OIG opened an investigation into the additional allegations.

District Response:

The district refuted the allegations.

Allegation -- Case #2002-0018

Based upon an Inspector General Case Review, the following allegations required further investigation:

- A family services counselor failed to disclose relevant and accurate information to the State Attorney's Office, leading to the complainant's arrest.
- A family services counselor provided inaccurate or incomplete testimony in a court hearing.
- A program administrator, senior attorney, operations and management consultant, and acting district administrator were aware that employees mishandled a Protective Services case and failed to take appropriate action.
- Unknown employees from two districts failed to facilitate court-ordered supervised visitation between the complainant and the children.
- A district attorney made a motion at a court hearing to have a psychological evaluation, which was unfavorable to the complainant's ex-spouse, sealed as confidential in order to obtain an evaluation from another psychologist that would favor the ex-spouse for custody of their children.
- A senior attorney withheld a videotape from a dependency

hearing where the complainant's ex-spouse recanted the sexual abuse allegations made against the complainant.

Investigative Findings:

It was the intent of this investigation to review allegations made by the complainant during prior investigations that the Office of Inspector General determined were not thoroughly investigated. Although none of the complainant's allegations were definitively supported, the findings in this report suggest that the former family services counselor went beyond normal duties by actively seeking the arrest of the complainant.

Information obtained supports that the Assistant State Attorney based the complainant's arrest on information provided by the counselor without verifying the information. However, it is difficult to determine what actions really occurred because almost four years have passed since the inception of the family's Protective Services case.

Inspector General Recommendation:

District administrator should review internal practices to ensure district Family Safety Program staff understand that parental rights must not be minimized unless such action is absolutely necessary to ensure the children's protection.

Family Safety Program staff should receive training regarding the sharing of all relevant and accurate information with the State Attorney's Office and the court when necessary.

The parameters of the child protective investigator and family services counselor positions should be explored, defined, and communicated to involved staff.

Recommend a copy of this report be forwarded to the 19th Judicial State Attorney for action deemed appropriate.

District Response:

Pending.

Allegation -- Case #2002-0026

A complainant provided a copy of an Abuse Report identifying the reporter of the abuse report. The complainant said the report was received from a family services counselor supervisor.

Investigative Findings:

The supervisor said he did not recall meeting with and giving the report to the complainant. However, he said that, as a supervisor, he was responsible for any information released from his unit, whether he or someone else actually printed the abuse report. The supervisor admitted that other employees also use his computer to obtain abuse reports.

Inspector General Recommendation:

District management should review the findings specific to the allegation and the need for improved accountability and security for Florida Abuse Hotline Information System (FAHIS) terminals and reports.

District Response:

A Florida Abuse Hotline Information System Report Request Log was created to maintain an accounting of all requests for copies of an abuse report. The list will be monitored to ensure only appropriate persons are given copies. The supervisor must date and initial the form reminding them of their accountability. A review of the log was added to the monthly monitoring report provided by the family safety specialist for investigations to ensure the log is accurately maintained.

The family services counselor supervisor was counseled regarding the necessity of securing his computer.

LISTING OF CLOSED INVESTIGATIONS BY DISTRICT AND REGION

FY 2001-2002

DISTRICT	ALLEGATIONS

District: 1

1. 2001-0044 Allegedly management showed bias and favoritism toward contractors in the awarding of contracts and services. ***Not Supported***

   Allegedly a conflict of interest existed with District management serving on the board of directors of a provider. ***Not Supported***

   Allegedly management denied a provider the opportunity to obtain specific certifications, resulting in the provider's loss of their Medicaid provider number. ***Not Supported***

   Allegedly employees accepted meals paid for by a provider and continued to do so despite directives. ***Supported***

   Allegedly employees' travel and other expenses were initially inappropriately paid for by the provider and were to be later reimbursed under the contract awarded to the provider. ***Supported***

2. 2002-0016 Allegedly management's conduct during a meeting with a provider, and the fact that the provider later agreed to previously contested conditions of a contract, were suspicious. ***Not Supported***

District: 2

3. 2001-0040 Allegedly inadequate direct care staffing at a State hospital endangered residents and management was aware of and covered up the problem. ***Not Supported***

4. 2001-0048 Allegedly family services counselors breached confidential information. ***Not Supported***

   Allegedly employees mishandled a child abuse investigation. ***Supported***

5. 2001-0062 Allegedly family services counselors provided false information to a court and falsified documents. ***Not Supported***

Allegedly information provided by district management was untrue and employees falsified information in a Petition for Dependency. ***Not Supported***

Allegedly a family services counselor supervisor threatened clients with removal of a child if they did not comply with his instructions and wrote false information in an abuse report. ***Not Supported***

6. 2001-0065 Allegedly a family services counselor breached confidential information. ***Not Supported***

Allegedly a family services counselor provided false testimony in a court proceeding and hid medical records regarding the complainant's children from the court and the complainant. ***Not Supported***

Allegedly a family services counselor and family services counselor supervisor are friends with relatives of the complainant and their personal friendship influenced an abuse investigation. ***Not Supported***

7. 2001-0087 Allegedly family services counselors unfounded alleged abuse because of a personal friendship. ***Not Supported***

Allegedly family services counselors did not return telephone calls. ***Not Supported***

District: 3

8. 2000-0098 Allegedly a protective investigator failed to conduct a thorough and accurate protective investigation and a former protective investigator supervisor failed to properly review the investigation and improperly closed the investigation as unfounded. ***Not Supported***

9. 2001-0037 Allegedly a senior public assistance specialist improperly used sick leave and accepted donated sick leave. ***Not Supported***

10. 2001-0083 Allegedly a former family services counselor showed favoritism to a client's relative by placing the client with this relative, despite the complainant's wishes. ***Not Supported***

Allegedly a human services program specialist provided an incorrect placement address for a child. ***Not Supported***

Allegedly, contrary to a court order, a human services program specialist and former family services counselor failed to ensure a

child had telephone contact with the complainant. ***Not Supported***

Allegedly former family services counselors failed to ensure a caregiver provided a child with the appropriate medication. ***Not Supported***

11. 2001-0091 Allegedly employees breached confidential information and failed to appropriately investigate two abuse reports. ***Not Supported***

12. 2001-0112 Allegedly a family services counselor failed to investigate the condition of a home out of state, resulting in the sheltering of the children in Florida. ***Not Supported***

Allegedly an operations and management consultant failed to assist the complainant with concerns about district staff. ***Not Supported***

Allegedly a family services counselor provided false information in an Affidavit for Order to Take Into Custody and a Dependency Petition. ***Not Supported***

Allegedly a former attorney certified a court document knowing that it contained false information. ***Not Supported***

13. 2001-0116 A case review involving several allegations, a quality assurance review, and required multiple requests from the district. ***Partially Supported***

14. 2001-0117 Allegedly a family services counselor slapped a client and a family services counselor supervisor restrained the client by sitting on him. ***Not Supported***

15. 2002-0023 Allegedly a foster parent coerced a father to sign consent to allow her to adopt his children. ***Not Supported***

District: 4

16. 2000-0091 Allegedly, after a report of neglect was made to the Abuse Hotline, client records were falsified. ***Not Supported***

Allegedly group home provider staff did not properly chart and monitor medications given to clients. ***Supported***

Allegedly group home provider staff did not receive the required in-service training and were instructed to sign their names in attendance when no training was given. ***Not Supported***

Allegedly a group home provider billed for services and treatment not provided to the client. ***Not Supported***

17. 2001-0010 Allegedly a program administrator demeaned a former family services counselor and unjustly targeted the family services counselor for disciplinary action. ***Supported***

Allegedly a program administrator demeaned and displayed rude, erratic, and unprofessional behavior toward staff. ***Supported***

Allegedly a program manager failed to take action against a program administrator. ***Not Supported***

18. 2001-0061 Allegedly a family services counselor breached confidential information. ***Not Supported***

Allegedly a family services counselor failed to remove a child within a time frame sufficient to comply with a court order. ***Not Supported***

Allegedly a family services counselor was influenced to find no abuse during an abuse investigation. ***Not Supported***

Allegedly a family services counselor failed to maintain accurate case notes. ***Supported***

19. 2001-0066 Allegedly a family services counselor failed to visit children as reported in a monthly report. ***Not Supported***

20. 2001-0069 Allegedly foster care licensing staff did not follow appropriate policies and procedures when licensing a foster home and placing children in the home. ***Supported***

21. 2001-0070 Allegedly a mental health hospital administrator threatened the complainant's future employment. ***Not Supported***

Allegedly an operations and management consultant II violated Department policy by ordering the complainant to make a key for a volunteer. ***Not Supported***

Allegedly a chaplain was inappropriately targeted to be disciplined or fired. ***Not Supported***

Allegedly a State hospital employee was twice charged with abuse of clients and was placed on alternate duty to allow the employee to work until retirement. ***Not Supported***

22. 2001-0078 Allegedly a human services counselor III misused her position to obtain financial gain from clients. ***Not Supported***

23. 2002-0025 Allegedly an economic self-sufficiency specialist used her position to gain personal information about a client. ***Not Supported***

Allegedly the specialist made harassing telephone calls from Department telephones during work hours. ***Not Supported***

24. 2002-0026 Allegedly a family services counselor supervisor provided the caregiver of an alleged child victim a copy of an abuse report identifying the reporter. ***Supported***

District: 7

25. 2001-0026 Allegedly a family services counselor reported inaccurate information in a home study. ***Inconclusive***

Allegedly a family services counselor reported inaccurate information in a home study. ***Supported***

26. 2001-0041 Allegedly a family services counselor accepted a bribe from a provider in exchange for not documenting noncompliance items on inspection reports. ***Not Supported***

Allegedly a provider facility failed to make a child abuse report concerning an employee. ***Supported***

27. 2001-0053 Allegedly an employee intentionally damaged a co-worker's personal property. ***Not Supported***

28. 2001-0056 Allegedly a human services program director falsified Medicaid eligibility information. ***Not Supported***

29 2001-0058 Allegedly a family services counselor supervisor failed to conduct a thorough and objective child abuse investigation. ***Not Supported***

Allegedly a family services counselor supervisor made false statements to the Court. ***Not Supported***

30. 2001-0068 Allegedly a public assistance interviewing clerk notarized a false document for a friend. ***Not Supported***

31. 2001-0077 Allegedly a family services counselor was involved in money laundering. ***Not Supported***

32. 2001-0082 Allegedly a family services counselor accepted bribes, falsified court documents, breached confidential information, and had inappropriate relationships with clients. ***Not Supported***

33. 2001-0097 Allegedly a family services counselor and a family services counselor supervisor circumvented Interstate Compact on the Placement of Children procedures on out-of-state adoptions. ***Not Supported***

Allegedly employees made adoption subsidy payments for clients to an unentitled recipient. ***Supported***

34. 2001-0099 Allegedly a family services counselor took a client's personal property. ***Not Supported***

35. 2001-0102 Allegedly the owner of a specialty vans company overcharged the Department. ***Not Supported***

36. 2001-0103 Allegedly a provider misappropriated Department funds. ***Not Supported***

37. 2001-0104 Allegedly a public assistance specialist used a client's Electronic Benefits Transfer card for personal gain. ***Referred to another entity after investigation. FDLE terminated the review due to lack of evidence.***

38. 2001-0121 Allegedly a family services counselor breached confidential information. ***Not Supported***

39. 2002-0001 Allegedly a marketing representative solicited and obtained clients personal information from Department and contractor employees in return for money. ***Not Supported***

40. 2002-0003 Allegedly a public assistance specialist used confidential client information to solicit and accept a gift from a client. ***Supported***

Allegedly a public assistance specialist used confidential client information to solicit a loan from a client and accepted a loan from a representative of another client. ***Inconclusive***

41. 2002-0004 Allegedly a family services counselor threatened to have a child removed without justification. ***Not Supported***

Allegedly a family services counselor used her position to improperly obtain a copy of the complainant's child's criminal juvenile record for personal use. ***Not Supported***

Allegedly a family services counselor had sex with the complainant's paramour during work hours. ***Not Supported***

42. 2002-0006 Allegedly a family services counselor breached confidential information. ***Not Supported***

43. 2002-0021 Allegedly a district administrator misused Department funds for personal gain. ***Not Supported***

District: 8

44. 2001-0067 Allegedly a public assistance specialist received "kickbacks" to inappropriately approve emergency Medicaid. ***Not Supported***

45. 2001-0100 Allegedly a provider health administrator is drug dependent. ***Not Supported***

Allegedly a provider health administrator is having an ongoing relationship with a staff member. ***Not Supported***

Allegedly a provider health administrator and the nursing staff dispensed the wrong medications to residents. ***Supported***

Allegedly a provider health administrator mismanaged the medical department. ***Not Supported***

Allegedly overtime was charged to the Department in violation of the provider's contract. ***Not Supported***

Allegedly the provider retaliated against an employee who voiced concern of wrongdoing to management. ***Not Supported***

District: 9

46. 2001-0014 Allegedly confidential Florida Abuse History Information System reports were obtained for personal use and released to unauthorized persons and media. ***Supported***

47. 2001-0076 Allegedly a program administrator ignored complaints of abuse and neglect by subcontractors, and continued to use the same unqualified subcontractors for services they were not qualified to perform. ***Not Supported***

Allegedly a program administrator allowed a provider to subcontract for services even though subcontracting was not permitted. ***Inconclusive***

Allegedly a program administrator instructed a billing clerk to process payments for services not rendered and without the provider submitting an invoice. ***Not Supported***

Allegedly a program administrator allowed providers to access the Allocation, Budget and Contract (ABC) Control System using a management information systems employee's security access code to gain entry. ***Not Supported***

Allegedly a program administrator gave a billing clerk's security access code for the ABC Control System to an employee who altered documents generating payments. ***Not Supported***

48. 2001-0119 Allegedly a developmental disabilities contract provider billed for services not rendered. ***Not Supported***

Allegedly a family services counselor neglected a child resulting in delayed medical treatment. ***Not Supported***

Allegedly a public assistance specialist filed false child abuse reports against the complainant in retaliation. ***Not Supported***

Allegedly a public assistance specialists and a human services program specialist were verbally rude and abusive. ***Not Supported***

49. 2002-0012 Allegedly a public assistance specialist breached confidential information. ***Supported***

District: 10

50. 2000-0072 Allegedly provider employees failed to report incidents of alleged child-on-child sexual abuse to the Abuse Hotline, the Office of Attorney General, and district management. ***Not Supported***

Allegedly a provider failed to provide the Office of Attorney General with complete records concerning a client after being subpoenaed. ***Supported***

51. 2001-0017 Allegedly provider management and a Department family services counselor failed to report alleged child-on-child sexual abuse to the Abuse Hotline. ***Not Supported***

52 2001-0043 Allegedly a public assistance specialist physically mishandled the child of a Department client. ***Supported***

53. 2001-0047 Allegedly a public assistance specialist falsified the complainant's

economic services file and provided false information during an administrative hearing. ***Not Supported***

Allegedly a public assistance specialist supervisor covered for a public assistance specialist's mishandling of a case. ***Not Supported***

54. 2001-0050 Allegedly a public assistance specialist falsified client records. ***Supported***

55. 2001-0054 Allegedly unknown employees made a unilateral decision to discontinue alert codes (pertaining to victims or aggressors of child sexual abuse) for children in out-of-home placements. ***Not Supported***

Allegedly unknown employee(s) failed to place required information in child resource records. ***Supported***

56. 2001-0057 Allegedly a family services specialist used the State's telephone system, her Department-assigned cellular telephone, and computer for personal use. ***Supported***

57. 2001-0059 Allegedly a provider failed to hire and train staff in accordance with contract provisions. ***Supported***

Allegedly provider counselors failed to maintain appropriate documentation to verify that services were provided. ***Supported***

Allegedly a provider billed the Department for case management units not allowed by the contract and double-billed the Department. ***Supported***

58. 2001-0071 Allegedly a public assistance specialist found cash jobs for a Department client and received a "kickback." ***Not Supported***

59. 2001-0079 Allegedly a distributed computer systems analyst and systems programmer I was not working 40 hours a week as required by his Telecommuting Agreement. ***Not Supported***

Allegedly a management information systems director signed attendance and leave records which were inaccurate. ***Not Supported***

60. 2001-0080 Allegedly a family services counselor recommended to the court that a dependency case be closed despite the parents' alleged failure to complete court assigned tasks. ***Not Supported***

Allegedly a family services counselor failed to notify the Guardian

Ad Litem of the recommendation to terminate supervision to the court which is required by Children and Families Operating Procedure 175-47. ***Not Supported***

61. 2001-0084 Allegedly a provider billed the Department and the county for the same services. ***Supported***

Allegedly a deputy director was informed of the alleged problems with the provider and failed to take appropriate action. ***Supported***

Allegedly the chief legal counsel was informed of the alleged problems with the provider and failed to take appropriate action. ***Not Supported***

62. 2001-0086 Allegedly a family services counselor fraudulently obtained subsidized childcare and furniture. ***Supported***

Allegedly a family services counselor and a unit secretary misused state "fee waived" applications to obtain birth certificates for their personal use. ***Supported***

Allegedly a family services counselor misused State postage for personal mail. ***Not Supported***

63. 2001-0101 Allegedly unknown person(s) used a clerk typist's assigned Department computer to access pornographic web-sites. ***Supported***

Allegedly employees allowed unauthorized person(s) access to Department computers. ***Supported***

64. 2001-0111 Allegedly a public assistance specialist supervisor told a public assistance specialist to falsify shelter expenses of a Department client. ***Not Supported***

Allegedly a public assistance specialist supervisor told a senior public assistance specialist to change an entry on the employees' sign-in and sign-out log. ***Supported***

65. 2002-0002 Allegedly a family services counselor had an inappropriate sexual relationship with a Department client and paid her rent. ***Not Supported***

66. 2002-0005 Allegedly a public assistance specialist authorized public assistance in seven cases without establishing the recipient's eligibility for public assistance. ***Supported***

District: 11

67. 2000-0026 Allegedly a family services counselor promised to assist a client in regaining custody of her child in exchange for sex. ***Not Supported***

Allegedly a family services counselor lied to the Dade County Monitored Release Program to have the client released from house arrest for purposes of having sex. ***Not Supported***

Allegedly a family services counselor knowingly allowed another family services counselor to use his apartment to have sex with a client and took photographs of the client with the employee. ***Not Supported***

68. 2001-0032 Allegedly a public assistance specialist supervisor consistently arrives late to work, takes long lunch breaks, and leaves work early. ***Supported***

69. 2001-0046 Allegedly a provider fraudulently billed the Department for conducting medical evaluations of Department clients. ***Inconclusive***

70. 2001-0073 Allegedly a public assistance specialist twice certified the benefit case for her relatives at the direction of a public assistance specialist supervisor. ***Supported***

71. 2001-0074 Allegedly a contracted certified behavioral analyst billed the Department for services he failed to render. ***Supported***

Allegedly a contracted certified behavioral analyst falsified signatures on service visit logs that he submitted to the Department for proof of services. ***Supported***

Allegedly a contracted certified behavioral analyst falsified clients' progress data and treatment notes. ***Supported***

72. 2001-0081 Allegedly unknown person(s) stole computer equipment which contained confidential information. ***Not Supported***

73. 2001-0090 Allegedly a provider fraudulently billed the Department for Human Immunodeficiency Virus (HIV) intervention services. ***Supported***

Allegedly unknown provider employee(s) released confidential HIV information over the telephone. ***Not Supported***

74. 2001-0094 Allegedly a stores supervisor misused his position and state time by picking up packages from a provider mailroom that were not

addressed to him. ***Supported***

Allegedly a stores supervisor offered a bribe to a property specialist to not report him for picking up packages not addressed to him. ***Supported***

75. 2001-0098 Allegedly unknown employee(s) backdated a foster care license in order to conceal the placement of a child into an unlicensed foster home. ***Not Supported***

76. 2001-0109 Allegedly a program administrator attended a university on State time and failed to document his work time properly on his attendance and leave records, with the knowledge of the district administrator and district operations and programs manager. ***Not Supported***

77. 2001-0120 Allegedly a family services counselor breached confidential information. ***Not Supported***

Allegedly a family services counselor failed to make the required home visits to foster care clients and made false entries into foster care clients' records. ***Not Supported***

Allegedly a family services counselor failed to make the required home visits to foster care clients. ***Supported***

Allegedly a family services counselor made false entries into foster care clients' records. ***Not Supported***

Allegedly three family services counselors claimed approximately 60 hours of overtime per pay period for work completed at home. ***Not Supported***

District: 12

78. 2002-0011 Allegedly a senior human services program specialist behaved inappropriately and violated Department policies and regulations as the instructor in a public assistance specialist training class. ***Supported***

Allegedly the district administrator and program administrator failed to act upon complaints made by a former public assistance specialist. ***Not Supported***

Allegedly a former public assistance specialist was processed as resigning from the Department without an official resignation. ***Not Supported***

District: 13

79. 2001-0016 Allegedly a report of abuse regarding the complainant's child was made to the abuse hotline, and neither the alleged victim, the reporter, nor law enforcement were interviewed, contacted or involved in the investigation. ***Not Supported***

Allegedly a provider family services counselor supervisor did not thoroughly investigate allegations of abuse and documented false information in the abuse report. ***Not Supported***

80. 2001-0033 Allegedly a family services counselor and a family services specialist improperly removed chronological notes and other pertinent case documents from case files in an attempt to interfere with or cause unnecessary work for a provider. And, a family services provider falsified chronological notes. ***Not Supported***

Allegedly disruptive conduct and threatening and abusive language by management interfered with the work performance of staff in the office. Staff complained to management, but no action was taken. ***Supported***

Allegedly management violated personnel rules and Department policies by not providing training and mentoring for family services counselors. ***Supported***

Allegedly a family services specialist and a program administrator have a financial interest in the building's vending machines. ***Not Supported***

81. 2001-0034 Allegedly employees failed to conduct thorough and accurate abuse investigations. ***Supported***

Allegedly employees wrote false information in an abuse report. ***Not Supported***

Allegedly the deputy district administrator was aware of the alleged employee wrongdoing and failed to take action. ***Not Supported***

82. 2001-0063 Allegedly provider employees stole drugs kept on-hand for clients. ***Not Supported***

Allegedly the provider hired a nurse whose pre-employment drug screen was positive for marijuana. ***Referred to another entity for investigation. The nurse did not have a positive pre-employment drug screen. However, all nurses were tested pursuant to the allegations. Completion of the testing disclosed the nurse trace amounts of cannabinoids.***

83. 2001-0064 Allegedly an independent provider submitted a bill to a Department contracted provider before the services were provided. ***Supported***

84. 2001-0110 Case Review of a complex and sensitive set of complaints with a myriad of allegations that required extensive review by the Office of Inspector General. ***Partially Supported***

District: 14

85. 2001-0072 Allegedly a former family services counselor had an inappropriate relationship with the complainant's ex-spouse and gave favored treatment as a result of the relationship. ***Not Supported***

Allegedly a family services counselor reported inaccurate information in a shelter petition regarding the type of residence occupied by the complainant's family. ***Supported***

Allegedly a family services counselor gave false testimony at a court hearing regarding a child abuse investigation. ***Not Supported***

86. 2001-0085 Allegedly a former public assistance specialist sexually harassed a client. ***Not Supported***

Allegedly a former public assistance specialist sexually harassed another client. ***Not Supported***

87. 2001-0088 Allegedly a provider case manager sexually harassed the mother of Department clients. ***Not Supported***

88. 2001-0089 Allegedly a clerk typist specialist aided a Department client in committing public assistance fraud. ***Not Supported***

89. 2001-0106 Allegedly the complainant was retaliated against by Department employee(s). ***Not Supported***

Allegedly the written Motion for Foster Care Placement prepared by a senior attorney contained incorrect information. ***Supported***

Allegedly a family services counselor lied to the court during the

foster care placement hearing. ***Not Supported***

Allegedly employees refused to accept an affidavit submitted by the client's mother to surrender her parental rights by mistakenly labeling the affidavit as "conditional." ***Not Supported***

Allegedly a family services counselor wrongfully followed the client and the client's father during an unsupervised visitation. ***Not Supported***

Allegedly employees did not attempt to locate the client's father before placing the client with non-relatives. ***Supported***

90. 2001-0118 Allegedly a family services counselor had an inappropriate relationships with clients' mothers. ***Not Supported***

91. 2002-0009 Allegedly a family services counselor made inappropriate comments about his personal life to the mothers of Department clients. ***Supported***

Allegedly a family services counselor failed to document all home visits, information obtained during his investigation, and face-to-face client contacts. ***Supported***

Allegedly a family services counselor threatened to shelter clients because they had not been enrolled in daycare. ***Inconclusive***

Allegedly a family services counselor harassed a client's mother. ***Not Supported***

District: 15

92. 2001-0018 Allegedly a computer systems administrator used Department computer equipment to view pornographic web sites. ***Inconclusive***

93. 2001-0021 Allegedly a family services counselor supervisor acted inappropriately with a client. ***Not Supported***

Allegedly a family services counselor supervisor was permanently suspended from a provider for improper conduct. ***Supported***

Allegedly a family services counselor supervisor submitted inaccurate vouchers for reimbursement of travel expenses. ***Supported***

Allegedly a family services counselor supervisor submitted

inaccurate attendance and leave records. ***Supported***

94. 2001-0038 Allegedly the district administrator and the senior attorney intentionally withheld relevant information from the complainant, the complainant's attorney, and the court during a dependency hearing concerning the complainant's children, until after the hearing was over. ***Not Supported***

Allegedly a family services counselor and a family services specialist failed to comply with a court order authorizing visitation between the complainant and the complainant's children. ***Not Supported***

Allegedly a senior attorney coerced the complainant's ex-spouse not to recant her or her child's allegations against the complainant with the threat of losing her children. ***Not Supported***

Allegedly a former family services counselor retaliated against the complainant for making complaints by calling in an abuse report. ***Not Supported***

95. 2001-0045 Allegedly employees wrongfully interfered with a private adoption. ***Inconclusive***

Allegedly employees failed to provide relevant information and documentation to the court. ***Not Supported***

Allegedly a former family services counselor supervisor coerced the client's father to retract sexual abuse allegations against the client's paternal grandfather. ***Not Supported***

Allegedly employees attempted to influence the client's pediatrician to stop giving support to the complainant. ***Not Supported***

Allegedly employees previously provided inaccurate information to the Office of Inspector General. ***Supported***

96. 2001-0095 Allegedly a program administrator requested that a former administrative assistant used her State equipment during working hours for the program administrator's personal travel. ***Not Supported***

Allegedly a program administrator failed to report alleged sexual harassment. ***Supported***

Allegedly other Department managers failed to report separate incidents of possible sexual harassment by a former acting district

administrator. ***Supported***

Allegedly an administrative assistant used State computers for personal use. ***Supported***

Allegedly a former criminal intelligence analyst used State computers for personal use. ***Not Supported***

Allegedly a former family services counselor used State computers for personal use. ***Not Supported***

Allegedly a family services counselor supervisor used State computers for personal use. ***Supported***

97. 2001-0107 Case Review. The result was a complex and sensitive set of complaints with more than 100 allegations that required extensive review by the Office of Inspector General. ***Partially Supported***

98. 2001-0108 Allegedly a public assistance specialist and a public assistance specialist supervisor falsified a document and presented this document at the complainant's appeal hearing. ***Not Supported***

Allegedly a public assistance specialist and a public assistance specialist supervisor gave false and prejudicial information about the complainant to employees at another service center. ***Not Supported***

99. 2002-0013 Case Review. The result was a complex and sensitive set of complaints with a myriad of allegations that required extensive review by OIG. ***Partially Supported***

100. 2002-0018 Allegedly a former family services counselor failed to disclose relevant and accurate information to the Circuit Court and State Attorney's Office. ***Inconclusive***

Allegedly a former family services counselor provided inaccurate or incomplete testimony in a court hearing. ***Inconclusive***

Allegedly a program administrator, a senior attorney, a former operations and management consultant II, and a former acting district administrator were aware that employees mishandled a Protective Services case and failed to take appropriate action. ***Not Supported***

Allegedly unknown District 12 and District 15 employees failed to facilitate court-ordered supervised visitation. ***Not Supported***

Allegedly a Department attorney made a motion at a court hearing to have a psychological evaluation, which was unfavorable to the complainant's ex-spouse, sealed as confidential in order to obtain an evaluation from another psychologist that would favor the ex-spouse's child custody. ***Not Supported***

Allegedly a senior attorney withheld, from a dependency hearing, a videotape where the complainant's ex-spouse recanted sexual abuse allegations previously made against him. ***Not Supported***

SunCoast Region

101. 2001-0013 Allegedly a family services counselor failed to conduct a fair and adequate child abuse investigation. ***Not Supported***

Allegedly a family services counselor failed to comply with the requirements of Section 39.301(5)(a), Florida Statutes. ***Supported***

Allegedly a family services counselor failed to immediately provide copies of the child protection team medical reports to the complainant upon request. ***Not Supported***

Allegedly a family services counselor failed to provide counseling to the complainant's children when requested. ***Not Supported***

Allegedly a family services counselor improperly used medical terminology to diagnose the complainant's children. ***Not Supported***

Allegedly a file containing personal information regarding a foster parent was left at the complainant's residence. ***Supported***

102. 2001-0052 Allegedly a public assistance specialist obtained a credit report without authorization and used information in the report to harass an individual. ***Supported***

103. 2001-0093 Allegedly a family services counselor placed inaccurate information in case notes concerning an abuse report. ***Not Supported***

Allegedly a family services counselor provided inaccurate information to the court. ***Not Supported***

Allegedly a senior attorney provided inaccurate information to the court. ***Supported***

Allegedly a senior attorney provided inaccurate information to the court. ***Not Supported***

Allegedly senior attorneys failed to provide the child protection team's medical report and other requested documents to the complainant and her attorney. ***Not Supported***

104. 2001-0113 Allegedly a former family services counselor breached confidentiality. ***Not Supported***

Headquarters

105. 2001-0039 Allegedly a Department employee breached confidentiality. ***Not Supported***

106. 2001-0051 Allegedly the deputy director of Family Safety, ignored the complainant's written correspondence concerning the well-being of his child and failed to initiate an investigation of his complaints that the child was being abused, abandoned or neglected by the child's mother. ***Not Supported***

107. 2001-0055 Allegedly a systems programming administrator showed favoritism toward a provider. ***Not Supported***

Allegedly a systems programming administrator acted inappropriately. ***Supported***

Allegedly a systems programming administrator failed to reject a contract Request for Proposal for fatal criteria when he first reviewed the proposal. ***Supported***

108. 2001-0096 Allegedly for approximately 6 months, an unknown subject(s) stole money and other items from State offices. ***Supported***

Section C: Office of Internal Audit

As authorized by Section (§)20.055, Florida Statutes (F.S.), internal auditing encompasses the examination and evaluation of the adequacy and effectiveness of the organization's system of internal controls and the quality of performance. To achieve this mandate, internal auditors ensure:

- the reliability and integrity of financial and operational information
- compliance with laws, regulations, and contracts
- safeguarding of assets
- resources are employed with economy and efficiency
- established objectives and goals for operations or programs are accomplished

Office of Internal Audit performs the following activities:

- conducts financial, compliance, performance, contract and information systems audits
- conducts management reviews relating to program operations and assesses the reliability and validity of program performance measures
- prepares a Department-wide Risk Assessment and Annual Audit Plan
- coordinates all Department responses to external audits and tracks corrective actions through resolution
- conducts ad hoc assignments from management, Auditor General, Legislature, Federal Auditors, and the Chief Inspector General.

Quality Assurance Review

Pursuant to §11.45(2)(j) and §20.55, F.S., the Office of Auditor General reviewed the system of quality control for the Office of Inspector General/internal audit function of the Department in effect for the period July 2000 through June 2001. The review also included a determination of compliance with specific provisions of §20.055, F.S., governing the operations of State agencies' offices of inspectors general and internal audit functions.

On July 24, 2002, the Auditor General issued the report stating, "the system of quality control related to the Office of Inspector General/internal audit function of the Department of Children and Family Services, as designed and implemented during the review period, provided reasonable assurance of compliance with applicable professional auditing standards and Office of Inspector General policies and procedures. Also, the Department had generally complied with those provisions of §20.055, F.S., which relate to the operation of State agencies' office of inspectors general and internal audit functions."

Internal Audit Staff

At the beginning of FY 2001-2002, the office was staffed with 16 positions in Tallahassee. Four positions were assigned to conduct performance audits, four to management reviews, three to contract audits, three to information systems audits, and one to staff support. Due to budget cuts effective in January 2002, the office lost three professional positions and was subsequently reorganized to three auditing units: Contract, Information Systems, and Performance.

Staff had the following certifications:

- Three were Florida Certified Public Accountants, three were Certified Internal Auditors, one was a Certified Government Financial Manager, and one was a Certified Inspector General
- Six had graduate degrees and seven had ten plus years of auditing experience.
- The Department had a sustaining organization membership with the Institute of Internal Auditors.
- Staff participated in various professional organizations and attended training seminars to comply with the continuing education requirements of the Government Auditing Standards and the Standards for the Professional Practice of Internal Auditing.

Audit Plan

The Audit Plan for Fiscal Year 2002-2003 will be based on the risk assessment that is in the process of being completed. Audit selection and assignments will be determined primarily by the rankings in the risk assessment.

Audit assignments are allocated to functional areas, such as performance, contract, or information systems audits, in proportion to the number of assigned staff.

Figure C.1 shows the broad range of audit coverage provided to the Department.

Workload Distribution
Fiscal Year 2001-2002

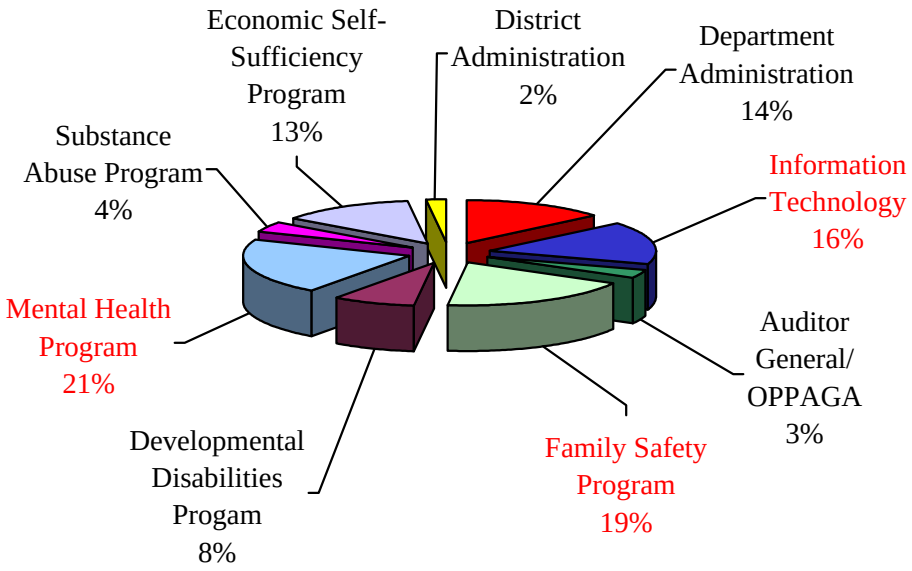


Figure: C.1
Source: Office of Internal Audit

Contract Audit

The contract audit function is responsible for conducting audits and reviews of Central Office as well as the District client services' contracts. In January 2002, Management Review staff and functions became part of the Contract Audit unit, expanding the unit's responsibilities to include management reviews, risk assessments, annual audit plans, and performance measure reviews.

The unit was staffed with a senior management analyst supervisor, a professional accountant specialist, a management review specialist, and a senior management analyst I.

Contract Audit and Review Highlights

The following are highlights of major projects that the contract audit unit participated in during FY 2001-2002.

Management Review 02-01-M: Gift of Life, Inc. for the Period July 1, 1998 through June 30, 2000

Purpose: To determine whether Gift of Life, Incorporated, misused funds and conducted questionable accounting practices; and complied with applicable regulations and agreement conditions in the expenditure and reporting of contract funds.

Review Finding:

According to records reviewed, the Gift of Life, Inc., complied with applicable rules, regulations and contract conditions. The allegation that the provider was misusing funds and conducting questionable accounting practices was not substantiated. There were some procedural deficiencies within the Department, which should be corrected.

- Payments made to the provider for seven client charges were coded as non-contractual services although they were for Alcohol, Drug Abuse and Mental Health (ADM) contracts.
- Approximately $509,317 and $524,155 for Fiscal Years 1998-1999 and 1999-2000, respectively, were spent for non-contractual services.

Inspector General Recommendations:

- Department financial personnel provide technical assistance to District offices to ensure client charges are recorded correctly.
- Department budget personnel provide technical assistance to the Family Safety Program and Alcohol, Drug Abuse and Mental Health staff so budget requests and actual expenditures reflect the needs of each program area.

Management Review 02-02-M: Martin County Advocates for the Rights of the Challenged (ARC) for the Period July 1, 2000 through May 24, 2001

Purpose: To determine the validity of a complaint made by the former Executive Director of Martin County Advocates for the Rights of the Challenged alleging that there was an unauthorized disbursement of funds and an unapproved solicitation of funds directed to a not-for-profit foundation by the President of the Martin County Advocates for the Rights of the Challenged and an attempt to "doctor" case notes in order to obtain Medicaid or general revenue funding.

Review Findings:

- Without the approval of the Martin County Advocates for the Rights of the Challenged Board of Directors, the President ordered funds solicited for the Advocates for the Rights of the Challenged be given to a not-for-profit foundation that he founded.
- The allegation that there was an attempt to "doctor" case notes in order to obtain Medicaid or general revenue funding could not be substantiated.

Inspector General Recommendation:

The Board amend the by-laws to require its approval prior to writing any checks and develop a policy to require all future fundraisers be solely for the benefit of the Martin County Advocates for the Rights of the Challenged.

Management Review 02-03-M: Mental Health Program Office for the Period July 1, 2000 through June 30, 2001.

Purpose: To review a complaint alleging that the Department Mental Health Program Office was not in compliance with Section 394.4574(3) and Section 394.75, Florida Statutes. This review consisted principally of inquiries of program personnel and verification of compliance with the referenced statutes.

Review objectives were to determine whether the program office:

- Received a Substance Abuse and Mental Health Plan from each District;
- Verified that each District's Substance Abuse and Mental Health Plan complied with Sections 394.4574(3) and 394.75, Florida Statutes;
- Completed a Substance Abuse and Mental Health State Master Plan; and
- Verified that the Substance Abuse and Mental Health State Master Plan complied with Section 394.75, Florida Statutes.

Review Findings:

- Each District developed a Substance Abuse and Mental Health Plan in accordance with Sections 394.4574(3) and 394.75, Florida Statutes, for Fiscal Year 2000-2001.
- District 4 and District 13 did not sufficiently document community input and Agency for Health Care Administration consultation in creating their plans.
- The Department Mental Health Program Office developed a Substance Abuse and Mental Health State Master Plan in accordance with §394.75, F.S., for the years 2000-2003.
- The State's Master Plan was not timely submitted to the Legislature.

Inspector General Recommendations:

The Department Mental Health Program Director ensure:

- Technical assistance is provided to the District offices to make sure sufficient documentation is maintained to evidence compliance with Section 394.4574(3), Florida Statutes.
- Compliance with the statutory requirement to submit the State Master

Plan to the Legislature by January 1 of each year.

Management Review 02-05-M: Benefit Recovery Backlog for the Period June 7, 1998 through June 7, 2001

Purpose: To review a sample of public assistance cases backlogged in the Benefit Recovery Section of the Economic Self-Sufficiency Program during the period June 7, 1998 through June 7, 2001.

The objective was to determine whether cases containing indicators of suspected fraud exist in the backlog and should have been referred to the Florida Department of Law Enforcement, Public Assistance Fraud Unit, for review.

Review Finding:

Indicators of suspected fraud were found in 22 of 78 Public Assistance case referrals (28%) examined.

Inspector General Recommendation:

Management should ensure:

- During Public Assistance Specialist staff training, emphasis is placed on properly identifying suspected fraud cases referred to Benefit Recovery.
- Continue collaboration with Public Assistance Fraud to ensure the case referral process is efficient and effective.
- Ensure Public Assistance cases backlogged since May 2, 2001 are promptly analyzed by Benefit Recovery staff for suspected fraud indicators and referred to Public Assistance Fraud, as necessary.

Management Review 02-06-M: Florida Abuse Hotline for the Period April 1, 2000 through March 31, 2001

Purpose: To determine whether the current organizational placement of the Florida Abuse Hotline is optimal to efficiently and effectively achieve management's mission and objectives, which included the following:

- Whether the efficiency and effectiveness of the Hotline processes related to receiving calls and sending abuse reports to District protective investigation units;
- The adequacy of the interface between Hotline staff and District protective investigators; and
- Whether the organizational placement of the Hotline within the Family Safety Program Office is appropriate.

Internal Audit conducted this review in response to a request from the Chief of Child Abuse Investigations.

To meet review objectives, the review team:

- Observed Hotline staff, reviewed policies and procedures, and interviewed management, supervisory, and counselor staff.
- Interviewed Adult Services and Family Safety Program headquarters staff, protective investigation personnel, and Pinellas County Sheriff's Office law enforcement investigators who are under contract with the Department to investigate abuse.
- Examined Hotline reports received in Districts 2, 4, and the SunCoast Region.

- Conducted telephone interviews with administrators from six other states that maintain a centralized Hotline operation to obtain information about organizational placement.

Review Findings:

- The Hotline staff was efficient and effective in receiving calls and sending reports to investigation units timely.
- The rate of abandoned calls to the Hotline decreased 12 percent since July 2000.
- Hotline reports were sent to District protective investigation units timely.
- The interface between the Hotline staff and District protective investigators was inadequate.
- Hotline counselors and protective investigators need a better understanding of each other's role in the child protection system.
- The function and operation of the Hotline's HELP Line has not been effectively communicated to District and Regional staff.
- Hotline and District protective investigator staff need a better communication process to resolve policy and operational issues.
- The appropriateness of the organizational placement of the Hotline within the Family Safety Program Office for optimal service requires additional research.
- The Hotline is not organizationally placed at a level above all programs that it serves.

Inspector General Recommendations:

- Management continue to reduce the call abandonment rate.
- Management ensure accurate and complete information in all immediate and 24-hour reports forwarded to the Districts for investigation, and that protective investigation supervisors ensure investigations commence within the mandated timeframe.
- Hotline and District management incorporate counselor shadowing and protective investigator visitations in the training curriculums for all staff.
- The Assistant Secretary for Programs chair a work group representing the Hotline, programs, and protective investigations units to meet at least quarterly to discuss and resolve programmatic and operational issues.
- The Assistant Secretaries for Programs and Operations perform an analysis to determine the optimal organizational placement for the Hotline; develop a work plan to demonstrate how the Department will ensure that the Hotline is efficiently and effectively serving all Departmental programs; and make the necessary recommendations to the Secretary.

Other Contract Audit Activities

Risk Assessment and Annual Audit Plan

Contract Audit staff completed the FY 2001-2002 Departmental Risk Assessment, which

was used to develop the 2002 Annual Audit Plan.

Audit Assist 02-01-S: Management Review of the District 4 Child Welfare Legal Services Office

Purpose: To evaluate management practices applicable to the District 4 Child Welfare Legal Services (CWLS) Office between September 1, 2001 through December 31, 2001 to determine:

- The level of efficiency and effectiveness of the current CWLS organizational structure;
- The adequacy of the administration for the CWLS Employee Satisfaction Survey; and
- Whether the Managing Attorney was performing her job responsibilities adequately.

This review was conducted in response to a request from the General Counsel of the Department, as a result of complaints from a Duval County Circuit Judge, a District 4 CWLS Attorney, the District 4 Administrator, and upon consideration of the preliminary results of a recently completed Employee Satisfaction Survey. To meet the objectives, the review team examined the organizational structure of CWLS, conducted interviews with two Circuit Court Judges, District management, District Legal Counsel, Managing Attorney, CWLS Attorneys, and paralegal and support staff, and reviewed the recently completed Employee Satisfaction Survey and employee performance evaluations.

Review Findings:

- Attorney, support, and caseworker staff are not performing as a team to enhance dependency case preparation;
- The Tree Case Assignment System needs further review and enhancement;
- District 4 CWLS Office should be granted additional budget authority to reward outstanding employee performance;
- The CWLS Employee Satisfaction Survey was not conducted in a confidential manner; and
- The District Managing Attorney needs to devote more time to supervision and other managerial functions.

Inspector General Recommendations:

- District 4 Office of Human Resources perform a desk audit to ensure that CWLS support staff are performing their work assignments in accordance with management's objectives.
- Ensure all counties are provided adequate support staff.
- CWLS Office Manager inform support staff that attorney opinions will become part of and given strong consideration within their annual performance evaluations.
- Family Safety Program Management address the issue of caseworkers not filing documents with the CWLS Office in a timely manner.
- Tree System should be evaluated by a Quality Assurance Review to determine whether revisions should be implemented to improve the system.

- CWLS be granted budget authority to create a system with incentives to reward outstanding employees.
- Management ensure future staff satisfaction surveys are conducted efficiently and effectively, under strict confidential procedures and the results expeditiously distributed to the participants. Disseminate deadlines for the completion and utilization of future surveys.
- A caseload assessment be conducted to determine whether caseloads are equitably distributed; that when all positions are filled and attorneys trained, the Managing Attorney spend more time in the office to maximize supervisory oversight and support for staff; and, that the Managing Attorney establish a constructive "team-work relationship" with Family Safety management.

Audit Assist: Department of Education Investigation

At the request of the Chief Inspector General, Contract Audit staff assisted Investigations staff in investigating allegations of improprieties relating to the Department of Education's Office of Inspector General, Division of Vocational Rehabilitation, and Bureau of Compliance and Oversight. The allegations were unsubstantiated. The report was issued by the Office of the Chief Inspector General.

Projects in Progress

Multi-Agency Task Force Contract Monitoring Review.

- Contract Audit staff are participating in a multi-agency task force review of contract monitoring with the emphasis on monitoring contracts for privatized operations. The goal of the task force is to assure a uniform approach to the review that will result in development of a process that will improve the way contract monitoring is performed and thereby assure greater accountability for the State.

Assessment of the reliability and validity of performance measures for the Developmental Disabilities Program Office.

- The fieldwork and draft report were completed during FY 2001-2002, and we anticipate the final report release by the end of the second quarter of FY 2002-2003.

Assessment of the reliability and validity of performance measures for the Economic Self Sufficiency Program Office.

- The fieldwork and draft report were completed during the fourth quarter of FY 2001-2002, and we anticipate the final report release by the end of the second quarter of FY 2002-2003.

Management Review to determine whether District 8 Revenue Maximization Unit staff failed to follow Children and Families Operating Procedure (CFOP) 175-71 and incorrectly coded children taken into care, and if so, whether miscoding children resulted in overpayments or underpayments to providers.

- The fieldwork and draft report were completed during FY 2001-2002, and we anticipate the final report release by the end of the second quarter of FY 2002-2003.

Audit of State and District Plans for Assisted Living Facilities with Limited Mental Health Licenses (ALF-LMHL), in response to a complaint, to determine whether the Department is in compliance with §394.75(10), F.S., regarding establishing written procedures for implementing District plans for ALF-LMHL.

- Responses to the findings and recommendations have been received and the report will be released during the first quarter of FY 2002-2003.

Audit of Sexually Violent Predator Program to determine whether the contract providers complied with Chapter 394, F.S., and DCF policies and procedures; met contract requirements; and whether selected expenditures were allowable and supported.

- The working papers and draft report are in the review process.

Information Systems Audit

The objectives of the information systems audit unit are to: provide an independent appraisal of the Department's security program and operational control of data and information technology resources and to assist management by reviewing information systems for compliance with applicable rules, regulations, and procedures. These objectives are accomplished through audits of statewide and District information systems. The information systems audit unit was comprised of three positions: a computer audit supervisor, a computer audit analyst, and, effective January 18, 2002, a professional accountant specialist, which replaced a computer audit analyst.

Information Systems Audit Highlights

The following are highlights of the audits and projects that information systems audit staff participated in during FY 2001-2002.

Management Review #02-04-M: The Department's Methadone Maintenance Program

Allegation: The Department may not be purchasing methadone services in the most cost efficient manner. The Executive Office of the Governor requested the Office of Inspector General to conduct a management review of the Methadone Maintenance Program.

Review Findings:

- Alcohol, Drug Abuse and Mental Health Data Warehouse had incomplete service event data for the methadone maintenance program.
- The Department's model unit cost for methadone maintenance services was $11.74. South Florida Substance Abuse, Inc., was paid $29.79 under Contract No. JH532, compared to Drug Abuse Comprehensive Coordinating Office, Inc., and River Region Human Services, Inc., who were paid $10.61 and $11.74 per unit, respectively.

- Clients identified in the Alcohol, Drug Abuse and Mental Health Data Warehouse as having received methadone maintenance services or in methadone maintenance could not be matched to provider lists of methadone clients.
- The unit cost paid compensated for dispensing the methadone medication and providing associated services required by Chapter 65D-16, Florida Administrative Code (FAC), although instances were found where providers separately reported the associated services.
- Although required under Purchase of Services Contract No. JH532 with South Florida Substance Abuse, Inc., evidence could not be located that clients had been authorized in writing by District 10's Alcohol, Drug Abuse and Mental Health Program Office. Although required under this contract, payments were not for services to specific clients.
- For clients tested, admission, discharge and placement dates were incorrect or could not be located in the Alcohol, Drug Abuse, and Mental Health Data Warehouse.

Inspector General Recommendation:

- District 10 management should obtain substance abuse services in accordance with *A Guide to Performance Contracting for Alcohol, Drug Abuse and Mental Health Services*. Contracted services should fall under an approved cost center and unit costs should not exceed model state rates for that cost center.
- District Alcohol, Drug Abuse and Mental Health Program Office staff should:
  - Verify the completeness of methadone maintenance service event data in the Alcohol, Drug Abuse and Mental Health Data Warehouse by periodically comparing the totals to those reported in Worksheet 1 that is part of the provider's invoices.
  - Work with providers to address and resolve unmatched client records in the Alcohol, Drug Abuse and Mental Health Data Warehouse and remind them of the need to submit discharge and placement end data.
  - Review associated methadone services erroneously reported to cost centers other than [13] for which the providers contract, and determine whether the Department made overpayments.
- If District 10 uses the Purchase of Services model contract Attachment I, District administration should ensure that procedures are in place whereby clients are approved, in writing, prior to service deliveries and that payments are authorized only for services to eligible clients.
- Central Office Mental Health and Substance Abuse Program staff should implement data integrity procedures that require periodic comparison of admission, discharge, and placement dates in the Alcohol, Drug Abuse and Mental Health Data Warehouse to documentation in client files.

Management Response:

- District 10 no longer "bundles" services and has established rates for each approved cost center that are below the state model rates.
- Where applicable, District 4 and SunCoast Region management agreed to follow the Inspector General recommendations regarding verifying the completeness of methadone maintenance service event data, resolving unmatched client records and reviewing reporting of associated methadone services.
- District 10 will ensure all clients are approved in writing prior to service delivery and payments are authorized only for services to eligible clients, if a Purchase of Services model contract Attachment I is utilized.
- Substance Abuse currently has in place a data validation process for contracted providers.
- Chapter 65E-14, Alcohol, Drug Abuse and Mental Health Financial Rule, is being revised and will propose financial penalties in the event a provider fails to submit data as required.

Special Project #02-01-S: Internal Inspection of the Safeguards and Security Measures Employed by the Department of Children and Families to Protect the Confidentiality of Federal Tax Information for the Period October 1 Through November 30, 2001.

Purpose: Pursuant to Section 6.3 of the Internal Revenue Service's Publication 1075, *Tax Information Security Guidelines for Federal State, and Local Agencies*, an internal inspection is required to be completed within an 18-month cycle.

Inspection Findings:

- Contrary to Section 6103(l)(7) of the Internal Revenue Code, two Agency for Health Care Administration employees had access to Federal Tax Information received by Department of Children and Families.
- Contrary to the Computer Matching Agreement, access to Federal Tax Information was not restricted to Department of Children and Families employees whose responsibilities include determining eligibility for, or the correct amount of, public assistance benefits.
- The Department of Children and Families had not taken all the necessary corrective actions agreed to in its response to the findings cited by the Internal Revenue Service in its May 2000 Safeguard Review.
- Signed Security Agreement Forms, documentation of attendance at Security Awareness Training, and forms authorizing access to the FLORIDA system could not be located for some individuals with access to Federal Tax Information.

Inspector General Recommendations:

- The Economic Self-Sufficiency Program Office periodically monitor:
  - With Office of Information Systems assistance, the complete list of users with access to Federal Tax Information to ensure that employees of other State agencies do not have access to Federal Tax Information.

- Complete list of users with access to Federal Tax Information to ensure that a need for such access exists.

- The Offices of Education and Training, and Information Systems take prompt action to implement the agreed upon corrective actions.
- For those end users whose documentation of attendance at Security Awareness Training and/or authorization to access the FLORIDA system could not be located, the Economic Self-Sufficiency Program Office, in conjunction with Information Systems, request the users' supervisor provide such documentation or action may be taken to revoke such access.
- Information Systems revise Children and Families Operating Procedure (CFOP) 50-2 to require systems' users attend Security Awareness Training within a specified period after gaining access or have such access revoked.

Management Response:

- Economic Self-Sufficiency Central Office Security Maintenance is currently reviewing all profile names issued to headquarters staff of all outside agencies and replacing them with new profile names that do not allow access to Federal Tax Information. An automated system for tracking user IDs is being developed that will enhance the above process. Information Systems will work with Economic Self-Sufficiency on this issue.
- User IDs for Economic Self-Sufficiency Central Office employees are currently under review to ensure Federal Tax Information is accessible only to those individuals whose duties require access. Quarterly monitoring of all Economic Self-Sufficiency Central Office user IDs will be completed.
- The information provided by the Office of Internal Audit was subsequently included by the training unit in their Economic Self-Sufficiency family track pre-service material and will be included in the Adult pre-service curriculum by July 1, 2002.
- Information Systems has revised CFOP 50-2 to direct network staff to follow standard guidance for use and control of network test equipment, and added a requirement for Annual Security Reports from Central Office, as well as from the Districts.
- Three of the individuals are no longer employed with the Department and their access to the FLORIDA system was revoked. Of the remaining employees, three completed and two were scheduled for Security Awareness Training, and five submitted a completed, signed and dated FLORIDA Individual Security Information Form.
- Information Systems will support Economic Self-Sufficiency in its request. CFOP 50-2 was revised to require systems' users to attend Security Awareness Training within a specified period after gaining access or have such access revoked.

Projects In Progress

Audit of the Central Office of Contracted Client Services for the Period July 1, 2000

Through June 30, 2001 to determine compliance with §492,62 and §402.73, F.S., Children and Families Operating Procedure 75-2, *Contract Management System for Contractual Services*, and the efficiency and effectiveness of the unit.

- Field work and the draft report were completed during FY 2001-2002 and we anticipate the final report release in the first quarter of FY 2002-2003.

Audit of the Florida Abuse Hotline Information System for the Period January 1, Through June 30, 2001 to determine the selected logical access controls assist management in protecting Florida Abuse Hotline Information Systems (FAHIS) data against unauthorized disclosure, loss, or modification; the service continuity plan and back-up procedures ensure the continuation of required FAHIS services; and, the selected data management controls ensure the integrity and reliability of data in FAHIS.

- Fieldwork was completed during FY 2001-2002 and we anticipate the final report release during the second quarter of FY 2002-2003.

Performance Audit

The performance audit unit is comprised of four positions: a senior management analyst supervisor, a professional accountant specialist, a senior management analyst I, and a senior professional accountant.

Performance Audit Highlights

The following are highlights of major projects of the performance audit unit during FY 2001-2002.

Audit A-02-01: Multi-Agency Audit of Purchasing Card Programs

Internal Audit participated in a multi-agency purchasing card (P-Card) audit coordinated by the Governor's Council on Integrity and Efficiency. The scope of the audit included a review of purchasing card transactions and related activities for the period of July 1, 2000 through March 31, 2001 and related transactions through the end of fieldwork. The audit objectives were to determine whether:

- The Department complied with relevant laws, rules, policies and guidelines;
- Management's system of internal controls was adequate to ensure effective and efficient use of agency resources; and,
- P-card transactions were properly authorized and recorded.

Audit Findings:

- The Department is not following the approved P-Card Program Model Plan; and
- Generally, P-Card transactions were properly authorized and recorded in accordance with the relevant laws, rules, policies, and guidelines.

Inspector General Recommendations:

- The Department should immediately begin to comply with the approved P-Card Program Model Plan; and,

- Management should:
  - Take the necessary steps to release the transaction for payment, or document a reason for disapproving the charge, before the required 10-day response period has expired;
  - Conduct on-going briefings and training to staff responsible for making purchases for the two quote requirements; and,
  - File supporting documentation for transactions at its designated location for the required retention period. All removed files should be replaced with a file card identifying the person who removed the file.

Performance Audit of the Foster Care/Residential Group Care Program in District 10 for the Period July 1, 1998 Through June 30, 2000 and Selected Actions Taken Through April 30, 2001

The performance audit of the Foster Care/Residential Group Care Program in District 10 was issued April 29, 2002. The audit focused primarily on review of Department and facility case files as well as contract and licensing files for the facilities for the period of July 1, 1998 through June 30, 2000. The audit objectives were to:

- Determine whether District 10 and the residential group care facilities are providing timely and effective case management services, to include permanency, placements, case planning and judicial reviews, as applicable;
- Assess the effectiveness of the District 10 Foster Care program in ensuring that the residential group care facilities have met the licensure requirements pursuant to the Florida Statute and Florida Administrative Code;
- Determine whether the District 10 Foster Care Program is effectively monitoring its contracts with residential group care facilities; and,
- Evaluate the internal controls to determine whether they promote an efficient and effective Residential Group Care Program.

Audit Findings:

- Eighty-one percent of the sampled clients did not achieve permanency within one year;
- Judicial review hearings were not held within the required timeframes;
- Family services counselor supervisors reviewed only 12 percent of the chronological recordings (client progress notes) tested for the audit period. Furthermore, the reviews that were completed were not conducted quarterly;
- The outcome evaluation system did not evaluate the effectiveness of case plan measurable objectives;
- The District did not provide documentation to substantiate that the responsible parties complied with 42 percent of the recommended services tested;
- The District did not provide documentation to substantiate that the responsible parties complied with 69 percent of the measurable outcomes outlined in the sampled case plans;

- Family services counselors insufficiently documented 30 percent of the case plan requirements;
- Of the sampled clients, 69 percent had five or more placements during the audit period;
- Of the 95 judicial review hearings held during the audit period, only 53 of 95, or 56 percent, of the Judicial Review Social Study Reports (JRSSR) were available for review. Of the 53 reviewed, family services counselors insufficiently documented 35 percent of the requirements;
- Adequate documentation of client monthly visits was not always maintained;
- For 124 of 322, or 39 percent, of the monthly visits documented in the client progress notes, 50 percent were insufficiently documented;
- The client or caretaker did not sign 18 percent of the visitation reports reviewed;
- The family services counselors did not participate in 33 percent of the clients' service plan reviews;
- The facilities did not maintain complete documentation in client case files;
- The District did not ensure that the facilities developed complete service plans for clients;
- The District did not provide the family's social history to enable the facilities to conduct a complete pre-admission study for 25 percent of the clients;
- The family services counselor's performance standards require contacts to be documented 90 percent of the time, which conflicts with the requirements of Children and Families Operating Procedure 175-42;
- The Pre-disposition Studies were insufficiently documented;
- Two of six, or 33 percent, of the sampled facilities did not have a provision to protect victims of child abuse as required by §65C-14.017(4), Florida Administrative Code (FAC);
- The District licensed 3 of 6, or 50 percent, of the sampled residential group care facilities, although they had not met personnel screening requirements of the Florida Statutes;
- The facilities could not demonstrate that 54 percent of the sampled staff, received 40 hours of required training each year;
- The position description for the Community Mental Health Practitioner at Friends of Children and the individual filling the position did not meet required qualifications set forth in Chapter 65C-14, Florida Administrative Code;
- Friends of Children's policy on food service does not comply with the requirements of the Florida Administrative Code;
- Two of six, or 33 percent, of the sampled facilities did not have a written plan to provide additional emergency staff;
- Alternate Family Care did not place toiletries in the bathrooms as required by Sections 65C-14.008(8)(b) and 65C-14.020(1), Florida Administrative Code;
- The isolation rooms at Alternate Family Care did not meet the Florida Administrative Code requirements;
- None of the sampled facilities could provide documentation of a written agreement with the child, guardian, and

Department as required by Section 65C-14.044, Florida Administrative Code;

- Residents at Impact Community Services were locked out of the facility;
- None of the sampled residents' files requiring written release plans contained documentation of a written release plan;
- Fifty-five percent of the sampled residents' files did not document a completed physical examination within 90 days prior to admission;
- Although the facility did not have a written plan for preventative, routine, emergency, or follow-up medical and dental care, the District re-licensed Crawford Center for the last five years;
- Alternate Family Care and Brown Schools did not have a written policy to involve children in community activities and services. Moreover, Alternate Family Care could not provide a written plan for a range of recreational and leisure activities;
- Eighty percent of the sampled facilities did not maintain a register of residents;
- Fifty percent, or three of six, of the sampled facilities were issued regular licenses for less than a one-year period;
- None of the sampled facilities required to submit an application for renewal during the audit period submitted one within 90 days prior to the expiration of their license;
- The licensure requirement checklist used by licensing personnel did not contain all the requirements outlined by Chapter 65C-14, Florida Administrative Code;
- Licensing personnel marked some licensure requirements as noncompliance, but omitted the deficiencies from the corrective action plan;
- The runaway rate at Impact Community Services exceeded the rate allowed by the contract's performance standard;
- Residents' safety was put at risk because facilities did not develop disaster preparedness plans;
- Staff at Friends of Children did not receive the required 20 hours of pre-service training;
- For the Fiscal Year Ending June 30, 2000, the District did not inspect and approve services within five working days for 46 percent of the invoices submitted by the sampled facilities;
- Our review of Impact Community Services' invoices revealed five areas of concern that involved excess payments totaling $15,675;
- The District overpaid $4,040.84 by allowing Brown Schools to charge for the date of discharge;
- The District did not adjust the risk assessment instrument for the contracts executed in District 10; and,
- Due to the lack of coordination between contract and licensing personnel, a contract was executed with a facility that did not have a valid license.

Inspector General Recommendations:

District management should:

- Review their processes and take appropriate action to ensure compliance with Section 39.001(1)(h), Florida Statutes.;
- Reevaluate the procedures implemented as a result of the corrective action plan and ensure that judicial reviews are held timely. The District should also ensure that documentation of judicial reviews is maintained in each client's file;
- Take action to ensure family services counselor supervisors perform quarterly reviews as required in Children and Families Operating Procedure 175-42 and use HomeSafenet to monitor the family services counselor supervisors quarterly review of client progress notes;
- Develop a system to evaluate the effectiveness of case plan measurable objectives; that this system include performance standards for evaluating District 10's effectiveness in meeting the case plan goals and objectives; and that when the case plan is not meeting expectations, management take the necessary action to assist the responsible party in improving performance;
- Concentrate on eliminating the waiting lists for existing services; work with providers to ensure needed services are more readily available; ensure that the family services counselors work more closely with parents to improve communications to ensure they receive the recommended services; and that family services counselors document in the client file reasons why certain specific services are not provided;
- Ensure required documentation for each measurable outcomes is maintained in each client's file;
- Implement a process to ensure each case plan is developed in accordance with Section 39.601, Florida Statutes, and reviewed prior to submission to the court; and that if a requirement cannot be adequately addressed, management document the reason(s) in the case file;
- Work with providers to find alternative ways to deal with foster care children with behavior problems and runaway; and that management complete more thorough and accurate initial assessments to ensure children are placed in more stable environments to meet their needs;
- Ensure that a complete JRSSR be submitted to the court for each judicial review hearing;
- Take appropriate action to ensure family services counselors conduct and document monthly visits on visitation reports and client progress notes and maintain this required documentation in client files;
- Take appropriate action to ensure each child receives a monthly visit and that the family services counselor sufficiently documents the visit in the client progress notes in accordance with Children and Families Operating Procedure 175-42; and for monthly visits that fail to occur, that management document the reason in the clients' files;
- Ensure that the client and/or caretaker sign each visitation form;
- Ensure family services counselors participate in service plan reviews for

each client assigned to them; and family services counselors obtain a copy of the client's review schedule to effectively plan for participation in service plan reviews;

- Require complete appropriate documentation in each client's file; and that licensing personnel verify that the documentation is complete in each file during re-licensing visits;
- Take appropriate action to ensure development of service plans and monitor them during re-licensing visits as well;
- Provide the family's social history to the facility prior to admission, and when parents are not compliant with providing information, alternative ways must be found to obtain the family's background to ensure that all the clients' needs are adequately addressed;
- Revise the family services counselors performance standards to require that all contacts with children, parents, guardians, relatives and foster care providers, are documented in the case file in accordance with Children and Families Operating Procedure175-42, 100 percent of the time;
- Take action to ensure that each PDS is sufficiently documented and document any reason why a requirement is not adequately addressed in the PDS;
- Ensure that Alternate Family Care and Impact Community Services include a provision to protect victims of child abuse; and ensure that licensing personnel confirm that each residential group care facility has a provision in place for protecting victims of child abuse;
- Implement a screening process for residential group care facilities to ensure that each employee hired is screened according to level 2 standards of Chapter 435, Florida Statutes, as a condition of employment or continued employment; and comply with Section 409.175(6)(b), Florida Statutes., and not license an applicant until the personnel screening requirements are met;
- Ensure staff receive 40 hours of training each year and that documentation is maintained in the licensing file and reviewed periodically by the licensing supervisor; and review the checklist used for reviewing personnel files to ensure that it includes the requirements of Section 65C-14.056(2), Florida Administrative Code;
- Develop a corrective action plan to ensure that job requirements comply with Chapter 65C-14, Florida Administrative Code; and ensure that Friends of Children take the required steps to ensure the person filling the Community Mental Health Practitioner position meets the required qualifications;
- Confirm that licensing personnel ensure Friends of Children obtain consultation from a professionally registered dietitian or the Health Department at least quarterly; and ensure that Friends of Children amend their policies and procedures to meet the requirements of Section 65C-14.051, Florida Administrative Code;
- Verify corrective actions to ensure that Alternate Family Care has a written plan to provide additional emergency staff when only one staff is on duty; and ensure that licensing personnel confirm

that each residential group care facility complies with Section 65C-14.024(4), Florida Administrative Code, and has a provision for protecting victims of child abuse in place;

- Ensure that Alternate Family Care make toiletries available in bathrooms, and ensure that they comply with Sections 65C-14.008(8)(b) and 65C-14.020(1), Florida Administrative Code;
- Ensure Alternate Family Care discontinues use of the isolation rooms until they are brought into compliance with licensing requirements, or until an alternate location that meets the requirements is identified; and ensure that facilities are in compliance with the Florida Administrative Code;
- Ensure Brown Schools, Impact Community Services, Kids in Distress, Friends of Children, and Alternate Family Care develop written agreements upon admission for each resident; and ensure that licensing personnel confirm that each residential group care facility has a written agreement pursuant to Section 65C-14.044, Florida Administrative Code;
- Continue to ensure that Impact Community Services does not use a lock-out policy and implements effective disciplinary methods that comply with Chapter 65C-14, Florida Administrative Code;
- Ensure the release plan is provided prior to release of each resident from Brown Schools and Kids in Distress; ensure that all residential group care facilities comply with Section 65C-14.048(3), Florida Administrative Code, and review checklists used when reviewing client files to ensure inclusion of the requirement of Section 65C-14.048(3), Florida Administrative Code;
- Ensure residents receive a physical exam within 90 days of admission to Alternate Family Care, Brown Schools, Friends of Children, Impact Community Services, and Kids in Distress, as well as other facilities in District 10; and provide this documentation to each facility prior to admission of the child;
- Ensure that Crawford Center is following the plan implemented February 2, 2001;
- Ensure that Alternate Family Care complies with Sections 65C-14.018(1) and 65C-14.019(1), Florida Administrative Code ; and ensure that Brown Schools implemented their policy in compliance with Section 65C-14.018(1), Florida Administrative Code;
- Ensure licensing staff verify during the re-licensure review that facilities have created and maintained a permanent register, in accordance with Section 65C-14.022, Florida Administrative Code;
- Ensure regular licenses are issued for one year, as required by Florida Statutes; and ensure that licensing personnel conduct full licensure reviews prior to issuing licenses;
- Require facilities to submit their application for re-licensing 90 days prior to expiration of their licenses; revise current processes to notify facilities to provide documentation to licensing 90 days prior to expiration; and advise licensing to consult with

legal to interpret this section of the Florida Statutes;

- Ensure the mentioned requirements are added to the re-licensure checklist and that compliance is confirmed prior to licensure;
- Require licensing personnel to complete a licensure checklist each time a licensing review is conducted; ensure a complete licensing review be conducted prior to issuance of a license; and ensure licensing personnel thoroughly review each requirement and include all deficiencies in the corrective action plan;
- Review with Impact Community Services the conditions that cause runaways and take action, as deemed appropriate to prevent the high occurrence rate and meet prescribed performance measure;
- Ensure Kids in Distress and Impact Community Services provide a disaster preparedness plan and that it is maintained in the contract manager's file as required;
- Ensure facility staff receive required pre-service training and maintain supporting documentation in each staff's file; and enforce contract requirements regarding the provider's failure to correct deficiencies;
- Ensure all services are inspected and approved within five working days in accordance with Section 215.422, Florida Statutes; and ensure that contract managers sign and date all invoices indicating their approval;
- Provide written authorization prior to a provider exceeding limits set forth in their contract, to include billing the Department twice the contract rate; ensure contracts contain only the total allowable units for the contract period; develop policies and procedures regarding off-contract payments for facilities; develop policies regarding payments for residents requiring their own room; and recoup the $15,675;
- Ensure the Department does not pay for the date of discharge when not permitted in the contract; ensure that contract managers review invoices thoroughly and compare the information to length-of-stay documentation maintained by the Family Safety Program Office; and recoup the $4,040.84;
- Adjust the Risk Assessment factors annually to make the instrument fit the current contract scenario in District 10; and
- Coordinate their visits to facilities and verify that licensing requirements have been met prior to executing contracts.

Projects in Progress

Follow-Up Audit To Task Force Case #99-0001 on Nova Southeastern University's Mental Health and Substance Abuse contract JH734, and obligations arising from the 1999 Settlement Agreement, for the period of July 1, 2000 through June 30, 2001. This audit was conducted in response to deficiencies found in a monitoring site visit and a provider reported overpayment of $327,219 received by Nova since 1999.

- We anticipate the final report release by the second quarter of FY 2002-2003.

Audit of Broward County Community Development Corporation to determine whether the provider complied with contract requirements; the extent to which funds were paid for unallowable items; and the amount, if any, of funds due the Department.

- The audit is scheduled for completion in the second quarter of FY 2002-2003.

Audit of the Mental Health Program and related activities for the period of July 1, 2001 through June 30, 2002.

- We anticipate beginning the formal audit procedures during the third quarter of FY 2002-2003.

Audit of the State Operated Support Coordination Program and Related Program Management Functions. The scope includes a review of the Developmental Disabilities technical assistance process and the Districts/Region licensing and long term residential care monitoring files for 15 randomly selected group homes in Districts 4, 11, 15 and the SunCoast Region for the period of July 1, 2001 through April 1, 2002 and selected actions through the end of fieldwork.

- The fieldwork is in progress and we anticipate the final report release by the third quarter of FY 2002-2003.

Audit of Community Intervention Center in District 2 for contract numbers BHL12 and BHM11. The scope of the audit focused primarily on a review of the contracts' performance measure requirements for Fiscal Years 2000-2001 and 2001-2002. Invoices and client files were reviewed for the period July 1, 2000 through December 31, 2001.

- Fieldwork is completed and the working papers are being reviewed. We anticipate the final report release by the end of the second quarter of FY 2002-2003.

Coordination with External Auditors

The Performance Audit unit is responsible for coordination of efforts with the Office of the Auditor General, Office of Program Policy Analysis and Governmental Accountability, and federal agencies, such as the U.S. Departments of Health and Human Services and Agriculture, Food and Nutrition Services. During Fiscal Year 2001-2002, the Performance Audit unit coordinated 95 external audit liaison activities, such as:

- Participating in entrance and exit conferences;
- Coordinating, reviewing, and preparing responses to audit recommendations for the Secretary's signature;
- Monitoring corrective action plans;
- Preparing 6-month and 18-month status reports;
- Preparing the Summary Schedule of Prior Audit Findings; and,
- Preparing the Report of Major Audit Findings and Recommendations for Legislative Budget Issues.

Prior Audits and Management Reviews for Which Corrective Action Has Not Been Completed

Audit Report A-01-01: Audit of the Acquisition and Use of Information Technology Consultants for the Period July 1, 1998 Through March 31, 2000

Corrective action remains ongoing regarding modification of the Information Resource Request (IRR) process.

Audit Report A-99-01: Use of the Innovation Investment Program for Energy Conservation in State Facilities Grant by South Florida State Hospital.

Two corrective action steps remain ongoing regarding revision of budget procedures.

Section D: Office of Appeal Hearings

The Office of Appeal Hearings provides administrative hearings for applicants or recipients of public assistance programs and individuals being transferred or discharged from nursing facilities. The office also provides disqualification hearings for individuals believed to have committed intentional program violations.

Appeal Hearings completed 6,235 fair hearing requests and 840 intentional program violation hearing requests. Appeal Hearings also completed 99 percent of the fair hearings within federal time standards.

The office operates pursuant to the following legal authorities:

- Section 409.285, Florida Statutes, Opportunity for Hearing and Appeal.

- Chapter 120, Florida Statutes, the Administrative Procedures Act, Section 120.80, Florida Statutes, Exceptions and special requirements; agencies.

- Section 400.0255, Florida Statutes., Resident hearings of facility decisions to transfer or discharge.

The administrative rules for the Department's fair hearing procedures appear in Rule 65-2.042, et seq., Florida Administrative Code, Applicant/ Recipient Hearings.

The major controlling federal regulations are:

- Temporary Assistance to Needy Families Personal Responsibility and Work Reconciliation Act of 1996;

- Medicaid
- 42 CFR Section 431.200, Fair Hearings for Applicants and Recipients; and,

- Food Stamps
- 7 CFR Section 273.15, Fair Hearings
  7 CFR Section 237.16, Disqualification for intentional Program violation.

For independence purposes, Appeal Hearings reports directly to the Inspector General. Federal regulations require a hearing officer to be a state-level employee.

Appeal Hearings has 21 full-time positions and is staffed with an administrator, 3 supervisors, 13 hearing officers and 4 support employees.

In order to deliver services, on a statewide basis, in the most efficient and effective manner, hearing officers are located in several geographical areas. Two positions are located in Jacksonville, Fort Lauderdale, and Miami; one is in Gainesville, Lakeland, Saint Petersburg, Orlando, Tampa, West Palm Beach, and Crestview; and one supervisor position is in Broward.

All administrative costs for hearings are funded at 50 percent federal administrative trust funds and 50 percent general revenue.

FAIR HEARINGS

The Department is required by the federally-funded assistance programs to offer a "fair" hearing prior to an action to terminate assistance which meets basic due process requirements as contained in Goldberg vs. Kelly, (1970). The Administrative Procedures Act, Chapter 120, F.S., sets forth the state procedural requirements the Department must meet in resolving issues which affect the substantial interest of individuals. The Appeal Hearings has been delegated the authority to complete final agency actions on a variety of issues arising out of most of the federally funded programs.

The Department recently settled a law-suit related to Medicaid waivers and due process. As a result the office has experienced an increase in Medicaid benefits hearings.

Appeal Hearings holds fair hearings for:

Economic Self Sufficiency

- Temporary Assistance to Needy Families (TANF)
- Food Stamps
- Medicaid Eligibility
- Refugee Assistance Program
- Individual of Family Grant Program
- Institutional Care Program
- Optional State Supplementation

Medicaid Benefits

Others

- Special Supplemental Food Program for Women, Infants and Children
- Certain Social Services Block Grant Programs
- Certain Child Support Enforcement issues for the Department of Revenue

Figure D.1, shows the number of Hearing Requests by district/region.

Hearing Requests by District/Region

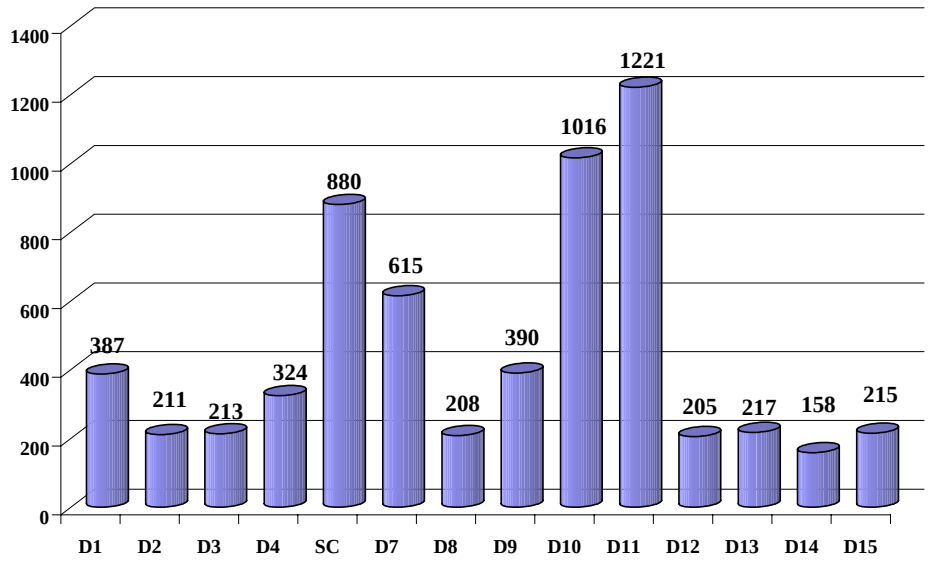


Figure: D.1
Source: Office of Appeal Hearings

NURSING HOME TRANSFER/ DISCHARGE HEARINGS

Appeal Hearings also conducts hearings to determine whether or not a nursing facility's decision to transfer or discharge a patient was correct. The facility may only discharge an individual based upon conditions set forth in law.

These hearings often involve expert medical testimony on complex medical issues. The hearing officer has the authority to prohibit the discharge or require the facility to readmit a resident if he/she has already been discharged.

ADMINISTRATIVE DISQUALIFICATION HEARINGS

The Department has the authority to disqualify an individual from receiving cash assistance and food stamp benefits when that individual has been found, through the administrative hearing process, to have committed an intentional program violation. Intentional program violations are such acts as making false or misleading statements, or misrepresented, concealed or withheld facts. The disqualification is for one year for the first offense, two years for the second, and a lifetime for the third offense.

In addition to disqualification hearing requests, the office tracks cases in which the individual agrees to accept the disqualification penalty and waive the right to a hearing. In Fiscal Year 2001, Appeal Hearings processed 3,831 disqualification's for temporary assistance to needy families or food stamp benefits based on signed waivers.

Section E: Office of Quality Control

In accordance with federal statutes and regulations, State plans for the administration of the Food Stamp program must provide for a system of quality control. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 provides Temporary Assistance to Needy Families (TANF). Although temporary assistance to needy families does not require quality control reviews, the Department conducts payment accuracy reviews of both programs.

The Office of Quality Control conducts reviews based upon statistically reliable samples of public assistance cases. Reviews provide management and federal administrators with information regarding erroneous payments in public assistance. Management uses the findings to establish corrective action plans for consistency problems regarding benefits. Federal agencies use the quality control statistics to determine the integrity of State assistance programs.

Federal statutes and federal regulations that provide for quality control are:

Food Stamp Title XIII, Public Law 95-113, 91 § 958, Food Stamp Act of 1977, 7 CFR Chapter II, 275.10, Subpart C - **Quality Control Reviews**

Medicaid Title XIII, Social Security Act, 42 CFR Chapter IV, 431.800 Subpart P - **Quality Control Reviews**

ADMINISTRATION OF QUALITY CONTROL

The Chief of Quality Control reports directly to the Inspector General. Quality Control is funded at 50 percent federal and 50 percent general revenue for all administrative costs. The office is composed of 45 positions located in 7 offices throughout the state. A quality control supervisor manages each unit and supervises four to seven analysts and a secretary. The seven offices are located in Tallahassee (with a satellite office in Panama City), Jacksonville, Orlando, St. Petersburg, Tampa and Miami (two). Headquarters staff is located in Tallahassee.

PROGRAMS REVIEWED

- Temporary Assistance to Needy Families (TANF)
- Food Stamps
- Medicaid Disability Application Reviews
- Medicaid Kidcare

During Federal Fiscal Year (FFY) 2001, Quality Control conducted the following reviews:

- **1,411** active food stamp cases.
- **1,313** active Temporary Assistance to Needy Families cases.

Review of negative actions (closures and denials) were completed on **862** food stamp cases, and **794** Temporary Assistance to Needy Families cases.

REVIEW PROCESS

The Quality Control review process is an in-depth study that focuses on the accuracy of benefits being paid to a sample of public assistance cases. The majority of cases require a field investigation and a definitive review of up to 50 elements of eligibility. Each element must be individually documented using acceptable standards of evidence. In addition to regulations, federal agencies issue manuals of instruction and other written guidelines to ensure that all states operate quality control measures uniformly. Reports On Findings for each case reviewed are sent to district administrators and the Department's executive staff as well.

Reviews result in one of the following findings:

(1) Correct,
(2) Underissuance,
(3) Overissuance,
(4) Totally Ineligible, or
(5) Subject cases not completed or not to review.

The U.S. Department of Agriculture re-reviews one-third of the quality control food stamp cases selected to validate the process. Differences in the re-reviews are used in a regression formula to determine the regressed error rate. The regressed error rate is used to determine sanctions that may be imposed against the State.

ERROR RATES

Error rates reflect the percentage of public assistance money misspent by the State. For Federal FY 2001, the error rate for food stamps was 9.8 percent **(Figure E.1)** and Temporary Assistance to Needy Families was 6.23 percent **(Figure E.2)**.

MEDICAID

The Medicaid program is administered by the Agency for Health Care Administration; however, this Department determines eligibility. Since the error rate has been below the 3 percent national tolerance level for several years, Florida was granted a waiver of the Medicaid error rate determination process in October 1999. Florida conducted a pilot project to increase identification and participation of eligible Medicare beneficiaries in the Medicaid Program, from October 1999 to September 2000 (FFY2000).

Phase 1 of Medicaid Pilot Project for FFY2001

The Disability Application Review (DAR) project was conducted to determine if Medicaid applications based on disability were being processed in a timely manner, or within 90 days of the application date. At least 92% of the cases had to have a determination made to be in compliance with the Department's goal. Cases that were delayed due to unusual circumstances (as defined by policy) were not considered out of compliance.

Quality Control completed **3,404** DAR reviews from November 2000 through July 2001. There were 280 applications that took over 90 days to process. Of these, 163 were delayed for unusual circumstances,

leaving 117 not processed timely. The Department was found to be in compliance 96.57% of the time.

Phase 2 of Medicaid Pilot Project for FFY2001

In January 2001, Quality Control began conducting reviews of the Medicaid KidCare (Florida Healthy Kids) program to determine the effectiveness of using a simplified application. In the simplified application process, cases are approved without an interview and before verifications are obtained. The project was part of a feasibility study to determine if a simplified application process should be expanded to other Medicaid groups.

A total of **1,391** KidCare cases were sampled from the KidCare Information Selection System (KISS). A systems and case record review was done on all cases. Income was verified to see if the initial approval was valid.

Quality Control found:

- 1066 cases were correct – 79%
- 283 cases were in error – 21%
- 42 cases were removed from the sample
- 87.2% of errors were due to earned income
- The client was responsible for 89.6% of the errors

REPORTS AND CORRECTIVE ACTION EFFORTS

Quality Control produces a monthly statistical analysis that contains information regarding erroneous payments. This report identifies areas of eligibility that contain errors, plus an analysis of what caused the errors. The report analyses district and agency-caused errors versus client-caused errors and presents trend information comparing the current year with last year.

The Quality Control unit also participates quarterly in a statewide Quality Service Committee to share error rate information and error rate reduction ideas.

Quality Control staff provide training on interviewing skills and error reduction techniques to the districts as required.

ERROR RATE SUMMARY
FOOD STAMPS
(Federal Fiscal Year 2001)

- Statewide Error Rate - 9.8%
- Agency Responsibility - 44.0% of the error rate
  - Failed to Act – 58.7%
  - Policy Incorrectly Applied – 36.5%
  - Arithmetic – 2.2%
  - Other – 2.6%
- 180 of 1,234 cases completed
- Client Responsibility - 56.0% of the error rate
  - Information Not Reported – 58.7%
  - Willful Misrepresentation – 32.1%
  - Information Incorrect – 9.2%
- Most error prone eligibility element:
  - Wages and Salaries 44.7%

Five-Year Trend

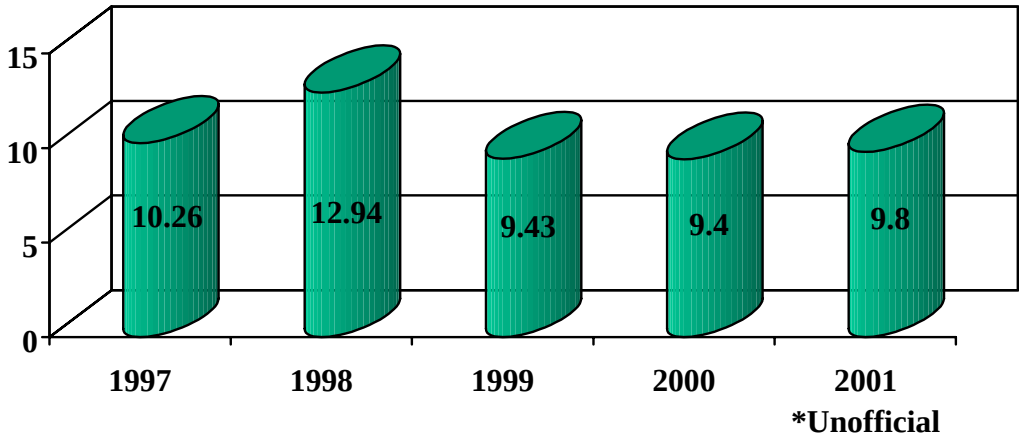


Figure: E.1
Source: Office of Quality Control

ERROR RATE SUMMARY
Temporary Assistance to Needy Families (TANF)
(Federal Fiscal Year 2001)

- Statewide Error Rate – 6.23%
- Agency Responsibility 53.4% of the error rate

  Failed to Act – 50.6%

  Policy Incorrectly Applied – 44.7%

  Arithmetic –3.8%

  Other – 0.9%
- 109 of 1,195 cases completed
- Client Portion 46.6% of the error rate

  Information Not Reported – 55.3%

  Willful Misrepresentation – 35.3%

  Information Incorrect –9.4%
- Most error prone eligibility element

  Wages and Salaries – 22.0%

Five-Year Trend

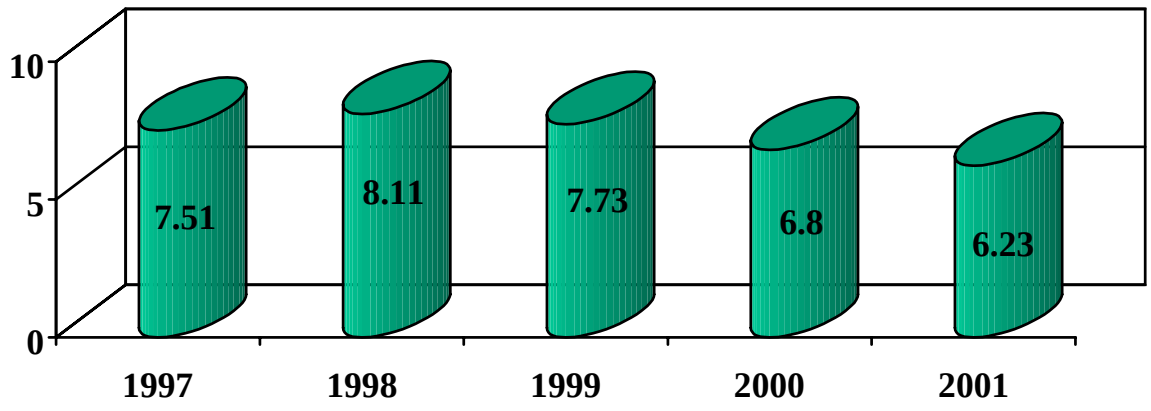


Figure: E.3
Source: Office of Quality Control

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