THRIVING MIND
SOUTH FLORIDA
A network of exceptional mental health and substance use providers.

Contracting As South Florida
Behavioral Health Network, Inc.

7205 Corporate Center Drive, Suite 200
Miami, Florida 33126
(305) 858-3335
ThrivingMind.org

September 20, 2019

Frank Rabbito, Sr. VP
Guidance Care Center, Inc.
1205 Fourth Street,
Key West, Florida 33040

Dear Mr. Rabbito,

The South Florida Behavioral Health Network, Inc. (SFBHN) conducted an on-site Contract Monitoring of Guidance Care Center, Inc. from April 29th – May 2, 2019. The purpose for the monitoring was to evaluate Guidance Care Center, Inc.'s compliance with SFBHN's contract ME225-9-27 and P-04. We had the exit conference on August 14, 2019 to discuss the findings and concerns identified during the monitoring.

We appreciate the immediate steps that were taken to correct the findings discussed during and after the monitoring.

Also incorporated into the attached report is the approved Corrective Action Plan that was submitted.

Any comments or questions may be directed to either me or your Contract Manager Elba Taveras at 305-858-3335.

Thank you for your agency's professionalism during the monitoring process. Their cooperation during our review facilitated the successful completion of our on-site visit.

Sincerely,

Jo Anna Cardwell, MSW, CHC

Joanna Cardwell, MSW, CHC
Vice President of Continuous Quality Improvement
South Florida Behavioral Health Network, Inc.
d.b.a. Thriving Mind South Florida

cc: John Newcomer, Thriving Mind South Florida President/Chief Executive Officer
Stephen Zuckerman, Thriving Mind South Florida Senior VP/ Chief Financial Officer
Laura M. Naredo, Thriving Mind South Florida Senior VP/ Chief Operating Officer
Carol Caraballo, Thriving Mind South Florida VP of Behavioral Health Services
Johnny Guimaraes, Thriving Mind South Florida VP of IT and Contract Compliance
Jose Vempala, Thriving Mind South Florida VP of Finance
Jessica Rodriguez, SFBHN Contract Management Supervisor
Elba Taveras, SFBHN Contract Manager
Maureen Dunleavy, GCC Area Director
Lourice Khoury, DCF Contract Manager

Partially funded by the Florida Department of Children & Families

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

CONTRACT MONITORING REPORT

For

GUIDANCE CARE CENTER, INC.

Contract # ME225-9-27 and P-04 (FY2018/2019)

Exit Conference on
August 14, 2019

By:

South Florida Behavioral Health Network, Inc.

TABLE OF CONTENTS

I. Executive Summary

Background

South Florida Behavioral Health Network, Inc. (SFBHN) Continuous Quality Improvement Division monitored Guidance Care Center, Inc. for compliance with contractual and programmatic requirements. Under contract ME225-9-27 and P-04 Guidance Care Center, Inc. provides Adult Substance Abuse (ASA), Child Substance Abuse (CSA) , Adult Mental Health (AMH) and Child Mental Health (CMH). These services include:

- ASA Intervention Individual
- ASA Assessment
- ASA Case Management
- ASA Crisis Support/ Emergency
- ASA In-home/On-site
- ASA Outpatient Individual and Group
- ASA Residential Level II
- ASA Medication-Assisted Treatment
- ASA Substance Abuse Detoxification
- ASA Outreach
- ASA Family Intensive Treatment
- ASA Task
- ASA Prevention
- ASA FITT Program
- AMH Assessment
- AMH Case Management
- AMH Crisis Stabilization
- AMH Crisis Support/ Emergency
- AMH Drop in/ Self-help
- AMH In-Home/ On-Site
- AMH Intervention Individual
- AMH Medical Services
- AMH Outpatient – Individual
- AMH Outpatient – Group
- AMH Outreach
- AMH Residential Level I
- AMH Incidental Expenses
- AMH Information and Referral
- AMH Room and Board w/ Supervision
- AMH Clubhouse Services
- CMH Assessment
- CMH Case Management
- CMH Crisis Support / Emergency
- CMH In-Home/On-Site
- CMH Intervention
- CMH Medical Services
- CMH Outpatient – Individual
- CMH Outreach
- CMH Incidental Expenses
- CMH Information and Referral
- CMH CAT Team
- CSA Prevention

Scope

A. Contract Number: ME225-9-27 and P-04.

The monitoring scope was based upon a risk-based analysis of the contract and available information. The monitoring period was February 2019.

The monitoring focused on administrative services and included the review of contract specific elements in the following areas:

- AMH Case Management
- AMH Crisis Stabilization
- AMH Medical Services
- AMH Room and Board w/ Supervision, Level III
- CMH In-Home/ On-Site
- CMH CAT Team
- ASA Medication Assisted Treatment
- ASA Substance Abuse Detox
- ASA Family Intensive Treatment Team
- CSA Prevention
- Block Grant requirements
- ADA Compliance
- Whistleblower Requirements
- SOAR
- Assisted Living Facility-LMHL
- Trauma Informed Care
- Service Event Validation
- Rule 65D-30.004, F.A.C. substance abuse client record
- Incident Reporting
- Sliding Fee Scale
- Limited business associate agreements and limited subcontracting review.
- Staff/ Client interviews
- HIPAA requirements through self-evaluation questionnaire.
- Rule 65E-14, F.A.C. Unit Cost Method of Payment.
- Personnel record review: Level II background screening requirements and E-Verify standards.
- Substance abuse personnel record review

B. Federal Block Grant and TANF funding

At the time of the on-site monitoring, Guidance Care Center, Inc. did not receive TANF funding and thus corresponding requirements were not included in the monitoring scope.

General block grant requirements are incorporated within the normal monitoring process.

The following Block Grant Funding and corresponding requirements were included in the monitoring scope:

- Block grants for Community Mental Health Services
    - MHCAT Community Action Treatment (CAT) Team $750,000
    - MHO72 Community Forensic Program $35,000
- Block grants for Prevention and Treatment of Substance Abuse
    - MSCBS Community Based Services Medication Assisted Treatment $10,000

    - MSO91 Family Intensive Treatment Proviso Allocation $633,188
    - MSO25 Prevention Services $199,063
- Community Health Services Block Grant of the Homeless
    - MMOPG PATH $102,167

Authorities

Contract ME225-9-27 and P-04 was monitored in accordance with 1) Standard Contract, Paragraph 8, Inspections and Corrective Action; 2) Attachment I, HC02(b) Section B. Manner of Service Provision, Section D. Special Provisions, Monitoring Requirements.
The following authorities were factored into the monitoring scope:

1. Contract Number(s): ME225-9-27 & P-04.
2. Rule 65E-14, F.A.C., Unit Cost Method of Payment.
3. 45 CFR 164, HIPAA.
4. Rule 65D-30, F.A.C., Substance Abuse Services Office.
5. Rule 65E-4.016, F.A.C., Mental Health Residential Treatment Facilities.
6. Rule 65E-15, F.A.C., Case Management.
7. 435, F.S., Employment Background Screening.
8. 409.1757, F.S., Persons not required to be re fingerprinted or rescreened.
9. 408.809, F.S., Background screening; prohibited offenses.
10. 397.451, F.S., Background checks of service provider personnel.
11. Rule 65E-4.014, Standards for Client Records, Treatment and Quality Assurance
12. 394.4574, Department responsibilities for a mental health resident who resides in an ALF that holds a limited mental health license.
13. 45 CFR 96.125 - Primary prevention.

Results

The preliminary results were discussed with the provider during an exit conference on August 14, 2019.

1. Strengths / Positives

A. Provider management and staff provided all requested support and information in a timely manner and were open to feedback.
B. Staff indicated satisfaction with their employment at Provider.
C. Client feedback was very positive regarding the program and staff.

2. Findings

During the course of the field work performed, the following findings were noted. **A corrective action plan will be required**.

A. Crisis Stabilization Client Record Tool

Four consumer records were reviewed resulting in the following findings:

- The required paperwork to be submitted to the court that could lead to a prohibition against firearm purchases or having a concealed weapon permit was missing.

- The General Authorization for treatment except psychotropic medication form and the Specific Authorization for Psychotropic Medications form was signed by the consumer prior to being deemed competent by the physician.

- The Personal Safety Plan was not signed by the consumer although the signature date had been filled in.

B. Family Intensive Treatment Team Exhibit AI Client Record Requirements

- One FITT consumer record was reviewed resulting in the following findings:
  - o The record did not clearly demonstrate that the consumer met eligibility requirements.
- The consumer record did not include documentation that indicates a determination of safety was made. **Partially Resolved**
- The consumer record did not include a child welfare case management plan with the permanency goal of reunification. **Partially Resolved**
- The FITT consumer record did not include a consumer signed consent for FITT services.
- The timely contact with the parent was not clearly documented in the consumer record.
- The initiation of services and admission date were not consistent nor was there a referral for FITT services.
- The consumer record did not include a signed consent form.
- The consumer record did not include a level of care and severity assessment/Clinical ASAM or a Biopsychosocial.
- The DLA-20 Adult Functioning Assessment was not completed timely.
- The DLA-20 was not re-administered within the required timeframes. Also, additional assessments were not completed timely.
- The Adverse Childhood Experience (ACE) in the consumer record did not have the consumer name or date.
- The treatment plan and case management plan was not developed timely.
- The FITT Individualized Wellness and Recovery Plan did not include all required elements.
- Informing the child welfare case manager through their progress updates was not documented consistently.

C. Trauma Informed Care

- The Provider's training plan matrix does not state amount of training time.
- Direct service staff did not complete the required hours of training.
- The consumer survey did not include a rating of the collaboration between the staff and the consumer.

D. Community Action Treatment (CAT) Teams

- One CAT consumer's discharge summary was incomplete, and a Bio-psychosocial Assessment was completed with errors that were not correctly amended.

E. PATH Client Record

Two PATH clinical records were reviewed resulting in findings related to the following:

- Service plans did not include the required signatures, not reviewed timely, identified problems and goals inconsistent.
- One PATH consumer record had two admissions, the first admission included a Preliminary Treatment plan with no Master Treatment Pan and the second included a late Individualized Treatment Plan.
- Two records reviewed contained documents that were not signed and dated.

F. PATH Organizational Requirements

- The provider does not have a distinct, scheduled, organized effort to find the homeless not already in shelters and who are living in places not meant for human habitation and to attempt to engage them in PATH services.
- As per the HMIS monthly and quarterly reports, the provider did not make contact with any individuals who spent the night in a place not meant for human habitation and there are discrepancies between the two reports.
- Referrals for non-community mental health services not being done consistently.

G. PATH Match Requirements

- The provider was not submitting a monthly local match expenditure report.

H. Subcontracting

- The provider's subcontract with a Psychiatrist did not incorporate by reference all the requirements.

I. Indicated Prevention Client Record Review

Two prevention indicated consumer records were reviewed. The following findings were identified:

- Signed informed consents for release of information with required areas left blank.
- Missing current SFBHN data sharing agreements and informed consent for services.
- Outdated release of information forms.
- Summary notes which were not specific as to the client's progress or lack of progress.
- Incomplete prevention plan.

J. ALF-LMHL

One ALF-LMHL consumer record was reviewed resulting in the following findings:

- Community Living Support Plan and Cooperative Agreement did not contain required elements.
- The consumer files did not contain a current copy of the ALF license. Partially Resolved

K. Unit Cost Method of Payment

- The provider's Room and Board with Supervision Level II census log was missing the required data elements.
- The provider billed for two days in which the consumer was not present at the midnight census. Partially Resolved
- The provider's Indicated prevention time sheets did not include the participant name and identification number.

L. Employment Screening **Repeat Finding**

- One applicable personnel file reviewed did not receive their five-year DCF screening completed timely.

3. Concerns with Required Action

During the course of the field work performed the following Concerns with Required Action were noted. Although a required action is mandated a corrective action plan is not required.

A. Care Coordination

It is of concern that:

- Consumer records did not show evidence of the Care Coordinator providing weekly following visits.
- Consumer records did not include any Care Coordination service notes.
- Progress notes for consumers with service events under entered under the care coordination Mental Health OCA MH0CN did not indicate that the consumer was a care coordination consumer or other otherwise describe care coordination specific activities.
- Case management and/or Care Coordination service events were not being entered in data system by the Care Coordinator under the appropriate OCA.
- The provider's Care Coordination Time Sheet/Outreach log did not include the description of the activity provided.

4. Concerns

During the course of the on-site monitoring visit, concerns in the following areas were identified by the monitoring team. No further corrective action will be required; however, processes should be implemented to avoid future findings.

A. PATH Client Record

- A service plan not complete during original enrollment in the PATH program.

B. Substance Abuse Personnel Requirements

- Performance appraisal not completed timely.

C. Crisis Stabilization Client Record Tool

- Application for Voluntary Admission-Receiving Facility and Notice of Voluntary Patient's Right to Request Discharge from a Receiving Facility forms did not have the signature time.
- Discharge summary forms did not include all requirements.

D. Sliding Fee Scale

- The provider's fee collection policy does not state the specified requirements.

E. SOAR Concern

- The provider did not meet their required 65% approval rating.

5. Resolved Findings/Concerns

During the monitoring or subsequent to the monitoring and prior to the issuance of this report, the following issues which would have been findings or concerns if not addressed, have been resolved. No further corrective action will be required.

A. Community Action Treatment (CAT) Teams

B. Payer of Last Resort

Conclusion

Further details concerning the findings and suggestion mentioned above can be found in Section IV. Detail Report. Guidance Care Center, Inc. management was cooperative and responsive throughout the on-site monitoring visit. SFBHN will continue to provide administrative and programmatic assistance to ensure that Guidance Care Center, Inc. complies with all consumer-driven needs and other requirements of the contract.

II. Provider Background Information

Provider:	Guidance Care Center, Inc.
Provider Address:	1205 Fourth Street, Key West, Florida 33040
Provider Type:	Non-Profit
Fiscal Year End:	June 30th, 2018
Contract Numbers:	ME225-9-27 $8,136,127 (annualized) P-04 $150,000
Local Match:	ME225-9-27 $1,203,593 P-04 $37,500
Fiscal Year Reviewed:	2018/2019
Monitoring Team:	Dr. Tracy Rodriguez-Miller, CQI Manager Joy Jowdy, Senior CQI Specialist Mary Lamazares, CQI Specialist Paige Singh, CQI Specialist Yisel Morrell, Lead Care Coordination Specialist
Covered Services Monitored:	ME225-9-27 ASA 01 Assessment ASA 02 Case Management ASA 13 Medication-Assisted Treatment ASA 24 Substance Abuse Detox ASA 99 Family Intensive Treatment AMH 02 Case Management AMH 03 Crisis Stabilization AMH 12 Medical Services AMH 38 Room and Board w/ Supervision CMH 08 In-Home/On-Site CMH CAT Team P-04 CSA 48 Prevention – Indicated CSA 49 Prevention - Selective
Corrective Action Required:	**See Section IV. Report Detail**

III. Contract Monitoring Report Methodology

Format of Contract Monitoring Report
This report discusses the on-site monitoring results for Guidance Care Center, Inc. contract with South Florida Behavioral Health Network (SFBHN). The report describes the most significant findings in terms of strengths, weaknesses, and most importantly material weaknesses of the reviewed areas.

Information and data were reviewed and collected during the monitoring utilizing specified tools based on the network provider's contract with SFBHN, as described below. These tools examine four major areas: 1) Provider QA process 2) programmatic compliance 3) administrative compliance and 4) fiscal compliance. The tools are used to identify compliance with contractual and statutory requirements and weaknesses that could lead to the issuance of a corrective action and/or additional monitoring. For the Validation of Mental Health Client Records and Personnel File Reviews, the percentage of non-compliance is equal to the total number of non-compliance divided by the total number of files reviewed. A score exceeding five percent (5%) could indicate a weakness that warrants corrective action.

Response to Contract Monitoring Report
If so indicated, the Provider is required to submit a response and/or Corrective Action Plan to SFBHN's Continuous Quality Improvement Division Monitor and Contract Manager within 10 business days of receiving this report. If an amendment of the original report is needed due to newly submitted documents, SFBHN's Continuous Quality Improvement Division Monitor will finalize the report and resubmit it to the Provider 10 business days later. At which point, the Provider is required to submit a final response and/or Corrective Action Plan within 10 business days of receiving the final revision of the Contract Monitoring Report. If the Provider does not require a Corrective Action Plan (CAP); no further action is necessary.

Tracking of Corrective Action
SFBHN requires that the Provider maintain a binder or electronic file that contains documentation that the corrective action has been taken. For example, if the corrective action involved training, the binder would contain copies of the training attendance log and/or copies of the certificates of completion; if the corrective action involved a change in policy, a copy of the revised policy, signed and dated by the authorized individual would be in the binder; etc. The SFBHN Continuous Quality Improvement Division Monitor will validate the Corrective Action Plan (CAP), as required. In the event the Provider fails to comply with the CAP, the SFBHN Continuous Quality Improvement Specialist will immediately notify SFBHN's Executive Management.

Tools used in Conducting the Contract Monitoring
The completed tools utilized for the monitoring are available to the Provider and SFBHN management upon request.

IV. Report Detail & Corrective Action Plan

Provider Name	Monitoring Team Leader	Contract Manager	Exit Conference Date	Onsite Dates	Contract Numbers
Guidance Care Center, Inc.	Joy Jowdy	Elba Taveras	August 14, 2019	April 29 - May 2, 2019	ME225-9-27 & P-04

Areas of Competency / Strengths	
Cooperation	Provider management and staff provided all requested support and information in a timely manner and were open to feedback.
Staff Interviews	Staff indicated satisfaction with their employment at Provider.
Client Interviews	Client feedback was very positive regarding the program and staff.

Finding No.	Authority	Findings Findings are deficiencies where sampled transaction / areas reviewed do not fulfill or meet established requirements. The Provider is required to develop and submit a corrective action to correct the identified deficiency.
1.	s. 790.06, F.S. 394,467(1)(a) 2, b, F.S.	**Area**: Crisis Stabilization Client Record Tool **Requirements:** The following applies to an individual who has had an involuntary examination initiated, has been found to be of imminent danger and requests a transfer to voluntary status in lieu of a petition for Involuntary Placement (BA 32) being filed with the court or if there is a request for a withdrawal of a petition already filed for Involuntary Placement. Chapter 790, FS does not define “imminent danger,” a physician can use clinical criteria he/she believes is appropriate. However, the following definition found in the criteria for Involuntary Placement [394,467(1)(a) 2, b, FS] as follows may be used: “There is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm.” The law requires a notification to and acknowledgement by the individual that information will be provided by the facility to the Court that will lead to a prohibition against firearm purchases or having a concealed weapon permit. A Certification of Competence conducted by a physician should be completed to ensure the individual is competent to make well-reasoned, willful and knowing

		treatment decisions. The form titled “Finding and Certification by an Examining Physician of Person’s Imminent Dangerousness” (see form page S-17) can be used to document the individual’s imminent dangerousness and competence to fully understand the meaning and consequences of converting to voluntary status. The Physician’s Finding and Certification must be provided to the patient with a full explanation that the conversion to voluntary status may result in a prohibition against firearm purchase. A copy of the physician’s Finding and Certification must be retained in the individual’s clinical record. General Authorization for Treatment Except Psychotropic Medications (recommended form 3042a).
	Rule 65E-5-170, F.A.C.	65E-5.170. Right to Express and Informed Consent (2) Authorization for Treatment.(c) When presented with an event or an alternative which requires express and informed consent, a competent person or, if the person is incompetent to consent to treatment, the duly authorized substitute decision-maker shall provide consent to treatment, refuse consent to treatment, negotiate treatment alternatives, or revoke consent to treatment. Recommended forms CF-MH 3042a, Feb. 05, “General Authorization for Treatment Except Psychotropic Medications,” which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, and CF-MH 3042b, Feb. 05, “Specific Authorization for Psychotropic Medications,” which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used as documentation of express and informed consent and any decisions made pursuant to that consent. If used, recommended form CF-MH 3042a, “General Authorization for Treatment Except Psychotropic Medications,” as referenced in paragraph 65E-5.170(2)(c), F.A.C., shall be completed at the time of admission to permit routine medical care, psychiatric assessment, and other assessment and treatment except psychotropic medications. The more specific recommended form CF-MH 3042b, “Specific Authorization for Psychotropic Medications,” as referenced in paragraph 65E-5.170(2)(c), F.A.C., or its equivalent, shall be completed prior to the administration of any psychotropic medications, except under an emergency treatment order. The completed forms, or equivalent documentation, shall be retained in the person’s clinical record.
	Rule 65E-5.120, F.A.C.	
	Rule 65E-5.170(2)(c), F.A.C.	
		Specific Authorization for Psychotropic Medications: (Recommended Form #3042b). 65E-5.170. Right to Express and Informed Consent. (2) Authorization for Treatment. When presented with an event or an alternative which requires express and informed consent, a competent person or, if the person is incompetent to consent to treatment, the duly authorized substitute decision-maker shall provide consent to treatment, refuse consent to treatment, negotiate treatment alternatives, or revoke consent to treatment. Recommended form CF-MH 3042b, Feb. 05, “Specific Authorization for Psychotropic Medications,” which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used as documentation of express and informed consent and any decisions made pursuant to that consent. The more specific recommended form CF-MH 3042b, “Specific Authorization for Psychotropic Medications,” as referenced in paragraph 65E-5.170(2)(c), F.A.C., or its equivalent, shall be completed prior to the administration of any psychotropic medications, except under an emergency
	Rule 65E-5.120, F.A.C	

	Rule 65E-5.170(2)(c), F.A.C. Rule 65E-5.180 (2) (e)&(h), F.A.C. Rule 65E-12.106 (5)(a), F.A.C.	treatment order. The completed forms, or equivalent documentation, shall be retained in the person's clinical record. Chart entries are legible, understandable, signed and dated. 65E-5.180 Right to Quality Treatment.(2) Each facility and service provider, using nationally accepted accrediting standards for guidance, shall adopt written professional standards of quality, accuracy, completeness, and timeliness for all diagnostic reports, evaluations, assessments, examinations, and other procedures provided to persons under the authority of Chapter 394, Part I, F.S. Facilities shall monitor the implementation of those standards to assure the quality of all diagnostic products. Standards shall include and specify provisions addressing:(e) Reports shall be legible and understandable; (h) Requirement that the completed report be signed and dated by the administering staff. Common Minimum Program Standards (5) Confidentiality and Clinical Records. (a) Entries placed in the clinical record to document the individual's progress or facility's actions must be objective, legible, accurate, dated, timed when appropriate, and authenticated with the writer's legal signature, title and discipline. The clinical record shall be organized and maintained for easy access. **Findings:** 4 consumer records were reviewed including 1 consumer with 2 admissions during the month of scope. 2 of 2 consumers records reviewed for consumers which were admitted into the Crisis Stabilization Unit under involuntary status and later signed voluntary did not include the required paperwork to be submitted to the court that could lead to a prohibition against firearm purchases or having a concealed weapon permit. The consumer records did not reflect any documentation or the "Finding and Certification by an Examining Physician of Person's Imminent Dangerousness" form indicating that there is no "substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm." 2 of 4 consumer records reviewed included the General Authorization for treatment except psychotropic medication form that was signed by the consumer prior to being deemed competent by the physician. Both records include consents signed upon admission, however, the physician did not sign the Certification of Person's Competence to Provide Express and Informed Consent until the following date. 2 of 4 consumer records reviewed included the Specific Authorization for Psychotropic Medications form that was signed by the consumer prior to being deemed competent by the physician. Both records include consents signed upon admission, however, the physician did not sign the Certification of Person's Competence to Provide Express and Informed Consent until the following date. 1 of 4 consumer records had a Personal Safety Plan which was not signed by the consumer although the signature date had been filled in.

		Required Actions: Provider to ensure there is documentation in the consumer record for those consumers the physician does not submit the Firearm Prohibition certification indicating the reason. Provider to ensure required documentation be submitted to the court for prohibition against firearm purchases or having a concealed weapon permit when applicable. Provider retrain staff on documentation including ensuring consents are not signed prior to the consumer being deemed competent. Provider to implement QA/QI process to ensure compliance with documentation. Provider to ensure all required documentation is signed and dated. **Corrective Action Plan:** Required – Yes.

Corrective Action Plan

Task(s) (Including but not limited to required action stated in finding above.)	Action 1. Review with RN's P&P for Imminent dangerousness documentation on all Involuntary admits, at RN meeting 8/22/19. Send ALL MDs informative email, regarding this policy, and be sure she has the proper updated form. Action 2. Review with RN's and MD's P&P for submitting petitions to the court for the purchase of firearms and applications for or retention of a concealed weapon or firearm license. Action 3. Retrain staff on documentation including ensuring consents are not signed prior to the consumer being deemed competent. Action 4. Ensure that items related to firearms prohibition and rules for containing informed consent are specifically captured on peer review form. Action 5. Review with RNs and Techs at next meeting policies regarding complete documentation.
Person(s) Responsible:	Jezel Rosa Lisa Marciniak
Estimated Completion Date of task(s):	1. 8/30/2019 2. 8/30/2019 3. 9/25/2019 4. 9/30/2019 5. 9/20/2019
CAP Due Date:	8/28/2019
CAP Approved by:	Tracy Rodriguez-Miller
CAP Approval Date:	9/19/2019

Finding No.	Authority	Findings Findings are deficiencies where sampled transaction / areas reviewed do not fulfill or meet established requirements. The Provider is required to develop and submit a corrective action to correct the identified deficiency.
2.	ME225-9-27, Attachment I, Exhibit AI ME225-9-27, Attachment I, Exhibit AI, B. Exhibit AI, B.3.	**Area**: Family Intensive Treatment Team Exhibit AI Client Record Requirements **Requirements**: <u>Client Eligibility</u> The FIT Team Providers shall deliver services to parents who meet all of the following criteria: 1. Are eligible for publicly funded substance abuse and mental health services pursuant to s. 394.674, F.S.; including persons meeting all other eligibility criteria who are under insured; 2. Have a substance use disorder; 3. Have at least one child between the ages of zero (0) and ten (10) years old, with priority given to families with a child between the ages of 0 and 8; **and** 4. At the time of referral to FIT, a. A child in the family has been determined to be "unsafe" and in need of child welfare case management; b. For children in out of home care, the family must have a child welfare case management plan with the permanency goal of reunification, or a concurrent case plan that includes reunification as a permanency goal; and c. The parent(s) are willing to participate in the FIT Program or the parent is court ordered to participate in FIT services. In either case, enhanced efforts to engage and retain the parent(s) in treatment are expected as a critical element of the FIT program. <u>FIT Process Requirements</u> The FIT Team Providers shall deliver an array of behavioral health services to eligible parents and other adult family members when necessary. Once a referral for an eligible parent(s) is received, the FIT Team Provider shall: 1. Initiate contact with the parent(s) within 2 business days of receiving a referral to services. The FIT Team Provider shall ensure that initial and recurring efforts to contact and engage the referred parent(s) are documented. 2. Document the date of enrollment as the date the parent signs consent for services. 3. Complete the initial assessments to determine the level of care and severity within fifteen (15) business days of enrollment and include the following assessments, at a minimum: a. American Society of Addition Medicine (ASAM) to assess

		level of care; and b. Biopsychosocial Assessment to assess the severity of substance use disorders. 4. Provide treatment services by the clinician within two (2) business days of completing the initial ASAM and Biopsychosocial Assessments. Completion of the treatment plan with the family may be the first service. 6. Complete the DLA-20 Adult Functioning Assessment within thirty (30) calendar days of enrollment. To effectively monitor changes in client functioning over time, the DLA-20 shall be re-administered within (60) calendar days of initial completion of the DLA-20 and continued to be administered in 60-day intervals throughout the course of formalized treatment. A final DLA-20 shall be administered when formalized therapeutic treatment is completed. 7. Complete additional assessments within thirty (30) calendar days of enrollment, to include the following at a minimum: a. A mental health assessment when indicated; b. Adult Adolescent Parenting Inventory (AAPI-2) to assess parenting capacity and family functioning; and c. Any other assessments as required by the Department. 8. Complete an initial Adverse Childhood Experience (ACE) screening within 60 calendar days of enrollment with each parent receiving FIT services and update as needed to consider new information related to trauma that may impact the ACE score. This may be completed sooner if clinically appropriate. 9. Within thirty (30) calendar days of enrollment, ensure the FIT Team's treatment plan and case management plan guide the provision of services. The FIT Team's treatment plan and case management plan is to be developed with the participation of the family receiving services and reviewed or revised with the family to address changes in circumstances impacting treatment. The FIT Team's treatment plan or case management plan shall: a. Identify how support services will be provided to the enrolled parent(s); b. Identify how support will be provided to parents to address the child's therapeutic, medical, and educational needs; c. Align with the child welfare case plan by enhancing caregiver protective capacity and/or support conditions for return. If the child welfare case plan has not been developed at the time of the development of the FIT Team's treatment plan or case management plan, they shall be revised upon completion of the child welfare case plan; and d. Establish a goal to address the coordination of clinical services received by the child(ren), to align with the parents' clinical services, in the case management plan. 10. If parents are not engaging in services, immediately notify the assigned child welfare case manager to allow for strategies to be developed jointly. Notification and strategy development efforts must be documented. 11. The FIT team will inform the child welfare case manager's ongoing assessments of caregiver protective capacities through their progress updates.

Findings: One FITT consumer record was reviewed resulting in the following findings:

Client Eligibility:
The client record did not clearly demonstrate that the FITT consumer met eligibility requirements.

- The record did not clearly show whether the family served had at least one child between the ages of zero (0) and ten (10) years old, with priority given to families with a child between the ages of 0 and 8.
    - The provider client register form only indicated there were two dependents under the age of 17.
        - No payback is due as an assessment which was obtained from a subcontracted provider of GCC indicated that the consumer had two children under the age of 8 years old.

At the time of referral to FITT the record did not indicate that:

- A child in the family has been determined to be "Unsafe" and in need of child welfare case management;
    - There is no documentation in the consumer record that indicates a determination of safety was made.

Partially Resolved: Provider revised their FITT referral form to include whether the children have been deemed unsafe.

- For children in out of home care, the family must have a child welfare case management plan with the permanency goal of reunification, or a concurrent case plan that includes reunification as a permanency goal;
    - The provider indicated that they did not receive the child welfare case management plan, however, there was no documentation that the provider had requested the plan.

Partially resolved: The provider revised their FITT referral form to include what the permanency plan is.

- The file did not indicate the parent(s) are willing to participate in the FITT or the parent is court ordered to participate in FITT services.
    - The consumer was engaged with GCC on 9/25/18 and was identified as being in FITT on 10/22/18; however, there was no consent signed by the consumer for participation for FITT services.

FITT Process Requirements

- The contact with the parent within 2 business days of receiving a referral to services was not clearly documented in the consumer record.

		o The MSS referral was dated 9/18/18 and states received 9/19/18. Consumer had an intake on 9/25/18. There is no documentation of a referral to FITT; therefore, it is unknown if contact by the FITT was made within 2 business days. • Provider initiated services with MSP on 9/25/18. The admission date to FITT was documented as being on 10/22/18; however, there was no referral to FITT located in the file. • Although the consumer was participating in services, there was no signed consent in the file. However, the provider did have a blank consent form for FITT as part of their FITT procedure. • The initial assessments to determine the level of care and severity were not completed within fifteen (15) business days of enrollment, did not include a Clinical ASAM and a Biopsychosocial. o The record did not include a Clinical ASAM. There was only a screen shot Data System ASAM form indicating ASAM date as 10/22/18. o The consumer was enrolled in FITT on 10/22/18. The required Biopsychosocial Assessment was not in the consumer record. Upon request the provider supplied a Biopsychosocial that was completed by the subcontracted provider (The Village) for residential substance abuse services on 11/15/2018, which was 3 days past the 15-business day requirement. • The DLA-20 Adult Functioning Assessment was not completed within thirty (30) calendar days of enrollment. o The DLA-20 was not completed until 2/22/19 and the consumer was identified as a FITT consumer on 10/22/2018. • The DLA-20 was not re-administered within (60) calendar days of initial completion of the DLA-20 nor was it continued to be administered in 60-day intervals throughout the course of formalized treatment. o The consumer record contained the original DLA-20 dated 2/22/19, however, no additional DLA-20 assessments were found at the 60-day intervals. • Not all required additional assessments were completed within thirty (30) calendar days of enrollment. • An initial Adverse Childhood Experience (ACE) screening is due within 60 calendar days of enrollment with each parent receiving FIT services and updated as needed to consider new information related to trauma that may impact the ACE score, however, it could not be determined if it was completed timely due to the fact that there was a completed ACE in the chart, but there was not a name or date documented on it. • The FIT Team's treatment plan or case management plan

		was not developed within thirty (30) calendar days of enrollment. o Staff reported that consumer was transferred to their subcontractor The Village South, Inc. and that it would have been done there. Client is identified as a FITT client on 10-22-19. The first completed Individualized Wellness and Recovery Plan provided was dated 3/18/19. • The FITT Individualized Wellness and Recovery Plan dated 3/18/19 did not: o Identify how support will be provided to parents to address the child's therapeutic, medical, and educational needs; o Indicate that a child welfare case plan had been consulted or revised upon completion of the child welfare case plan; o Establish a goal to address the coordination of clinical services received by the child(ren), to align with the parents' clinical services, in the case management plan. • The FITT did not consistently document informing the child welfare case manager through their progress updates of caregiver protective capacities. o At the time of the onsite monitoring there was no documentation that Provider was communicating with child welfare case management agency after 3/18/19. **Required Actions:** Provider to ensure documentation is maintained in the consumer record to evidence compliance with the FITT Guidance 18 Document and the FITT Contract Exhibit AI requirements. Provider retrain staff on FITT Guidance 18 Document and the FITT Contract Exhibit AI requirements. Provider to implement QA/QI process to ensure ongoing compliance with FITT Guidance 18 Document and the FITT Contract Exhibit AI requirements. **Corrective Action Plan:** Required – Yes.

Corrective Action Plan

Task(s) (Including but not limited to required action stated in finding above.)	Action 1: A comprehensive training on all requirements included in the FITT Guidance Document and Contract Exhibit AI requirements will be conducted with the Team. Action: 2 All items covered above will be documented in the client record.

	Action 3: A QA/QI process will be implemented through the quarterly Peer and Utilization Review Processes to ensure ongoing compliance with Guidance Document 18 and Contract Exhibit AI. QA/QI forms will be revised to ensure covering all FITT requirements which is tracked and analyzed by our Evaluator and documented in the semi-annual QA report submitted to managing entity. Action 4: A procedure will be developed so that FITT specific Assessments can be administered while clients are in residential treatment.
Person(s) Responsible:	Deb Matthews is responsible for training. Deb Matthews and Frank Scafidi will develop a Peer Review addendum to cover all FITT requirements.
Estimated Completion Date of task(s):	Training to be completed by Sept. 12, 2019 Peer Review to be implemented in November 2019
CAP Due Date:	8/28/2019
CAP Approved by:	Tracy Rodriguez-Miller
CAP Approval Date:	9/19/2019

Finding No.	Authority	Findings Findings are deficiencies where sampled transaction / areas reviewed do not fulfill or meet established requirements. The Provider is required to develop and submit a corrective action to correct the identified deficiency.
3.	Contract ME225-9-27, Attachment I, A.2.a. & B.1. a. (21)(b)	**Area**: Trauma Informed Care **Requirements**: Domain1. D. Collaboration - Maximizing Collaboration and Sharing Power: "To what extent do the program's activities and settings maximize collaboration and sharing of power between staff and consumers?" Consumer Ratings of Collaboration: Consumers rate the program and its staff as collaborative—sharing power and respecting consumer perspectives—at the "agree" (or comparable, better than neutral) point on the rating scale or higher. Domain 5. Staff Trauma Training and Education: General Trauma Education for All Staff: All new staff receive at least one hour of trauma education as part of orientation. Direct service staff have received at least three hours of

		education involving trauma-informed modifications in their content areas (e.g., care coordination, housing, substance use). Education for Direct Services Staff: Direct service staff have received at least three hours of education involving trauma-specific techniques (e.g., grounding, teaching trauma recovery skills). **Findings:** • Provider's training plan matrix does not state amount of training time. • Direct service staff did not complete at least 3 hours each of education related to trauma-informed modification or trauma specific techniques. o The direct service staff completed one two-hour training rather than the required two three-hour trainings. • Consumer survey did not include a rating of the collaboration between the staff and the consumer. **Required Actions:** Provider to revise their training plan to include the following: General Trauma Education for All Staff (A): All staff (including administrative and support personnel) have participated in at least three hours of "basic" trauma education that addresses at least the following: a) trauma prevalence, impact, and recovery; b) ensuring safety and avoiding retraumatization; c) maximizing trustworthiness (clear tasks and boundaries); d) enhancing consumer choice; e) maximizing collaboration; and f) emphasizing empowerment. General Trauma Education for All Staff: All new staff receive at least one hour of trauma education as part of orientation. Direct service staff have received at least three hours of education involving trauma-informed modifications in their content areas (e.g., care coordination, housing, substance use). Education for Direct Service Staff: Direct service staff have received at least three hours of education involving trauma-specific techniques (e.g., grounding, teaching trauma recovery skills). Provider to ensure staff personnel files document required trainings. Provider to include in their consumer survey a rating of the collaboration between the staff and the consumer.

		Corrective Action Plan: Required – Yes.

Corrective Action Plan

Task(s) (Including but not limited to required action stated in finding above.)	Added the one-hour TIC to orientation to be completed on first day of hire Develop curriculum for TIC three-hour training (inpatient, & outpatient setting) Inpatient setting to be done in person Outpatient as Webinar format. Three additional hours on trauma specific techniques will be documented in our Netsmart system annually. Human Resources audits staff personnel files and ensures documentation of required trainings. Consumer survey include a rating of the collaboration between the staff and the consumer.
Person(s) Responsible:	Maureen Dunleavy, Jezel Rosa Maureen Dunleavy Diana Alvarez Dr. Scafidi
Estimated Completion Date of task(s):	08/19/19 11/1/2019 06/30/2020 06/30/2020 12/31/19
CAP Due Date:	8/28/2019
CAP Approved by:	Tracy Rodriguez-Miller
CAP Approval Date:	9/19/2019

Finding No.	Authority	Findings Findings are deficiencies where sampled transaction / areas reviewed do not fulfill or meet established requirements. The Provider is required to develop and submit a corrective action to correct the identified deficiency.
4.		**Area**: Community Action Treatment (CAT) Teams **Requirements:**

	ME225-9-27 Attachment I, Exhibit AJ- Community Action Team (CAT) Guidance Document 32 Client Record Requirements ME225-9-27, Attachment I, Exhibit AJ., XI. Guidance Doc. 32, XII. Discharge Rule 65E-4.014(3)(e)1. and 3., F.A.C.	Provider shall complete a Discharge Summary containing the following items, at a minimum a summary of the individual's progress toward each treatment goal in the Master Plan of Care. Mental health service providers shall have written policies and procedures regarding client records which insure the following: • Client records are current and accurate, • The information in client records is safeguarded against loss, defacement, tampering or use by unauthorized persons. **Findings**: • One CAT consumer's discharge summary was incomplete and did not include the individual's progress toward each treatment goal in the Master Plan of Care. o The discharge summary had a statement "Describe the goals and objectives achieved from client tx plan"; however, the summary only addressed 1 of 4 identified objectives. • One CAT consumer had a Bio-psychosocial Assessment done 1/10/2019. The Bio-psychosocial Assessment included in the Parenting and Parental Attitudes, Diagnoses and Developmental History sections; scratch outs which were not initialed or dated. **Required Actions**: Provider to develop quality assurance policies and procedures to ensure errors are amended with a single line crossing out and a date and initials. Provider to develop quality assurance policies and procedures to ensure that CAT discharge summaries are complete and include the individual's progress toward each treatment goal in the Master Plan of Care. **Corrective Action Plan:** Yes – Required

Corrective Action Plan

Task(s) (Including but not limited to required action stated in finding above.)	Action 1: Staff to be trained on all required documentation procedures including correction of errors and completion of Discharge Summaries. Action 2: Implementation to be monitored through Peer and Utilization Review processes
Person(s) Responsible:	Deb Matthews

Estimated Completion Date of task(s):	Training to be completed by September 13, 2019 Peer and Utilization Management Reviews are done on a quarterly basis and will next be done in November, 2019
CAP Due Date:	8/28/2019
CAP Approved by:	Tracy Rodriguez-Miller
CAP Approval Date:	9/19/2019

Finding No.	Authority	Findings Findings are deficiencies where sampled transaction / areas reviewed do not fulfill or meet established requirements. The Provider is required to develop and submit a corrective action to correct the identified deficiency.
5.	PATH Standards of Provider's Intended Use Plan FY18-19 DCF Guidance Document 15 Projects for Assistance in Transition from Homelessness (PATH) State PATH Contact Welcome Manual Contract ME225-9-27, Attachment I, Exhibit X, II. c. and d. Contract ME225-9-27, Attachment I, Exhibit AP,B.(1)(b)2. Contract ME225-9-27, Attachment I, Exhibit X, II. c. and d. Rule 65E-4.014(3)(e), F.A.C.	**Area**: PATH Client Record **Requirements**: The Network Provider shall establish a service plan for all PATH-enrolled individuals including: • Goals to obtain community mental health services for the individual; • Coordinating and obtaining needed services for the individual, including services relating to shelter, daily living activities, personal and benefits planning, transportation, habilitation and rehabilitation services, prevocational and employment services, and permanent housing; • Assistance to obtain income and income support services, including housing assistance, Supplemental Nutrition Assistance Program (SNAP) benefits, and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI); • Referrals to other appropriate services; and • Review of the plan not less than once every three months. The Service Plan must be on a single identifiable and dated document, developed within 15 days of a completed Assessment and signed by the client, case manager, the case manager's supervisor, and other appropriate participants involved in the service plan development. Maintain individual client files containing an intake form, a determination of eligibility for PATH-funded services, a service plan, and progress notes for each person served with PATH funds. Mental Health service providers shall have written policies and

		procedures regarding client records which insure Client records are current and accurate
	Rule 65E-4.014(3)(b)3., F.A.C.	Mental health consumer records are to include among other items: service plans, assessment information, information on results from diagnosis and evaluation, and medication profiles. **Findings**: • 1 of 2 had a PATH service plan which was not signed by the consumer or the staff. • 2 of 2 PATH consumers had service plans that were not reviewed every three months. o The service plans showed scheduled reviews at a six-month interval rather than three-month interval as required for PATH consumers. • 1 of 2 PATH consumers had a Service Plan, which in addition to substance use and mental health issues, identified "Economic Problems, Housing Problems, Occupational Problems and Problems with primary support group." However, the goals did not address all of these identified areas of need. o The goals on the Service Plan were Completing the Mind Program (which included therapy, psychiatric care and Care Coordination), medication compliance and AA Recovery/12-Step. Other than completion of the Mind program which included care coordination, the goals did not address economic, housing, or occupational needs. • 1 of 2 PATH consumers had an original enrollment in PATH on 1/4/2017 and a second enrollment in PATH on 1/3/2019. There is one Preliminary Treatment plan dated 1/4/2017 at the time of the first admission, but there was not an individualized treatment plan completed until 2/28/2019. • 2 of 2 PATH mental health consumer records reviewed contained documents that were not signed and dated: o 1 of 2 records contained an Interpretive Summary and Clinical Recommendations which includes the date of admission, but staff, clients, Qualified Supervisor signatures and date of completions are all blank. o A Specific Authorization for Psychotropic Medications without consumer name on it which listed three medications and the dosage range however the form did not include the client name and was not signed or dated.

		o 1 of 2 had a PATH service plan which was not signed by the consumer or the staff. **Required Actions**: Provider to adopt quality assurance policies and procedures to ensure timely completion of service plans and PATH service plan reviews every three months. Provider to train staff on the timely completion of service plans and service plan reviews. Provider to ensure service plan goals address identified all identified needs. Provider to adopt policies and procedures to ensure records are accurate and complete with required signatures and dates. Provider to train staff on ensuring client record documentation is signed and dated. **Corrective Action Plan**: Yes – Required.

Corrective Action Plan

Task(s) (Including but not limited to required action stated in finding above.)	Train staff on the service plans and PATH service plan reviews every 3 months. Supervisor will review cases quarterly. All staff will be trained on service plan goals addressing all identified needs and client record documentation is signed and dated. Record accuracy is part of performance improvement plan that includes weekly supervision and quarterly peer review.
Person(s) Responsible:	Megan Davidson Dr. Frank Scafidi Megan Davidson
Estimated Completion Date of task(s):	9/30/19 12/31/19 Next peer review is November 2019
CAP Due Date:	8/28/2019
CAP Approved by:	Tracy Rodriguez-Miller
CAP Approval Date:	9/19/2019

Finding No.	Authority	Findings Findings are deficiencies where sampled transactions / areas reviewed do not fulfill or meet established requirements. The Provider is required to develop and submit a corrective action to correct the identified deficiency.
6.	ME225-9-27 Attachment I, Exhibit X, II.a. PATH Standards of Provider's Intended Use Plan FY18-19 4.a. ME225-9-27 Attachment I, Exhibit C Required Reports Provider's PATH Monthly Report (generated from the HMIS system) FY 2018-19 PATH Program HMIS Manual Released September 2018, p. 6.-7.	**Area:** PATH Organizational Requirements **Requirements:** In accordance with PATH contract, Guidance Document and the provider's intended use plan requirements, the provider is to: • Target persons who are experiencing homelessness as a priority population and maximizing services to vulnerable adults who are literally and chronically homeless. • Conduct street outreach and case management as priority services. • Conduct outreach services which target such areas as homeless shelters, detention centers, and areas known for homeless to gather. Additional outreach opportunities will be used as they are identified. The provider is also to submit by the 5th of each month following the month of services a monthly report containing the information submitted into the Homeless Management Information System (HMIS). The HMIS manual defines the reporting requirements for Street Outreach and Support Services as follows: The **Street Outreach** component of PATH is used by PATH projects that provide outreach and engagement to those living in places **not meant** for human habitation. These PATH activities are designed to meet the immediate needs of unsheltered homeless persons by connecting them with emergency shelter, housing, and/or critical health services. Examples of persons who are living in places **not meant** for human habitation are those who sleep on the streets, under bridges, in camps, camp grounds, abandoned buildings, structure meant for animals, vehicles, and public places. The **Supportive Services** component is used by PATH projects to provide outreach and engagement to those living in places **meant** for human habitation. This includes both persons who are residing in shelter, and those doubled up in housing or at-risk of homelessness. **Findings**: Although the provider does some community outreach to reach the homeless, the provider does not have a distinct, scheduled, organized effort to go out into the streets to find the homeless not already in shelters and who are living in places not meant for human habitation and attempt to engage them in PATH services. As per the HMIS monthly progress reports for July 2018-June 2019 and the

quarterly report for January through March 2019, the provider did not make contact with any individuals who were the night before living in a place not meant for human habitation.

As per the HMIS monthly and quarterly reports the provider is to report the following answers regarding the persons served:

HMIS PATH Quarterly Report January – March, 2019	
Persons served during this reporting period:	**Count**
9. Number of new persons contacted this reporting period in a **PATH Street Outreach project**	0
10. Number of new persons contacted this reporting period in a **PATH Services Only project**	23

HMIS PATH Monthly Reports June 2018 – July, 2019	
Persons served during this reporting period:	**Count**
9. Number of new persons contacted this reporting period in a **PATH Street Outreach project**	0
10. Number of new persons contacted this reporting period in a **PATH Services Only project**	32

When comparing the fact that referrals indicated in the monthly and quarterly reports are only for Community Health services to the two PATH consumer records reviewed, it also appears that the data reports may not be capturing all of the referrals actually made. However, regardless of whether the zero referrals for non-community mental health services is caused by a combination of a data reporting error and/or a lack of pursuing referrals for PATH consumers in other areas identified; the provider needs to increase their referrals for non-community mental health services.

Additionally, there are discrepancies between the total numbers reported in the provider HMIS quarterly and HMIS monthly PATH reports.

Based on the provider's PATH Monthly Data Report generated in the HMIS system from July 2018 through June 2019, 10 referrals were made for Community Mental Health services and 9 were attained. However, in only one quarterly report for January through March 2019 it shows 22 referrals made and 22 attained for Community Mental Health services. These 22 referrals achieved for the quarter exceeds the number of 10 referrals reported from July 2018 through June 2019 in the monthly reports.

PATH Monthly Data Report July 2018 through June 2019 Question 18: Referrals Provided		
Type of Referral.	**Number receiving each referral**	**Number who attained the service from the referral**
Community Mental Health	**10**	**9**
Substance use treatment	0	0
Primary health/dental care	0	0

Job training	0	0
Educational Services	0	0
Housing Services	0	0
Permanent housing	0	0
Temporary housing	0	0
Income assistance	0	0
Employment assistance	0	0
Medical insurance	0	0

PATH Quarterly Data Report January 2019 through March 2019 Question 18: Referrals Provided		
Type of Referral.	**Number receiving each referral**	**Number who attained the service from the referral**
Community Mental Health	**22**	**22**
Substance use treatment	0	0
Primary health/dental care	0	0
Job training	0	0
Educational Services	0	0
Housing Services	0	0
Permanent housing	0	0
Temporary housing	0	0
Income assistance	0	0
Employment assistance	0	0
Medical insurance	0	0

Required Actions: The provider to develop a distinct, scheduled and organized process for conducting street outreach to engage the homeless in PATH services that are not living in a place not meant for human habitation.

The provider is still to reach out to those who have obtained temporary shelter, however emphasis should be to engage those who are who are literally and chronically homeless.

Provider to ensure any HMIS data problems are addressed to ensure accuracy of reporting.

Provider to obtain technical assistance from their HMIS Administrator as needed.

The provider to review the data and develop a plan to address increasing the number of PATH referrals made and attained in areas other than Community Mental Health.

Corrective Action Plan: Yes – Required

Corrective Action Plan

Task(s) (Including but not limited to required action stated in finding above.)	Provider will develop a distinct, scheduled and organized process for conducting street outreach to be done at minimum of twice per month to engage the homeless in PATH services that are not living in a place not meant for human habitation. Provider will contact those clients who have obtained temporary shelter at minimum weekly with emphasis on engaging those who are who are literally and chronically homeless. Retrain all staff on eligibility and HMIS to ensure accuracy of reporting and Data staff spot check in HMIS and offer technical assistance. Data staff will review the data in HMIS system for enrollment accuracy. HMIS training will include PATH referrals and documenting in the HMIS system
Person(s) Responsible:	Megan Davidson Case Managers Megan Davidson Deb Genners
Estimated Completion Date of task(s):	9/1/19 9/16/19 PATH eligibility Training on 8/30/19 HMIS Refresher 9/30/19
CAP Due Date:	8/28/2019
CAP Approved by:	Tracy Rodriguez-Miller
CAP Approval Date:	9/19/2019

Finding No.	Authority	Findings Findings are deficiencies where sampled transaction / areas reviewed do not fulfill or meet established requirements. The Provider is required to develop and submit a corrective action to correct the identified deficiency.
7.	PATH Standards of Provider's Intended Use Plan FY18-19 DCF Guidance Document 15 Projects for Assistance in Transition from Homelessness	**Area**: PATH Match Requirements **Requirements**: Provide at least one dollar of local matching funds for every three dollars of PATH funds received and expend local matching funds to provide eligible services to PATH eligible persons. Match-funded expenditures must align with the services identified in the Local Intended Use Plan. The formula to be followed is cited in

	(PATH) Contract ME225-9-27, Attachment I, Exhibit X, IV.(a) and (b)	Title V, Part C, Section 524 of the Public Health Services Act (42 U.S.C. 290cc-21 et. seq.). Eligible PATH local match funds must be expended in the provision of PATH eligible services to PATH eligible persons. The expenditures must match the types of services outlined in the Local Intended Use Plan. The formula to be followed is cited in Title V, Part C, Section 524 of the Public Health Services Act (42 U.S.C. 290cc-21 et. seq). The Network Provider will submit a monthly local match expenditure report demonstrating how the agency is meeting its PATH local match obligations. The expenditure report shall be submitted along with the monthly invoice which is due by the 8th of each month following the month of services. The expenditure report shall identify, by funding source, the expenditures incurred on PATH eligible services. **Findings**: The provider was not submitting a monthly local match expenditure report demonstrating how the agency is meeting its PATH local match obligations. **Required Actions**: The Network Provider will submit a monthly local match report along with the monthly invoice which is due by the 8th of each month following the month of services. The expenditure report shall identify, by funding source, the expenditures incurred on PATH eligible services. The expenditures must match the types of services outlined in the Local Intended Use Plan. The formula to be followed is cited in Title V, Part C, Section 524 of the Public Health Services Act (42 U.S.C. 290cc-21 et. seq). **Corrective Action Plan**: Yes – Required.

Corrective Action Plan

Task(s) (Including but not limited to required action stated in finding above.)	Review Local Intended Use plan formula and develop local match report to be approved by managing entity as meeting requirements and submit local match report with monthly invoice by 8th of each month following services beginning FY20. Provider to submit a FY18-19 year end PATH Match report.
Person(s) Responsible:	Alex Martinez
Estimated Completion Date of task(s):	9/30/19

CAP Due Date:	8/28/2019
CAP Approved by:	Tracy Rodriguez-Miller
CAP Approval Date:	9/19/2019

Finding No.	Authority	Findings Findings are deficiencies where sampled transaction / areas reviewed do not fulfill or meet established requirements. The Provider is required to develop and submit a corrective action to correct the identified deficiency.
8.	ME225-9-27, Attachment I, B.2.d.(5) ME225-9-27, Standard Contract, 12.b. ME225-9-27, Standard Contract, 2.f.	**Area:** Subcontracting **Requirements**: All agreements, for services contemplated under this contract, shall adopt the applicable terms and conditions of the Network Provider's contract with the ME, including but not limited to, any Federal block grant requirements. In addition, all subcontract agreements shall contain the applicable terms and conditions, and any amendments thereto, found in the ME's contract with the Department (Prime Contract), which is incorporated herein by reference The Network Provider shall ensure that all subcontract agreements, at any tier, for work contemplated under this contract, adhere to all of the requirements of the ME's Prime Contract with the department and all the requirements of this contract. A copy of the Prime Contract can be found at the ME's website. www.sfbhn.org. Additionally, the Network Provider shall include, or cause to be included, in all subcontracts (at any tier) the substance of all clauses contained in the Standard Contract that mention or describe subcontract compliance. **Findings**: The provider's subcontract with a Psychiatrist did not incorporate by reference all the requirements of the provider's contract with the ME or the ME's Prime Contract with DCF. **Required Actions**: Provider to adopt policies and procedures to ensure all agreements, for services contemplated under this contract, shall adopt the applicable terms and conditions of the Network Provider's contract with the ME, including but not limited to, any Federal block grant requirements. In addition, all subcontract agreements shall contain the applicable terms and conditions, and any amendments thereto, found in the ME's contract with the Department (Prime Contract), which is incorporated herein by reference.

		Additionally, the Network Provider shall adopt policies and procedures to include, or cause to be included, in all subcontracts (at any tier) the substance of all clauses contained in the Standard Contract that mention or describe subcontract compliance. Provider to amend their subcontract to incorporate by reference the ME contract with the Provider as well the ME's prime contract with DCF. **Corrective Action Plan**: Yes – Required.

Corrective Action Plan

Task(s) (Including but not limited to required action stated in finding above.)	a. Standard language was obtained from managing entity contract manager b. Language forwarded to WestCare Legal approval c. Subcontract Agreements revised to include all required language from the finding
Person(s) Responsible:	Maureen Dunleavy
Estimated Completion Date of task(s):	a. obtained on 8/14/19 b. forwarded on 8/15/19 c. amend and revise current contracts beginning 9/30/19
CAP Due Date:	8/28/2019
CAP Approved by:	Tracy Rodriguez-Miller
CAP Approval Date:	9/19/2019

Finding No.	Authority	Findings Findings are deficiencies where sampled transaction / areas reviewed do not fulfill or meet established requirements. The Provider is required to develop and submit a corrective action to correct the identified deficiency.
9.	Contracts ME225-9-27 & P-04 Rule 65D-30.004(12)(c)4.e., F.A.C. Rule 65D-30.004(19)(c), F.A.C.	**Area**: Indicated Prevention Client Record Review **Requirements**: The following applies to Level II prevention. Information shall include: Informed consent for services; Summary notes shall be completed in Level 2 prevention where individual client records are required. Summary notes shall contain information regarding a participant or client's progress or

		lack of progress in meeting the conditions of the prevention plan.
	Rule 65D-30.004(12)(c)4.h., F.A.C. 45CFR164.508(c)(1)(i) 45CFR164.508(c)(1)(iii)	Informed consent for release of information; A valid authorization to release information must include: • the description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion. • the name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure.

	Rule 65D-30.004(19)(a), F.A.C.	The prevention plan shall be signed and dated by staff who developed the plan and signed and dated by the client.
		
		Findings: Two Indicated Prevention consumer records were reviewed. One consumer was served under PPG contract P-04 and one was served under contract ME225-9-27.
		
		• 2 of 2 indicated prevention consumers had informed consents for release of information which were signed and dated and included language "I consent to the following information to be disclosed," but were blank as to the information to be disclosed.
		• 2 of 2 consumer records did not include current SFBHN data sharing agreements .
		  o One consumer record had a data sharing agreement which appeared to indicate that they did not agree to share information with SFBHN. The form was not the current SFBHN data sharing form.
		  o The other consumer record had a data sharing agreement signed by the consumer, but it did not indicate to whom the information was being shared with.
		• A sample consumer Consent to Release Information Form was requested as part of the monitoring document request. The forms found in the consumer records for consents for release of information were not the current Consents for Release of Confidential information which was provided in response to the provider's document request and in addition contained outdated DCF logos.
		
		One consumer served under ME225-9-27 included the following additional findings:
		
		• The consumer record did not include an informed consent for services.
		• The consumer record had summary notes which were not specific as to the client's progress or lack of progress on meeting the conditions of the prevention plan.

		• The consumer's prevention plan was dated 1/25/2019 at the top of the plan and signed by the client and staff however, the dates by the staff and client signatures were left blank. **Required Action**: Provider to train indicated prevention staff on the Rule 65D-30.004(12)(c)4., F.A.C. Level II prevention requirements. Provider to implement quality improvement procedures to ensure ongoing compliance with Rule 65D-30.004(12)(c)4., F.A.C. Level II prevention requirements. Provider to ensure staff are trained on the HIPAA requirements for authorizations to release information. Provider to utilize the most recent SFBHN data sharing agreement. Provider to implement quality improvement procedures to ensure ongoing compliance. **Corrective Action Plan:** Yes – Required

Corrective Action Plan

Task(s) (Including but not limited to required action stated in finding above.)	Action 1: All Prevention staff will be trained on required documentation for Level II clients, including completion of consents to release information, utilization of current forms, and consents for services, standards for progress notes and requirements for Prevention Plans. Action 2: Implementation will be monitored through Peer and Utilization Management Processes.
Person(s) Responsible:	Deb Matthews Tammy Hansen
Estimated Completion Date of task(s):	Training to be completed by September 13, 2019
CAP Due Date:	8/28/2019
CAP Approved by:	Tracy Rodriguez-Miller
CAP Approval Date:	9/19/2019

Finding No.	Authority	Findings Findings are deficiencies where sampled transaction / areas reviewed do not fulfill or meet established requirements. The Provider is required to develop and submit a corrective action to correct the identified deficiency.
10.	429.02(7), F.S. Rule 58A-5.029,(2)(c.)3.f. F.A.C. ME225-9-27, Exhibit L, I.1) 394.4574, F.S	**Area**: ALF-LMHL **Requirements**: A Community Living Support Plan is to include: A list of factors pertinent to the care, safety, and welfare including signs/symptoms that indicate immediate need for mental health services. Ensure that the ALF-LMHL where the consumer is residing at, or referred to, maintains a current Agency for Health Care Administration (AHCA) license for ALF-LMHL facilities. The Network Provider shall maintain a copy of the AHCA ALF-LMHL facility license in each consumer file. Referrals to unlicensed ALF-LMHL are unlawful and are subject to sanctions by AHCA. The ME shall monitor the Network Provider's compliance with the terms and conditions of this exhibit. **Findings**: One ALF-LMHL consumer record was reviewed. The consumer's combined Community Living Support Plan and Cooperative Agreement did not contain factors pertinent to the care, safety, and welfare including signs/symptoms that indicate immediate need for mental health services. The consumer's file did not include a copy of the ALF-LMHL license. Partially Resolved: The provider placed a copy of the license in the file. **Required Action**: The provider to ensure all Community Living Support Plans include factors pertinent to the care, safety, and welfare including signs/symptoms that indicate immediate need for mental health services. The provider to ensure all ALF-LMHL consumer files contain a current copy of their ALF license. Provider to develop quality assurance processes to ensure ongoing compliance. **Corrective Action Plan:** Yes – Required

Corrective Action Plan	
Task(s) (Including but not limited to required action stated in finding above.)	1. ALF administrator / designee, Case Manager, Case Manager Supervisor, and Mental Health Provider will attend training on 429.02(7), F.S. Rule 58A-5.029,(2)(c.)3.f. F.A.C. ME225-9-27, Exhibit L, I.1) 394.4574, F.S 2. The community living support plan will be updated to include a component that captures factors pertinent to the care, safety, and welfare including signs/symptoms that indicate immediate need for mental health services. 3. Resident file Index will be updated to include “Copy of Current ALF license”
Person(s) Responsible:	1. Lisa Marciniak 2.Clare Condra 3.Clare Condra
Estimated Completion Date of task(s):	1. 8/23/19 2. 8/23/19 3.8/23/19
CAP Due Date:	8/28/2019
CAP Approved by:	Tracy Rodriguez-Miller
CAP Approval Date:	9/19/2019

Finding No.	Authority	Findings Findings are deficiencies where sampled transaction / areas reviewed do not fulfill or meet established requirements. The Provider is required to develop and submit a corrective action to correct the identified deficiency.
11.	Rule 65E-14.021(4)(gg), 4.a., F.A.C. Rule 65E-14.021(3)(a)3.a. (II)	**Area**: Unit Cost Method of Payment **Requirements**: The Service Documentation for Room and Board with Supervision Level II is a census log that includes certain data elements including: (I) Covered Service; (II) Program; (III) Recipient name and identification; (IV) Clinical diagnosis; (V) Service date; and (VI) Residential type. The measurement standard for Room and Board with Supervision, Level II is a day in which an individual receiving services is physically present at the midnight census, including the day the individual is admitted and excluding the day the individual is discharged. The Service Documentation for Indicated Prevention is a Time

	Rule 65E-14.021(4)(v), 4.a.(X)	Sheet which is to include the participant name and identification number. **Findings**: Room and Board with Supervision, Level II • The provider's Room and Board with Supervision Level II census log was missing the following data elements: o Covered Service (Room and Board with Supervision, Level II) o Program (AMH) o Recipient identification (Included name but not id.) o Clinical diagnosis o Residential type • The provider billed for two days in which the consumer was not present at the midnight census. o 1 consumer was not present on the 2/22/2019 midnight census but was entered in data. o 1 consumer was not present on the 2/25/2019 midnight census but was entered in data. <u>Partially Resolved</u>: During the monitoring the provider removed from data billing for the 2 days in which the Room and Board with Supervision Level II consumers were not physically present at the midnight census. <u>Indicated Prevention</u> The provider's Indicated prevention time sheets when combined with the provider's activity logs did not include the participant name and identification number. **Required Actions**: Provider to revise their Room and Board with Supervision, Level II census logs to include all required data elements. Provider to adopt quality assurance and billing practices and procedures to ensure the ME is not billed for Room and Board with Supervision, Level II consumers are not physically present at the midnight census. Provider to revise their Indicated Prevention Activity logs to include Participant name and Identification number. **Corrective Action Plan:** Yes – Required

Corrective Action Plan

Task(s) (Including but not limited to required action stated in finding above.)	1. Census report revised to include the required data elements pursuant to Rule 65E-14.021(4)(gg), 4.a., F.A.C. 2.ALF administrator reviews all service entries by 5th of the month following

	the month being reported - prior to submission for billing. Administrator / designee will sign off each census log to validate that the review has been done. 3. Provider revised their Indicated Prevention Activity logs to include Participant name and Identification number.
Person(s) Responsible:	1. Clare Condra 2. Clare Condra 3. Deb Genners
Estimated Completion Date of task(s):	Both Completed 8/21/19 3. Completed 8/28/19
CAP Due Date:	8/28/2019
CAP Approved by:	Tracy Rodriguez-Miller
CAP Approval Date:	9/19/2019

Finding No.	Authority	Findings Findings are deficiencies where sampled transaction / areas reviewed do not fulfill or meet established requirements. The Provider is required to develop and submit a corrective action to correct the identified deficiency.
12.	ME225-9-27, Attachment I, B.2.4.(4)(b) 394.4572(1)(a), F.S. s. 408.809(2), F.S. Rule 65D-30.004(4)(b), F.A.C. 39.001(2)(a) & (b), F.S. 435, F.S.	**Area**: Employment Screening **Repeat Finding** **Requirement**: All employees have been initially screened or rescreened at least once in the past five years using Level 2 standards. The department shall require employment screening and rescreening no less frequently than once every 5 years, pursuant to chapter 435, using the level 2 standards set forth in that chapter for personnel in programs for children or youths. **Finding:** • 1 of 1 applicable staff file reviewed did not receive their five-year DCF screening timely. o The staff had been screened 11/14/2011 and their screening was conducted late on 11/9/2017. **Required Actions**: Provider to implement a tracker to ensure timely completion of DCF five-year screenings.

		Provider to develop quality assurance procedures to ensure ongoing compliance. **Corrective Action Plan:** Yes – Required

Corrective Action Plan

Task(s) (Including but not limited to required action stated in finding above.)	HR continues to monitor the screening spreadsheet monthly and send out notifications to staff to be rescreened. As staff continue to be screened into the DCF/AHCA clearinghouse, HR receives notifications 60 days in advance when staff fingerprints will expire in the system
Person(s) Responsible:	Diana Alvarez-Mendez, HR Director Nazneen Khatib, HR Specialist
Estimated Completion Date of task(s):	Completed 8/14/19
CAP Due Date:	8/28/2019
CAP Approved by:	Tracy Rodriguez-Miller
CAP Approval Date:	9/19/2019

Authority	Concerns with Required Action Concerns are potential issues that, although not regarded as a current finding, may develop into one if not proactively addressed by the provider. Although a required action is mandated a corrective action plan is not required.
*DCF Guidance 4 III.B.8. Care Coordination Protocols-Procedure v.9., III, Section 11. ME225-9-23, Attachment I, Exhibit B, 7.c. Rule 65E-14.021(4)(u), 4.a.(II), F.A.C.	**Area**: Care Coordination **Requirements:** The provider's Care Coordination is funded through the Outreach and Case Management Covered Services. The Care Coordinator will follow up on a weekly basis (at a minimum) with the direct staff providing the behavioral or primary health services to assure that the consumer is complying with the recommended levels of care and/or making additional recommendations/referrals as needed. The Network Provider shall ensure that all services provided are entered into KIS, PBPS, or other data system designated by the ME. The service documentation for Outreach is a timesheet which includes certain data elements including the description of the activity, including time to plan and prepare. **Concerns with Required Action**: It is of concern that: • 3 of 3 consumer records did not show evidence of the Care Coordinator following up on a weekly basis (at a minimum) with the direct staff providing the behavioral or primary health services to assure that the consumer is complying with the recommended levels of care and/or making additional recommendations/referrals as needed. The three consumer records did not include any care coordination service notes by the care coordinator. • The three care coordination consumers reviewed had 22 of 23 case management service events entered in data for February 2019 by Case Managers under the care coordination Mental Health OCA MH0CN which did not indicate in the progress note that the consumer was a care coordination consumer or other otherwise describe care coordination specific activities. • Only 1 of 23 case management service events entered in data for February 2019 under the Care Coordination Mental Health OCA MH0CN for the three consumers reviewed was entered by the Care Coordinator. Not all care coordination and/or case management activities such as time spent emailing referrals or case staffings had not been entered in data by the Care Coordinator either under MH0CN or MS0CN. • It is of concern that the provider's Care Coordination Time Sheet/Outreach log did not include the description of the activity including the time to plan and prepare. The log included a service code which indicated whether it was an individual or community service and the age group, but no other description of the activity or the time to plan and prepare.

Authority	Concerns with Required Action Concerns are potential issues that, although not regarded as a current finding, may develop into one if not proactively addressed by the provider. Although a required action is mandated a corrective action plan is not required.
	Required Actions: It is of concern that for 3 care coordination consumer's case management notes: • Provider's Care Coordination Case Managers to ensure all care coordination consumer's progress notes include language that the consumer is a care coordination consumer. • Provider's Care Coordinator to prepare notes and enter care coordination case management services in data for any Care Coordination Case Management efforts not previously entered in data from December 1, 2018 to June 30, 2019 including emails of referrals, case staffing etc. for care coordination clients either under MH0CN or MS0CN as appropriate. Care Coordinator to enter these events in data going forward. • Revise Care Coordination Outreach Log to include description of activity, including time to plan and prepare.

Required Action

Task(s) (Including but not limited to required action stated in finding above.)	Training on Care Coordination documentation including documenting language that the consumer is a care coordination consumer and will conduct a monthly meeting to review. Care Coordinator will enter notes and case management services in data for Care Coordination. Will use managing entity Care Coordination Outreach Log which includes description of activity and time.
Person(s) Responsible:	Megan Davidson
Estimated Completion Date of task(s):	9/30/19 7/1/19 Began 7/1/19
Required Action Due Date:	8/28/2019
Required Action Approved by:	Tracy Rodriguez - Miller

Authority	Concerns Concerns are potential issues that, although not regarded as a current finding, may develop into one if not proactively addressed by the provider. Although a recommendation is provided, a corrective action is not required.
Contract ME225-9-27, Attachment I, Exhibit X, II. c. PATH Standards of Provider's Intended Use Plan FY18-19 DCF Guidance Document 15 Projects for Assistance in Transition from Homelessness (PATH) State PATH Contact Welcome Manual	**Area**: PATH Client Record **Requirements**: The Network Provider shall establish a service plan for all PATH-enrolled individuals. **Concern**: It is of concern that one PATH consumer did not have a service plan during his original enrollment in the PATH program. • The PATH consumer was originally enrolled 1/4/2017 and discharged from PATH services on 3/15/2018. The consumer was then re-enrolled in PATH on 1/3/2019 and the consumer's first service plan was not completed until 2/28/2019. **Recommendation**: The provider to ensure all service plans are completed timely.
Rule 65D-30.004(4)(a)3., F.A.C.	**Area**: Substance Abuse Personnel Requirements **Requirement:** Substance abuse personnel records shall include the employee's annual performance appraisal. **Concern**: • It is of concern that 1 of 3 substance abuse staff had not had their performance appraisal completed within the last year. o 1 staff's last performance appraisal was conducted on 7/31/2018 which was conducted over one year from the previous appraisal on 5/23/2017. **Recommendation**: Provider to have develop a tracker to ensure performance appraisal are completed annually. Provider to develop quality improvement policies and procedures to ensure ongoing compliance.
s. 394.459, F.S., s. 394.4625, F.S. Rule 65E-5.270 (1), F.A.C. F.S. 394.4625 (3) Rule 65E-5.270 (2),	**Area**: Crisis Stabilization Client Record Tool **Requirements:** Adults Only: "Application for Voluntary Admission-Receiving Facility" (recommended form 3040). 65E-5.270 Voluntary Admission. (1) Recommended form CF-MH 3040, "Application for Voluntary Admission," as referenced in paragraph 65E-5.1302(1)(b), F.A.C., may be used to document an application of a competent adult for admission to a receiving facility. "Notice of Voluntary Patient's Right to Request Discharge from a Receiving

Authority	Concerns Concerns are potential issues that, although not regarded as a current finding, may develop into one if not proactively addressed by the provider. Although a recommendation is provided, a corrective action is not required.
F.A.C. Rule 65E-5.1303, F.A.C. Rule 65E-12.106(5)(c)18, F.A.C.	Facility" (recommended form 3051a). Discharge planning including transportation, access to housing, aftercare appointment, access to psychotropic drugs, and referrals. 65E-5.1303 Discharge from Receiving and Treatment Facilities. (2) Discharge planning shall include and document consideration of the following: (a) The person's transportation resources;(b) The person's access to stable living arrangements;(d) Assistance in obtaining a timely aftercare appointment for needed services, including continuation of prescribed psychotropic medications; not later than 7 days after the expected date of discharge. (h) The person shall be provided contact and program information about and referral to any needed community resources; Individualized discharge plan. **Concerns:** 1 of 4 consumer records included an Application for Voluntary Admission-Receiving Facility form that was signed and dated, however, did not have the signature time. 1 of 4 consumer records included a Notice of Voluntary Patient's Right to Request Discharge from a Receiving Facility form that was signed and dated, however, did not have the signature time. 3 of 3 consumer records reviewed had a discharge summary form that did not include all requirements: transportation, living arrangements, aftercare appointment and medication. However, on the discharge progress note the missing elements from the discharge summary were included. **Recommendation:** It is recommended the provider retrain the staff on completeness of documentation including signatures, date and time on all consents. It is recommended the provider include all elements of discharge planning on the discharge summary.
Rule 65E-14.018, F.A.C. Rule 65E-14.018,(1)(a) 2., F.A.C.	**Area**: Sliding Fee Scale **Requirements**: The service provider shall make a determination of ability to pay in accordance with the sliding fee scale for all individuals seeking substance abuse or mental health services. The sliding fee scale shall not apply to services provided under the following Covered Services as defined in Rule 65E-14.021, F.A.C:

Authority	Concerns Concerns are potential issues that, although not regarded as a current finding, may develop into one if not proactively addressed by the provider. Although a recommendation is provided, a corrective action is not required.
Rule 65E-14.018,(2)(b)2. F.A.C. Rule 65E-14.018, (4) (d), F.A.C.	Crisis Stabilization, when charging a fee is contraindicated as specified in Section 394.674(2), F.S. Nominal co-payments for the following substance abuse and mental health services shall apply: Residential treatment services – $2 per day. The total charges to an individual shall not exceed 5% of gross household income. Although the provider's fee collection policy states it is to be developed, applied and administered in accordance the provisions of Rule 65E-14.018, it is of concern that: • The policy does not specifically state that the total charges to an individual shall not exceed 5% of gross household income. • The provider is billing at the $2.00 in-patient rate for Substance Use Detoxification which is one the services excluded under the sliding fee scale rule. • For Crisis Stabilization the provider is applying the $2.00 rate in- patient rate, but the policy does not address not charging the fee when it is contraindicated as specified in Section 394.674(2), F.S. because of the crisis situation. **Recommendations**: It is recommended the provider revises their sliding fee scale to state that the total charges to an individual shall not exceed 5% of gross household income. It is also recommended that the sliding fee scale not be applied to substance use detoxification and only applied to Crisis Stabilization consumers if it is not contraindicated because of the crisis situation.
ME225-9-27, Attachment I, Exhibit AN, 11.b.	**Area**: SOAR **Requirements**: At a minimum, the Network Provider shall have a sixty-five percent (65%) SOAR application approval rating during each fiscal year. **Concern**: Although the provider far exceeded their 16 applications target for completed applications by completing 27 applications in the fiscal year, they had 6 approved applications with a 60% approval rating rather than the required 65%. **Recommendation**: The provider reach out to the Social Security Administration for technical assistance on improving their application approval rating and train SOAR processors on the SSA advice.

Authority	Resolved Findings/Concerns Areas of non-compliance or partial non-compliance which are addressed during the monitoring or within five business days following the on-site review. These Resolved Findings/Concerns do not require a CAP as they have already been corrected unless they were repeat findings. If they were repeat findings, even if the individual consumer or staff file or policy is corrected the finding/concern will only be partially resolved and a CAP will still be required to ensure that compliance is maintained. Additionally, financial penalties may be imposed due to the repeat finding.
ME225-9-27 Attachment I, Exhibit AJ-, VII. Community Action Team (CAT) Guidance Document 32 Client Record Requirements VIII.	**Area**: CAT **Requirements**: Within 45 days of an individual's admission to services, the Network Provider shall complete the North Carolina Family Assessment Scale for General Services and Reunification® (NCFAS-G+R) as the required initial assessment to assist in identifying areas of focus in treatment. The NCFAS-G+R and Plans of Care (Initial and Master) must be completed for all individuals served, to include those transferred from another program within the same agency. **Finding/Concern:** 2 of 2 CAT tools contained NCFAC-G+R completed, however the assessment does not include a cover page and did not include the date of completion or date of enrollment. Therefore, it was not possible to determine whether the assessment was conducted within the required 45 days. It also could not be determined who completed the assessment. **Resolved Finding/Concern**: The provider developed a FACE sheet to utilize which included among other items, the date of Completion of the NCFAS-G+R and the date of CAT enrollment and the individual completing the survey.
ME225-9-27, Attachment I, Exhibit B, 3.a.	**Area**: Payer of Last Resort **Requirements**: The Department is always the payer of last resort. The ME and the Network Provider specifically agree that the Department, through the ME, is never a liable third party. The Network Provider shall not bill the ME for services provided to: Medicaid enrollees or recipients of another publicly funded health benefits assistance program, when the services provided are covered by said program. **Findings**: Provider entered 8 days of billing in data under the ME fund code for a Substance Abuse Detoxification Consumer who had Medicaid. **Resolved Finding Concern**: Provider corrected the funding for the consumer in data during the onsite review.

Attachment 1 – Corrective Action Plan Instructions

As identified in the report, a Corrective Action Plan (CAP) is required to address one or more findings. A template for the CAP is provided within the 2018/2019 Combined CAP & Onsite Monitoring Exit Log to help facilitate the process as outlined below.

What is a CAP and why do I need to develop one?
Corrective Action Plans (CAPs) are tools to ensure that the terms and conditions of a contract are being carried out. The CAP outlines a plan of action for correcting any deficiencies in service delivery or administrative practice which may have been uncovered by a monitoring visit or by another form of oversight. When requested by a Department of the Managing Entity, it is the provider's responsibility to develop a CAP to address findings of contract non-compliance. The Combined CAP & Onsite Monitoring Exit Log indicates after each finding the required actions which should be addressed in the CAP.

Florida Statutes, Florida Administrative Code, and the ME's Standard Contract all address the need for timely compliance with a request for a CAP. Working in partnership with your Contract Manager to correct deficiencies will ensure maximum benefit for the clients we serve.

What is included in a CAP?
A CAP needs to include what steps will be taken, what measurable milestones are expected, and other specific, measurable parameters that will track the success or failure at reasonable intervals. The next page provides specific examples of the required elements. It may be tempting to include an explanation for the deficiency, but that is not the purpose of the CAP. The focus should be on how the provider will come into compliance and how it will be prevented from happening again.

A well-written CAP comprehensively looks at all the issues which may be causing the deficiency and outlines how each of these issues will be improved over time. Clear success indicators and measure methodologies are also needed in order to verify that the specific deficiency has been resolved. A thorough CAP is more than a contract enforcement tool – it will ultimately benefit the provider's organization through process improvements.

What's involved in the CAP process?
The process begins when a Department of the Managing Entity requests a CAP from the provider. The CAP is developed by the provider and returned to the Continuous Quality Improvement Division Manager and Contract Manager by the due date provided (not to exceed 10 business days from the request). The Continuous Quality Improvement Manager will review the CAP, make sure that it is acceptable, and addresses all of the necessary issues. The Continuous Quality Improvement Manager will let the provider know if the CAP is approved or needs additional information. When it is approved, the provider should begin implementing the plan. The Continuous Quality Improvement Manager and Contract manager then keeps an electronic record of the CAP.

The Continuous Quality Improvement Manager may regularly check on the progress of corrective actions and may be involved in verifying success. If the provider needs to change details of the original CAP (e.g., estimated completion date cannot be met, the original tasks are not producing desirable results and another approach is needed), they should contact their Continuous Quality Improvement Manager to negotiate changes to the CAP. Once the deficiency is resolved and verified, the CAP can then be closed.

Continuing with preventive measures will help ensure that there are no repeat findings from future contract oversight reviews. Together, we can make certain that the services provided to our clients are of the highest possible quality.