Audit Reports, Listed Chronologically:

1. 2013-10-11 Greenville MHC
2. 2014-2-24 Santee-Wateree Community MHC
3. 2014-2-28 Individual Placement and Support Program (IPS)
4. 2014-6-10 Tri-County CMHC
5. 2014-7-17 C.M. Tucker Nursing Care Center (CMTNCC) - Petty Cash
6. 2014-10-28 DIS Facilities - Petty Cash
7. 2015-2-18 CMTNCC - Patients' Personal Fund Accounts
8. 2015-2-20 Coastal Empire CMHC
9. 2015-7-8 Pee Dee MHC
10. 2016-2-19 G. Werber Bryan Psychiatric Hospital
11. 2016-2-29 Catawba CMHC
12. 2016-8-26 AOP CMHC
13. 2017-2-14 Physical Plant Services - Vehicle Management
14. 2018-2-2 Santee Wateree MHC
15. 2018-5-4 Spartanburg Area MHC

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

Review of Selected Activities of Greenville Mental Health Center

October 11, 2013

DMH South Carolina Department of Mental Health

State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:

Alison Y. Evans, PsyD, Chair
Joan Moore, Vice Chair
Beverly Cardwell
Jane B. Jones
Everard Rutledge, PhD
J. Buxton Terry
Sharon L. Wilson

2414 Bull Street•P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

John H. Magill
State Director of Mental Health

Memorandum

DATE: October 11, 2013

TO: Al C. Edwards, M.D.
Executive Director
Greenville Mental Health Center

FROM: Bryant Collins, CGAP, Senior Auditor BC
SCDMH Office of Internal Audit

RE: Review of Selected Activities for
Greenville Mental Health Center

BACKGROUND

The Greenville Mental Health Center (GMHC) serves approximately 5,402 clients for northern Greenville County. The annual budget is approximately $8.5 million. There are 125 individuals employed at the Center. The Center's last Internal Audit report was issued by our office on September 8, 2009.

AUDIT SCOPE

Our audit of the Center was conducted in accordance with the standard internal auditing procedures for community mental health centers. The scope included a review of selected activities for billing/accounts receivable, cash operations, accounts payable, computer services, and other general administrative activities we deemed appropriate. Our review consisted primarily of testing by sampling records to determine their reliability and the soundness of the Center's internal control procedures. In addition to testing and sampling records, we held discussions with the Center's staff and management to obtain an understanding of the control procedures.

FINDINGS & RECOMMENDATIONS

Our attached audit report contains findings and recommendations which should assist in strengthening internal controls and operational compliance. **The Center's only repeat finding was "Consider Reducing Petty Cash on Hand".** We sincerely thank all employees of the Greenville Mental Health Center for their cooperation, time and assistance during the audit.

Cc: Audit Committee Members
John Magill
Geoff Mason
Mark Binkley
David Schaefer
Michele Murff
Julia S. Bishop, Board Chair

GREENVILLE
MENTAL HEALTH CENTER
AUDIT REPORT

ACCOUNTS PAYABLE

Create Purchase Orders Prior to Purchases and Blanket Purchase Orders for Frequently used Vendors

Although the center uses an internal form for pre-approval of all purchases, our sample review of accounts payable transactions revealed that purchases were made prior to creating purchase orders in the SCEIS accounting system. We reviewed sixteen purchases made via purchases orders for fiscal year 2013. Fifteen (93.75%) of the purchases were before purchase orders were created in the system. Center management stated that some vendors prefer for them to make an initial purchase prior to the purchase order being established. We discussed this matter with management of DMH Central Procurement after completing the audit field work. They confirmed that the proper procedure is to create purchase orders before making purchases even though there are a **few** vendors who require SCDMH to make a purchase beforehand.

DMH Central Procurement management also stated that the center would benefit by establishing blanket purchase orders (BPO's) for frequently used vendors. BPO's would allow the center to procure items for an entire year from a vendor. Funds set aside for BPO's are based on previous year's expenditures with vendors. If additional funds are needed preceding the end of a fiscal year, a request must be made to Central Procurement.

We recommend that vendor purchase orders are created prior to purchases unless there is a restriction by the vendor. We also recommend creating blanket purchase orders for frequently used vendors.

MANAGEMENT RESPONSE:

In response to your finding, the majority of invoices reviewed were purchased for ICBS program this summer. The ICBS Program is for the kid's in the summer when school is out. This is our way of staying in touch with the kid's through the summer. Our program runs from June to the middle of August. We have an internal system set up using a Purchasing Request form to purchase food items and services on a daily basis. We make contact with the vendor to purchase items that are needed or schedule time for services. The items in question were made due to the canceling or the rescheduling of the event time. A lot of these decisions have to be

made when staff and clients have left our center and are in the community.

We will start doing BPO's on all of our ICBS Vendors in the future. This new procedure will encumber a lot of our operating funds and will limit what we can do as a center.

Contract Administration

Consider Entering A Memorandum of Agreement With Mental Health America of Greenville County

The Representative Payee Program at the center operates through Mental Health America (MHA) of Greenville County. This program helps clients that need assistance in paying their personal bills. The center has a written policy that gives details of the program and the responsibilities of MHA and the center. Although there is a written policy, no official agreement exists which indicates both parties are aware of their responsibilities.

We recommend that center management consider entering a Memorandum of Agreement with Mental Health America of Greenville County.

MANAGEMENT RESPONSE:

Management has looked at the whole Representative Payee Program at GMHC and has decided to make some major changes. We will be rewriting our procedures that are currently in place. The biggest change we made was that we will no longer store their personal fund checks at GMHC, but we can transport the client to MHA to pick up their check. We will continue to educate and train the clients on how to budget their money. The clients will communicate with MHA on all matters related to their personal funds. By making these changes a MOA should not be needed.

CASH

Consider Reducing Petty Cash on Hand (Repeat 2009)

In the 2009 audit report we recommended that management consider reducing petty cash on hand. Management responded that they had reviewed the petty cash requirements and a request was made to reduce the balance from $300 to $250.00.

Our review of petty cash revealed that the center did not use any cash for small essential purchases during fiscal year 2013 and the balance on hand was still $300. Petty cash is segregated into a $250.00 fund for small essential purchases and two $25.00 change funds for clients served at the center.

We continue to recommend that center management consider reducing the amount of petty cash on hand.

MANAGEMENT RESPONSE:

In August of 2009 we reduced our Petty Cash by the amount of $50.00. Based upon Audit recommendation we are reducing our Petty Cash to $50.00 and each cash drawer to $25.00. There will be a total of $100.00 in Petty Cash now.

ADMINISTRATION

Reconcile Fuel Receipts to Fuel Usage Reports

Although SC Fuel Card Usage Reports are monitored on a monthly basis and receipts are maintained for all vehicles, receipts are not reconciled to the reports. Receipts should be traced to fuel transactions on the report to ensure all receipts have been submitted and verify the appropriateness of all fuel charges.

We recommend that fuel receipts are reconciled to the SC Fuel Card Usage Report to verify the appropriateness of all fuel charges.

MANAGEMENT RESPONSE:

GMHC will be reviewing and revising our procedures on how we will be handling the receipts for fuel usage. This job function will shift to the supervisor of this department. New policies and procedures will be written and put in place.

Greenville Mental Health Center
Management Response and Monitoring

Audit Finding Area	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
ACCOUNTS PAYABLE						
Create Purchase Orders Prior to Purchases and Blanket Purchase Orders for Frequently used Vendors	We will be reviewing our internal procedures and all are vendors that will or will not except PO's. We will start creating BPO on all vendors	Start Date 11/01/2013	Debra Robbins and Liesbeth Vanackere	DER		
CONTRACT ADMINISTRATION						
Consider Entering A Memorandum of Agreement With Mental Health America of Greenville County	**We are changing the procedures of Representative Payee. GMHC will no longer receive and store clients personal fun checks.**	**Start Date 11/01/2013**	**April Simpson**			**Because of this change we feel that on MOA is not needed. See attached Procedure (27.1)**
CASH						
Consider Reducing Petty Cash on Hand (Repeat)	We are reducing are Petty Cash down to $50. 00 and are cash drawers to $25.00 each. A total of $100.00.	By the end of October 2013	Debra Robbins	DER		
ADMINISTRATION						
Reconcile Fuel Receipts to Fuel Usage Reports	**This job function will be assigned to the supervisor of that department.**	**Start with November receipts**	**Liesbeth Vanackere**	NLC		

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

Review of Selected Activities of Santee-Wateree Community Mental Health Center

February 24, 2014

DMH South Carolina Department of Mental Health

State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:

Alison Y. Evans, PsyD, Chair
Joan Moore, Vice Chair
Beverly Cardwell
Jane B. Jones
Everard Rutledge, PhD
J. Buxton Terry
Sharon L. Wilson

2414 Bull Street•P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

John H. Magill
State Director of Mental Health

Memorandum

DATE: February 24, 2014

TO: Richard B. Guess, M.Ed
Executive Director
Santee-Wateree Community Mental Health Center

FROM: Bryant Collins, CGAP, Senior Auditor BC
SCDMH Office of Internal Audit

RE: Review of Selected Activities for
Santee-Wateree Community Mental Health Center

BACKGROUND

The Santee-Wateree Community Mental Health Center serves approximately 5,200 clients for Sumter, Kershaw, Clarendon and Lee counties. The annual budget is approximately $8.7 million. There are 132 individuals employed at the Center. The Center's last Internal Audit report was issued by our office on July 22, 2009.

AUDIT SCOPE

Our audit of the Center was conducted in accordance with the standard internal auditing procedures for community mental health centers. The scope included a review of selected activities for billing/accounts receivable, cash operations, accounts payable, computer services, and other general administrative activities we deemed appropriate. Our review consisted primarily of testing by sampling records to determine their reliability and the soundness of the Center's internal control procedures. In addition to testing and sampling records, we held discussions with the Center's staff and management to obtain an understanding of the control procedures.

FINDINGS & RECOMMENDATIONS

Our attached audit report contains findings and recommendations which should assist in strengthening internal controls and operational compliance. We sincerely thank all employees of the Santee-Wateree Community Mental Health Center for their cooperation, time and assistance during the audit.

Cc: Audit Committee Members
John Magill
Geoff Mason
Mark Binkley
David Schaefer
Mallory Miller
Larry P. Graham, Board Chair

SANTEE-WATEREE COMMUNITY MENTAL HEALTH CENTER
REPEAT AUDIT FINDINGS

- **Report All Donations and Volunteer Services on a Monthly Basis (2005 and 2009)**

- **Follow DoFS Policy for Self-Pay Client Fee Reductions (2005 and 2009)**

AUDIT REPORT
SANTEE-WATEREE
COMMUNITY MENTAL HEALTH CENTER

ADMINISTRATION

Report All Donations and Volunteer Services on a Monthly Basis (Repeat 2005 and 2009)

The Center completed monthly Volunteer Services Reports in fiscal year 2014, but they failed to submit them to the Director of Community Resources Development. These reports should be submitted on a monthly basis in accordance with SCDMH Directive 796-96.

We recommend that the Center submit monthly Volunteer Services report as required by SCDMH Directive 796-96. This will allow SCDMH to properly and correctly identify the amounts received across all components of the Agency.

MANAGEMENT RESPONSE:

The information was not sent to Columbia due to a transfer of these duties from one employee to another and a subsequent oversight on the second employee's part. We were obtaining the information and completing the reports internally, but they were not forwarded to Columbia. In order to address this issue, a new employee recently received updated training at another Center and is now responsible for this duty. We will report all donations of goods and services and prescription medications for indigent clients on the Volunteer Services report and forward it to Columbia on a monthly basis as required by SCDMH.

Revise Section I, Article III of the of Board By-Laws

Section I, Article III of the Center's board by-laws state that the board should consist of **fifteen** members with seven for Sumter, two for Clarendon, three for Kershaw and two for Lee County. Currently the board has **nine** members. It is comprised of four members from Sumter County, two members from Clarendon County, two from Kershaw County and one from Lee County. Management does not plan on filing anymore board vacancies. South Carolina code of laws 44-15-60 states in part, "A mental health board can consist of seven to fifteen members". The Center's board by-laws should be specific and reflect the number of board members assigned to the board.

We recommend that management revise Section I, Article III of the board by-laws to reflect the number of board members assigned to the board.

MANAGEMENT RESPONSE:

As their official minutes reflect, the SWCMHC Board of Directors does consider the Board to have vacancies and is attempting to recruit persons to fill those vacancies. However, the Executive Director and Senior Management of SWCMHC will recommend to the Board that they amend their bylaws to reflect an acceptable range of members from seven to fifteen as allowed by South Carolina Code of Laws 44-15-60.

CONTRACT ADMINISTRATION

Ensure Vendor Invoice Rates Comply with Contract Rates Prior to Making Vendor Payments

We reviewed nine (29%) of thirty-one contracts that included ten professional services contracts, nineteen Homeshare contracts, a participation agreement and one revenue contract. Information pertaining to contract payments was found for all files reviewed. We also examined individual payment transactions for these contracts in the SCIES Accounting System. Two payments to Staff Care, Inc., a professional service contract, were overpayments in the calendar year 2013. These overpayments were a result of the Center paying the invoice rate that was $10.00 more than the contract rate of $140.00 an hour. The overpayments totaled $800.00.

We recommend that Center personnel carefully observe vendor invoice rates to ensure they comply with contract rates prior to making vendor payments.

MANAGEMENT RESPONSE:

The Center did not submit the amendment to the contract to match the invoices verified by the auditor. The department has since been restructured to include an accounts payable supervisor which will improve accountability and compliance and reduce errors. As a result of training and improved communication, the Center will submit all amendments to SCDMH in a timely manner. We will carefully monitor all vendor invoice rates to ensure they comply with contract rates prior to making vendor payments. We will follow all policies and procedures required by SCDMH.

ACCOUNT RECEIVABLE & BILLING

Follow DoFS Policy for Self-Pay Clients Fee Reductions (Repeat 2005 & 2009)

According to an October 23, 2013 Crystal Report, the Center had 576 clients who were receiving a reduction of their self-pay balances. We examined records for sixteen non-Medicaid self-pay clients who receive fee reductions ranging from 60% to 99%. Deficiencies were as follows:

- Annual income for four (25%) clients receiving reductions was not computed properly according to income documents in SCDMH's Electronic Medical Record, EMR.

- Another Crystal Report generated for the audit indicated that 78 (13.54%) of 576 clients receiving fee reductions in their self-pay balances had past due annual reviews. This was an improvement from the 2009 audit report when 27.2% of these clients had late reviews.

We recommend that Center personnel carefully follow DoFS policy and procedure 3.3 regarding documentation requirements and annual reviews for clients who receive self-pay fee reductions.

MANAGEMENT RESPONSE:

We have focused a great deal of attention on this issue; however there is currently no tracking measure or report available to a manager to indicate whether all portions of the policy have been followed. We will require that every office manager to audit at least 10% of each "self-pay reduction" caseload at their clinic to increase the rate of compliance with the self-pay reduction policy. We also plan to survey other Centers to determine whether any of their procedures for complying with this policy might be transferable to our Center.

Santee-Wateree Community Mental Health Center
Management Response and Monitoring

Audit Finding Area	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
ADMINISTRATION						
Report All Donations and Volunteer Services on a Monthly Basis (Repeat 2005 and 2009)	We will report all donations of goods and services and prescription medications for indigent clients on the Volunteer Services report and forward it to Columbia on a monthly basis as required by SCDMH	January, 2014	Catherine Russell	CJR	15th of every month and on-going	
Revise Section I, Article III of the Board By-Laws	Governing Board will revise Section I, Article III of the Board By-Laws	July, 2014	Lawrence Graham		On-going	
CONTRACT ADMINISTRATION						
Ensure vendor invoice rates comply with contract rates prior to making payments to vendors	All amendments will be submitted to DMH in a timely manner. We will carefully monitor all vendor invoice rates to ensure they comply with contract rates prior to making vendor payments.	February, 2014	Tracey Hunt	JLH	5th of every month and on-going	
Accounts Receivable & Billing						
Follow DoFS Policy for Self-Pay Clients Fee Reductions (Repeat 2005 and 2009)	We will require that every office manager to audit at least 10% of each "self-pay reduction" caseload at their clinic to increase the rate of compliance with the self-pay reduction policy.	February, 2014	Tracey Hunt	JLH	5th of every month and on-going	
	We will survey other Centers to determine whether any of their procedures for complying with this policy might be transferable to our Center.	July, 2016		JLH	on-going	

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

Individual Placement and Support Program Review

February 28, 2014

DMH South Carolina Department of Mental Health

State of South Carolina
Department of Mental Health

2414 Bull Street•P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

John H. Magill
State Director of Mental Health

Memorandum

DATE: February 28, 2014

TO: Demetrius Henderson,
Director of Client Employment and Recovery Services

Jeff Ham
Program Manager CMHS

Geoff Mason
Deputy Director CMHS

FROM: Amanda Henry, Senior Auditor
SCDMH Office of Internal Audit

RE: Review of the Individual Placement and Support Program

BACKGROUND

The Individual Placement and Support (IPS) program is one of SCDMH's evidence based best practice programs whose goal is to place people with severe mental illness in competitive supported employment within communities. SCDMH works collaboratively with SC Vocational Rehabilitation Department (SCVRD) to implement this supported employment program in nine community mental health centers. These programs have consistently met high fidelity standards and as a result outcomes have been very good. The IPS program annually serves over 500 people with mental illness and in the past five years placed approximately 1200 in competitive supported employment within the communities.

AUDIT SCOPE

Our audit of the IPS program was conducted in accordance with internal auditing standards. The scope included reviews of contracts and memorandum of agreements between SCDMH and

SCVRD. Discussions were held with the program director and other IPS personnel to obtain an understanding of the program and procedures and a site visit was conducted at the Santee-Wateree MHC. Accounting records were tested and reviewed to determine reliability and soundness of internal controls.

FINDINGS & RECOMMENDATIONS

Findings with recommendations are documented in the attached audit report.

The program director and staff have worked diligently and collaboratively with SCVRD to successfully implement and maintain the IPS program. In return supportive employment for people with mental illness has been obtained throughout communities of nine mental health centers.

We sincerely thank the program director and staff for their cooperation, time and assistance during the audit.

Cc.
Audit Committee
John Magill
Mark Binkley
Ligia Latiff-Bolet

Review of the Individual Placement and Support Program (IPS)

Resolve the Open Compliance Issue Concerning Pay Back of Federal Funds Obtained by SCDMH and SCDVR through the IPS Program

A compliance issue dated 12/6/2012 concerning the pay back of approximately $135,000 of federal funds by SCDMH has not been entirely resolved.

The Director of Client Employment and Recovery Services brought to the attention of Senior Counsel for Compliance, a concern regarding a potential compliance issue. This issue dealt with federal funds obtained by both SCDMH and SCDVR through billing and use of DMH staff's salaries. A compliance form was completed by Senior Counsel for Compliance on December 6, 2012 and forwarded to the Division of Quality Management (QM).

QM has determined that a pay back of $135,000 of federal funds will need to be made by SCDMH. This came about because federal funds were obtained by each state agency, SCDMH and SCDVR. SCDMH received federal funds through fee for services billing for the clients of the IPS Program. SCDVR also received federal funds by using SCDMH IPS program staff's salaries to draw federal funds for rendering these services.

Currently, QM has provided information to management concerning the amount of the pay back but has not obtained resolution of the issue.

Recommendation

Management should resolve and document the resolution of the open compliance issue concerning DMH's pay back of federal funds obtained through the IPS program. This should be done as soon as possible to avoid potential penalties or additional fees.

Management Response

Management agrees with this finding. DMH has paid the funds to HHS to resolve the compliance issue.

Review Current MOA between SCDMH and SCDVR for Possible Misrepresentation of the Intent of the Agreement

SCDMH entered into an agreement with SCDVR July 1, 2013 effective until June 30, 2014. According to the Memorandum of Agreement (MOA) the purpose of the agreement is to describe the manner in which SCDVR shall purchase and SCDMH shall provide mental health employment coach services to eligible individuals. The agreement also states that SCDVR will provide financial resources in the amount of up to $135,000, client referrals, monitoring and caseload review and appoint a representative to attend team meetings.

The $135,000 amount referenced in the MOA is the same amount as SCDMH's open compliance issue. Also, the MOA originated subsequent to the open compliance issue. Thus, the MOA could be viewed as SCDVR reimbursing SCDMH for its payback of federal funds and therefore, possibly misrepresenting the intent of the agreement.

Recommendation

Management should review the current MOA that SCDMH maintains with SCDVR and determine if the intent of this agreement is misrepresented. If it is determined that the MOA does misrepresent the actual intent then it should be terminated.

Management Response

The contract has been rescinded as of 1/31/14. Management believes use of the word 'misrepresentation' by the auditor is inappropriate. This was a good faith attempt by DMH to assist another state agency with funding, and then once the compliance issue was identified, VR wanted to reimburse DMH for the mistake through a written contract.

Auditor's Response to Management

The auditor has concluded, based upon research, that the rescinding of the contract (MOA) is an appropriate remedy for "possible misrepresentation in agreements"; therefore, it is the opinion of the auditor that satisfactory corrective action has been taken by management. The Internal Audit department has effectively evaluated the established IPS program and its agreements to ensure compliance with laws and regulations which may impact the SCDMH, and has taken appropriate action by reporting their findings to management.

Obtain a New Contract with SCDVR

The contract between SCDMH and SCDVR ended June 30, 2013. The purpose of the contract was to effectively coordinate mental health and vocational rehabilitation services for individuals with mental illness in obtaining competitive supported employment. Both departments share responsibility in providing those services. Currently there is no signed contract between the two departments however; services are still being provided to clients at SCDMH centers.

Recommendation

Management should obtain a current contract with SCDVR.

Management Response

Management agrees. The new contract was approved and signed by DMH's State Director on February 20, 2014. The contact was also signed by VRD on February 21, 2014.

Maintain a Contract Administration File

A contract administration file was not maintained by the contract monitor. According to DoFS Policy #10.27 adequate records concerning the contractor's performance should be maintained. To accomplish this objective an official contract administration file must be established and all related contract documents maintained in this file.

Recommendation

The contract monitor should establish and maintain an official contract administration file in accordance with DoFS policy.

Management Response

Management agrees. All past and current invoices and contracts have been placed in one administration file at one location.

Appropriately Review the Invoices for Payment and Maintain Supporting Documentation

Monthly invoices received from SCDVR for payment were reviewed for fiscal years 2012 and 2013 for appropriate and supporting documentation. The following findings were noted.

- None of the invoices reviewed maintained the contract monitor's certification stamp or a #UN-45 Certification of Services Rendered form.
- Two of the 24 or 9% of the invoices reviewed were approved for payment by the contract monitor, but did not have supporting documentation. Because supporting documentation was not maintained verification of the amount that DMH was invoiced and paid could not be done.

Recommendation

The contract monitor should appropriately review, approve and maintain supporting documentation of the monthly invoices in order to ensure that SCDVR has performed in accordance to the contract. The contract monitor certification stamp or a #UN-45 form should be with all invoices. Refer to DoFS P&P#10.27 for required procedures concerning monitoring of contracts.

Management Response

Management agrees. Staff will ensure that appropriate documentation is included with all invoices for FY12 and FY13 prior to approval and supporting documents will be maintained in the invoice files for all on-going contracts.

Obtain Contract Monitoring Training

Employees who are appointed as contract monitors are required to obtain contract monitor training within 30 days of the appointment.

Recommendation

The contract monitor should take the SCDMH Contract Acquisition and Monitoring Process training module provided by DMH.

Management Response

The contract monitor has completed DMH's on-line contract monitoring training.

SCDMH Review of Individual Placement and Support Program (IPS)
Management Response and Monitoring

Audit Findings	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
Resolve open compliance issue concerning pay back of federal funds	Management has identified funds to satisfy paybacks totaling $135,000	3/1/2014	Jeffery Ham Demetrius Henderson	SH DH	2/25/2014	Management agrees with this finding. DMH has paid the funds to HHS to resolve the compliance issue.
Review the current contract between SCDMH and SCDVR for possible misrepresentation	The contract to obtain funds from VRD has been rescinded	3/1/2014	Jeff Ham Demetrius Henderson	SH DH	1/31/2014	The contract has been rescinded as of 1/31/14. Management believes use of the word 'misrepresentation' by the auditor is inappropriate. This was a good faith attempt by DMH to assist another state agency with funding, and then once the compliance issue was identified, VR wanted to reimburse DMH for the mistake through a written contract.
Obtain a new contract with VR	A new VRD/DMH interagecy contract was initiated to set forth principles and operating procedures for working together	3/1/2014	Jeff Ham Demetrius Henderson	SH DH	2/21/2014	Management agrees. The new contract was approved and signed by DMH's State Director on February 20. 2014. The contact was also signed by VRD on February 21, 2014.
Maintain a contract administration file	A complete contract file has been setup in the contract monitor's office	2/18/2014	Jeff Ham Demetrius Henderson	SH DH	2/3/2014	Management agrees. All past and current invoices and contracts have been placed in one administration file at one location.

SCDMH Review of Individual Placement and Support Program (IPS)
Management Response and Monitoring

Audit Findings	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
Appropriately review the invoices for payment and maintain supporting documentation	Contract monitor will review/sign invoices, maintain any/all supporting/pertinent documentation in the administration file	3/1/2014	Jeff Ham Demetrius Henderson	SH DH	2/18/2014	Management agrees. Staff will ensure that appropriate documentation is included with all invoices for FY12 and FY13 prior to approval and supporting documents will be maintained in the invoice files for all on-going contracts.
Obtain contract monitoring training	Contract monitor has taken appropriate training via Pathlore	3/1/2014	Jeff Ham Demetrius Henderson	SH DH	2/1/2014	The contract monitor has completed DMH's on-line contract monitoring training.

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

Review of Selected Activities of Tri-County Community Mental Health Center

June 10, 2014

DMH South Carolina Department of Mental Health

State of South Carolina
Department of Mental Health

2414 Bull Street•P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

John H. Magill
State Director of Mental Health

Memorandum

DATE: June 10, 2014

TO: Michael Rooney
Executive Director
Tri-County Community Mental Health Center

FROM: Bryant Collins, CGAP, Senior Auditor BC
SCDMH Office of Internal Audit

RE: Review of Selected Activities for
Tri-County Community Mental Health Center

BACKGROUND

The Tri-County Community Mental Health Center serves approximately 1,160 clients for Chesterfield, Dillon and Marlboro counties. The annual budget is approximately $4.2 million. There are 49 individuals employed at the Center. The Center's last Internal Audit report was issued by our office on February 10, 2009.

AUDIT SCOPE

Our audit of the Center was conducted in accordance with the standard internal auditing procedures for community mental health centers. The scope included a review of selected activities for billing/accounts receivable, cash operations, accounts payable, computer services, and other general administrative activities we deemed appropriate. Our review consisted primarily of testing by sampling records to determine their reliability and the soundness of the Center's internal control procedures. In addition to testing and sampling records, we held discussions with the Center's staff and management to obtain an understanding of the control procedures.

FINDINGS & RECOMMENDATIONS

Our attached audit report contains findings and recommendations which should assist in strengthening internal controls and operational compliance. **The Center's only repeat finding was "Follow DoFS Policy for Self-Pay Clients Fee Reductions".** We sincerely thank all employees of the Tri-County Community Mental Health Center for their cooperation, time and assistance during the audit.

Cc: Audit Committee Members
John Magill
Geoff Mason
Mark Binkley
David Schaefer
Jeff Ham
Clifford C. McBride, Board Chair

AUDIT REPORT
TRI-COUNTY COMMUNITY
MENTAL HEALTH CENTER

ADMINISTRATION

Monitor Board Members' Attendance in Accordance to Board Bylaws

We reviewed board members' attendance for the calendar year 2013 by examining board minutes. Meetings were held each month except for July. In accordance to the board bylaws deficiencies can be summarized as follows:

- **Five (45%) of the eleven board meetings did not have a quorum.** Article III, Section 5 of the bylaws also emphasizes that attendance at board meetings is essential to properly conducting business.

- **Minutes did not indicate whether absences were excused.** On four occasions a board member failed to attend three consecutive meetings. Article III, Section 5 of the bylaws state in part, "It is the policy of the Board that any Board member who fails to attend three consecutive meetings without being excused by the Chairperson will be sent written correspondence requesting written explanation of the reasons for the absences and whether or not the Board member wishes to remain on the board. The response(s) by the Board member(s), if they do not result in an excuse from the Chairperson, will be evaluated case-by-case and a decision made by vote of the Board about notifying the Legislative Delegation and/or the Governor of the need to remove and/or replace the non-attending Board member."

We recommend that board members attendance is monitored in accordance to the board bylaws. This includes encouraging board members to attend monthly meetings and documenting absences as excused or unexcused.

MANAGEMENT RESPONSE:

Beginning June 2014, a notation will be made within the minutes stating whether or not a member is excused or unexcused as determined by the Board Chair. Additionally, the Executive Director will explore with the Board of Directors additional days and times that may improve attendance.

Resume the Community Resource Development Program

The Center is not performing any aspects of the Community Resource Development Program in accordance with SCDMH Directive 796-96 and the South Carolina Government Services Act (8-25-10). This program is vital to establishing relationships within the community through volunteer training, contributions, and donations that support clients served by the Center. Community Mental Health Centers are also responsible for submitting monthly reports to SCDMH Central Administration pertaining to the value of volunteer services, contributions, and donations.

We recommend that the Center resume all aspects of the Community Resource Development Program. Once the program is resumed, ensure that monthly reports are submitted to SCDMH Central Administration.

MANAGEMENT RESPONSE:

The Executive Director has begun reviewing SCDMH Directive 796-96 and will begin work on the reimplementation of the Community Resource Development Program. This will be a project that will take some time to revitalize and we anticipate progress will be made within six months.

ACCOUNT RECEIVABLE &BILLING

Perform Write-Offs in Accordance With DoFS Policy 8.3.5 and Investigate Self-Pay Balances

Write-offs for inactive self-pay client accounts were not performed during the 2013 calendar year. DoFS policy and procedure 8.3.5 states, "Accounts shall be reviewed and uncollectible accounts written off a minimum of three times a year". According to management, participation in the Setoff Debt Collection Program (SDCP) has made

write-offs rare because inactive clients with self-pay balances are reported to the current phase of the SDCP. This program was established for all Centers to maximize their revenue collections for services previously rendered. To analyze this matter we compared a Crystal Report of inactive self-pay clients with balances to a spreadsheet of clients participating in the SDCP with the amounts they owe. A large percentage of clients (77%) in the SDCP appeared on the inactive self-pay clients' report. The report also revealed inactive clients' self-pay balance totals of $94,733.74 and 98,713.91 for 2008 and 2009 respectively. If these totals are accurate, an effort to collect these balances should have been made in previous phases of the SDCP because balances prior to 2010 are now uncollectable.

We recommend that the Center perform write-offs in accordance with DoFS policy 8.3.5. This also includes investigating the accuracy of inactive self-pay balances from 2008 and 2009.

MANAGEMENT RESPONSE:

Since the audit, the Director of Administration and Fiscal Tech performed a large write-off of uncollectible self-pay balances. The total write-off was $152,326.67. Some of the accounts dated back to 1996. Uncollectible self-pay balances will be assessed at each self-pay billing cycle and write-offs will be performed at a minimum of three times per year in accordance with the policy.

Enter Income Data for Homeshare Clients into Client Information Services and Import Supporting Documentation into Electronic Medical Record

Income data for clients participating in the Homeshare Program is not reflected in Client Information Services (CIS). Supporting income documentation for these clients has not been imported into Electronic Medical Record (EMR). This information is vital to monitoring standard Homeshare Provider invoices because income helps determine the portion of payment the client and SCDMH are responsible to pay the provider.

We recommend that Center intake personnel enter income data for Homeshare clients into CIS. We also recommend that supporting income documentation for Homeshare clients is imported into EMR.

MANAGEMENT RESPONSE:

Homeshare income information was entered as requested on May 23, 2014; this was an oversight from the Homeshare audit that occurred last year. The Clinic Director and Human Services Coordinator will enter updated information yearly for all Homeshare participants.

Follow DoFS Policy for Self-Pay Clients Fee Reductions (Repeat)

During the preliminary audit phase we obtained a Crystal Report that revealed 120 non-Medicaid self-pay clients receiving fee reductions in their balances ranging from 70% to 99%. We examined records for fifteen clients. Although tremendous improvement has been made in this area since our last audit, two deficiencies were identified. The deficiencies were as follows:

- Annual income for three (20%) clients receiving reductions was not computed properly according to income documents in SCDMH's Electronic Medical Record, (EMR). Reduction percentages are determined by clients' incomes and family members in their households.

- Five annual updates for clients in our sample were past due; however the center was only responsible for two (13.33%) late reviews. Clinical Service Notes in EMR indicated that services were recently provided for these clients. Attempts should have been made by Center personnel to obtain updated financial data during these services.

We recommend that Center personnel carefully follow DoFS policy and procedure 3.3 regarding documentation requirements and annual reviews for clients who receive self-pay fee reductions.

MANAGEMENT RESPONSE:

The Director of Administration requested a correction of records indicated during the audit in which proof of income and the income entered did not match. Since that time all Clerical staff and their Clinical Directors have received guidance on this issue and this will be a standing training item for Clerical staff. Clerical staff and their Clinical Directors have received direction on obtaining timely financial updates; this issue will be a standing training item for Clerical Staff.

HUMAN RESOURCES

Ensure Private Practice Forms are Completed and on File

Three employees at the Center are engaged in off-duty employment with private businesses. However, private practice forms for these employees were not completed and on file when we began our audit field work.

We recommend that Private Practice Forms are completed and filed for all employees engaged in private practice in accordance with SCDMH Directive 808-98. Management should also ensure that this process is done annually in accordance to the directive.

MANAGEMENT RESPONSE:

The Human Resource Manager sent a request to all Tri County Employees who engage in private practice requesting completion of this form. We have two employees currently engaged in Private Practice and the forms have been completed and filed in the personnel file. This will be completed annually. During the audit three employees were identified, however, only two are engaged in private practice at this time.

Tri-County Community Mental Health Center
Management Response and Monitoring

Audit Finding Area	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
ADMINISTRATION						
Monitor Board Member's Attendance in Accordance to the Board By-laws	Discuss with Board, Begin making a notation of excused and unexcused members in monthly minutes	6/16/2014	Michael Rooney, Director			The Center Director will explore strategies with the Board President on increasing attendance.
Resume the Community Resource Development Program	Review SCDMH Directive 796-96 and begin reimplementation of a Community Resource Development Program.	12/10/2014	Michael Rooney		Continual	The Center Director will explore what type of program best fits the needs of Tri County Mental Health Center.
ACCOUNTS RECEIVABLE BILLING						
Perform Write-Offs in Accordance With DoFS Policy 8.3.5 and Investigate Self-Pay Balances	**Tri County Has already taken initiative and performed a long overdue write off, totaling $152,326.67.**	**Completed**	**Crystal McLendon**		**5/22/2014**	**Write offs will be performed at least three times per year as policy states.**
Enter Data For Homeshare Clients into Client Information Services and Import Supporting Documentation into Electronic Medical Record	**Homeshare income data has been entered.**	**Completed**	**Michael Truluck**		**5/23/2014**	**Will update information annually.**
Follow DoFS Policy for Self-Pay Clients Fee Reductions (Repeat)	Clerical staff has been informed by Director of Administration to follow policy and ensure proof of income matches the income entered in CIS	Continual	Crystal McLendon		Continual	These issues will be standing training items for all clerical staff.
HUMAN RESOURCES						
Ensure Private Practice Forms are Completed and on File	Human Resource Manager has requested and received Private Practice Forms from staff. This applies to 2 staff members.	Completed	Sallie Rouse		5/30/2014	This form will be requested and updated annually.

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

C.M. Tucker Nursing Care Center – Petty Cash

July 17, 2014

DMH South Carolina Department of Mental Health

State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:

Alison Y. Evans, PsyD, Chair
Joan Moore, Vice Chair
Beverly Cardwell
Jane B. Jones
Everard Rutledge, PhD
J. Buxton Terry
Sharon L. Wilson

2414 Bull Street•P.O. Box 485
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Information: (803) 898-8581

John H. Magill
State Director of Mental Health

Memorandum

DATE: July 17, 2014

TO: Versie J. Bellamy, MN, RN, Deputy Director
Division of Inpatient Services

Norma Jean Mobley, RPh, NHA
C.M. Tucker Nursing Care Center
Administrator – Roddey Pavilion

Frances Corley, RN, NHA
C.M. Tucker Nursing Care Center
Administrator – Stone Pavilion

FROM: Amanda Henry, Senior Auditor
Office of Internal Audit

RE: Audit of Petty Cash
C.M. Tucker Nursing Care Center (CMTNCC)

BACKGROUND

Petty cash funds are utilized at the inpatient facilities for small, essential purchases; patient outings/activities; patient travel with an escort; and cash withdrawals for patients and residents. C.M. Tucker Nursing Care Center maintains $8,000 in petty cash funds. These funds are divided into two separate cash funds; $4,000 each for the Roddey and Stone pavilions.

This review of petty cash was initiated by a notification received from the Administrator of the Roddey Pavilion concerning a resident's funds.

AUDIT SCOPE

Our audit was conducted in accordance with standard internal auditing procedures. We counted and balanced all cash to the general ledger for petty cash funds maintained at the C.M. Tucker Nursing Care Center. We interviewed management and staff, and reviewed supporting documentation for compliance with DMH policy and procedures.

FINDINGS & RECOMMENDATIONS

All cash was accounted for however, a few additional findings were noted. These findings with recommendations are documented in the attached audit report.

We sincerely thank the mangement and staff for their cooperation, time and assistance during the audit.

Cc.
Audit Committee
John Magill
Doug Glover
Dave Schaefer

C.M. Tucker Nursing Care Center – Petty Cash Audit

Obtain Authorization for Petty Cash

During the count of petty cash maintained at C.M. Tucker Nursing Care Center (CMTNCC) cashiers' offices, audit became aware that an additional $50 (total $100) of unauthorized petty cash is being maintained at each of the Nursing Supervisors' offices, at the Roddey and Stone pavilions. The cash is maintained in locked boxes and was established to comply with a federal regulation concerning the resident's access to his or her funds.

Upon further review it was determined that the transactions establishing these funds were approved by the CMTNCC facility administrators and business office.

Recommendation

Management should review the Department of Financial Services (DoFS) policy and procedures #5.2 concerning the establishment of petty cash and adhere to those requirements. The transactions used to secure the unauthorized petty cash should be reversed and correcting entries made. Authorized petty cash should then be obtained.

Management Response

The money that was expensed in error to create the weekend change funds will be deposited as a refund of prior-year expenditures. After the appropriate personnel have been trained as cashiers, each facility cashier will transfer $50 to the weekend cashier and the procedures outlived in Section 3 of the SCDMH DoFS Manual.

Verify the Sundry Items Purchased with Petty Cash to Original Receipts

There is no documentation that the sundry (non-personal) items purchased with petty cash are verified to the original receipts.

Recommendation

Strengthen controls on sundry items purchased by verifying those items against the original receipts. The person verifying the items should be someone other than the purchaser. The verifier should initial the receipt documenting the verification of purchased items. By strengthening these controls the risks of theft and the purchase of unapproved sundry items are reduced.

Management Response

All purchases will be verified on the original receipt by someone other than the requestor and the receiver. Verification will include tick marks by the items, initials of verifier and date of verification.

Determine if the Unit's Weekend Financial Report Can Be Automated

Presently, at the end of each week, the cashiers obtain the balance of each resident's personal funds maintained on SCDMH's Avatar financial system and record those balances on the Unit's Weekend Financial Report. This report is then given to the Nursing Supervisor. The supervisor uses the report to determine if a resident has funds that they can access on the weekend or evenings when the Cashier's office is closed. If it is determined that they have funds the Nursing Supervisor then accesses the petty cash maintained on the unit and gives the resident their requested funds.

Recommendation

Management should contact the Office of Network and Information Technology (ONIT) to determine if a weekly report can be generated through the Avatar system with the resident's personal fund balances thus, eliminating the need for the cashiers to manually record balances.

Management Response

The request has been made that the list of personal funds balances be generated through Avatar.

C.M. Tucker Nursing Care Center - Petty Cash
Management Response and Monitoring

Audit Finding	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
Obtain Authorization for Petty Cash	The money that was expensed in error to create the weekend change funds will be deposited as a refund of prior-year expenditures. After the appropriate personnel has been trained as cashiers, each facility cashier will transfer $50 to the weekend cashier and the procedures outlived in Section 3 of SCDMH DoFS Manual	Est completion date is Oct 1, 2014	Robert Morgan			
Verify Sundry Items Purchased with Petty Cash to Original Receipts	All purchases will be verified on the original receipt by someone other than the requestor and the receiver. Verification will include tick marks by the items, initials of verifier and date of verification.	Estimated date is October 1,2014.	Norma Jean Mobley,NHA Frances Corley, NHA			
Determine if the Unit's Weekend Financial Report Can Be Automated	Request has been made that the list of personal funds balances be generated through Avatar.	Estimated date is October 1,2014.	Barbara Glasgow			

Format Requested by the SCDMH Commission

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

DIS Facilities – Analysis of Petty Cash

October 28, 2014

DMH South Carolina Department of Mental Health

State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:

Alison Y. Evans, PsyD, Chair
Joan Moore, Vice Chair
Beverly Cardwell
Jane B. Jones
Everard Rutledge, PhD
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2414 Bull Street•P.O. Box 485
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John H. Magill
State Director of Mental Health

Memorandum

DATE: October 28, 2014

TO: Versie J. Bellamy, MN, RN, Deputy Director
Division of Inpatient Services

FROM: Amanda Henry, Senior Auditor AH
Office of Internal Audit

RE: Division of Inpatient Services (DIS) - Analysis of Petty Cash

- G. Werber Bryan Psychiatric Hospital
- Patrick B. Harris Psychiatric Hospital
- William S. Hall Psychiatric Institute/Child & Adolescent,
- Morris Village Alcohol & Drug Addiction Treatment Center,
- Crafts Farrow Post Office

BACKGROUND

Petty cash funds are utilized at the inpatient facilities for small, essential purchases; patient outings/activities; patient travel with an escort; and cash withdrawals for patients and residents. The petty cash funds totaling $31,000 were counted and analyzed at five DIS facilities between July and September 2014. These funds are divided as follows G. Werber Bryan Psychiatric Hospital (Bryan Hospital) $10,000; Patrick B. Harris Psychiatric Hospital (Harris Hospital) $6,000; William S. Hall Psychiatric Institute/Child & Adolescent (WSHPI) $3,000; Morris Village Alcohol & Drug Addiction Treatment Center (Morris Village) $5,000; Crafts Farrow Post Office (Crafts-Farrow) $7,000.

Note: C.M. Tucker Nursing Care Center's petty cash was counted in May, 2014 and a report was issued July 17, 2014.

AUDIT SCOPE

Our audit was conducted in accordance with standard internal auditing procedures. We counted and balanced cash maintained at the five facilities to the authorized amounts. In-transit transactions were reviewed to ensure appropriate and timely posting to the general ledger and patient personal fund accounts. We interviewed management and staff, reviewed supporting documentation for compliance with DMH policy and reviewed controls and procedures for the safeguarding of the cash. We also reviewed the cashiering operations and analyzed cash maintained at each location.

FINDINGS & RECOMMENDATIONS

All cash was accounted for however, some additional findings were noted. These findings with recommendations are documented in the attached audit report.

Please note that Harris Hospital has only one finding in this report. The finding concerns the sale of postage stamps.

We sincerely thank the mangement and staff for their cooperation, time and assistance during the audit.

cc.
Audit Committee
John Magill
Mark Binkley
John Fletcher
Doug Glover
Dave Schaefer

DIS Facilities – Analysis of Petty Cash

Properly Complete and Increase Oversight of the Balance Sheet

We reviewed the balance sheets for the months of January and February 2014. These sheets are completed daily by the cashiers to balance cash to the authorized amount of the location. Several sheets reviewed were not properly completed. The following items were noted.

- For one cashier, individual items listed as in-transit did not balance to the total of in-transit items documented on the sheet. The totals, however, were used by the cashier to balance the cash. This occurred seven out of the thirty seven days reviewed or 19%.
- Totals of currency were not being recorded for several cashiers.
- Location of cashier offices was not always documented on the sheets.

Recommendation

Properly complete the balance sheet to the authorized amount. All in-transit items should be listed and totaled. All currency should be listed by denomination and totaled. Oversight of the daily balancing should be increased. Review of the sheets should be done quarterly with the cashier supervisor initialing the sheet indicating the review. For increased accountability the location of the cashier office should be indicated on the balance sheet. Refer to P&P #5.6.2 of the Division of Financial Services (DoFS) manual.

Management Response

The need for additional training has been recognized and staff reassignments have been made to reduce the likelihood of recurring balancing issues. Unannounced audits and regular rotation of staff among the locations will help to identify discrepancies, as was the case in the balancing errors.

Consider Automating the Balance Sheet

The balance sheets are manually completed by the cashiers. By automating the sheet, totals will be automatically calculated after cashiers input their information. The sheets can then be stored digitally on the computer and sent via email to the Business Office.

Recommendation

Management should consider automating the balance sheet. This could be done by creating the sheet on a spreadsheet application such as Excel.

Management Response

The automated balance sheet has been created and the cashier staff is being scheduled for training by SCDMH. Training will be completed by November 30, 2014.

Review the Amount of Cash Being Maintained and Determine if Amount Should Be Reduced

The amount of cash maintained at the five locations was reviewed and analyzed for the months of January and February 2014. The amount of in-transit items and the length of time for reimbursement were also considered. In-transit items are reimbursed by the Business Office within five to seven business days. Three of the five locations, WSHPI, Crafts-Farrow and Bryan Hospital should be reviewed for possible reduction of cash on hand. For the months reviewed the following was noted:

- WSHPI maintained an average of $2,000 (vault and drawer) or 67% of the authorized amount of $3,000 on hand per day; in-transit items averaged $647
- Crafts-Farrow maintained an average of $5,600 or 80% of the authorized amount of $7,000 on hand per day; in-transit items averaged $1,154.
- Bryan Hospital maintained an average of $ 6,900 or 69% of the authorized amount of $10,000 on hand per day; in-transit items averaged $2,800

Recommendation

Management should review the cash on hand at WSHPI, Crafts-Farrow and Bryan Hospital locations and determine if the amount should be reduced.

Management Response

Funds will be reduced by $1,000 at WSHPI, changing the balance from $3,000 to $2,000, and reduced by $2,500 at CFSH, changing the balance from $7,000 to $4,500. At this time, Bryan Hospital will retain the amount of $10,000 to assure that funds are available in the NE campus area in the event of a shortage at any of the three facilities. These reductions overall will reduce the five DIS locations cash balance from $31,000 to $27,500. Once WSHPI is relocated to the NE area, we will reevaluate our needs and adjust accordingly.

Consider Discontinuing the Sale of Postage Stamps

Postage stamps are purchased with petty cash and maintained at all the cashier locations. The amount of stamps maintained at each location ranges from $250 to $350. When interviewing the cashiers, it was determined that most of the sales of postage stamps are to SCDMH employees.

Recommendation

Management should consider discontinuing the sale of postage stamps by the cashiers. If continued, sales should only be for the patient's benefit and the amount of stamps on hand should be reduced.

Management Response

The amount maintained at each location will be reduced to approximately $100. Metered postage may also be available for use.

Strengthen Controls on Sundry Items Purchased with Petty Cash

Sundry (non-personal) items purchased with petty cash are not verified to the original receipts at WSHPI. The person verifying the items should be someone other than the purchaser. The verifier should initial the original receipt documenting the verification of purchased items.

Recommendation

Strengthen controls on sundry items purchased by verifying those items against the original receipts. By strengthening these controls the risks of theft and the purchase of unapproved sundry items are reduced.

Management Response

All purchases will be verified on the original receipt by someone other than the requestor and the receiver. Verification will include tick marks by the times, initials of verifier, and date of verification.

Use Current Forms for Replenishment of Petty Cash

During our review of petty cash forms we noted that some locations were not using the current S-5C "Request for Issue or Turn-In of Supplies" form. This form is used to request replenishment of petty cash. Also, the DMH Imaging Coversheet was being used instead of the F-11A "SCDMH Invoice Voucher". This form is used to document expenditure and fund codes.

Recommendation

Review forms being used at each location and begin using current forms for petty cash replenishment. Refer to Cash Operations Policy and Procedure #5.2.3 of the DoFS manual.

Management Response

The current version of the S-5C "Request for Issue or Turn-In of Supplies" form will be required by all cash offices to disburse petty cash to anyone. This form has been revised (July 2014) based on Internal Audit findings at CM Tucker and all staff have been informed of the change.

Effectively immediately, cashiers are to discontinue the use of the DMH Imaging Coversheet and to itemize the reimbursement requests on the F-11A "SCDMH Invoice Voucher."

DIS Facilities - Analysis of Petty Cash
Management Response and Monitoring

Audit Finding	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
Properly Complete and Increase Oversight of the Balance Sheet	The need for additional training has been recognized and staff reassignments made to reduce the likelihood of recurring balancing issues.	Nov. 30, 2014	Barbara Glasgow/ Ann Thornley	BD		
	Unannounced audits and regular rotation of staff among the locations help to identify discrepancies, as was the case in the balancing errors.					
Consider Automating the Balance Sheet	The form has been created and cashier staff is being scheduled for training by SCDMH in using the form and saving the files.	Nov. 30, 2014	Barbara Glasgow	BB		
Review the Amount of Cash Being Maintained and Determine if Amount Should Be Reduced	Funds will be reduced by $1,000 at WSHPI, changing the balance from $3,000 to $2,000, and reduced by $2,500 at CFSH, changing the balance from $7,000 to $4,500. At this time, Bryan Hospital will retain the amount of $10,000 to assure that funds are available in the NE campus area in the event of a shortage at any of the three facilities. These reductions overall will reduce the five DIS locations cash balance from $31,000 to $27,500. Once WSHPI is relocated to the NE area, we will reevaluate our needs and adjust accordingly.	Nov. 30, 2014	Barbara Glasgow/ Ann Thornley	BD		
Consider Discontinuing the Sale Of Postage Stamps	The amount maintained at each location will be reduced to approximately $100. Metered postage may also available for use .	Nov. 30, 2014	Barbara Glasgow/ John Fletcher	BB		

Format Requested by the SCDMH Commission

DIS Facilities - Analysis of Petty Cash
Management Response and Monitoring

Audit Finding	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
Strengthen Controls on Sundry Items Purchased with Petty Cash	All purchases will be verified on the original receipt by someone other than the requestor and the receiver. Verification will include tick marks by the items, initials of verifier, and date of verification	Nov. 30, 2014	Barbara Glasgow/ Terry Mayers	BG TBM		
Use Current Forms for Replenishment of Petty Cash	The current version of the S-5C "Request for Issue or Turn-In of Supplies" form will be required by all cash offices to disburse petty cash to anyone. This form has been revised (July 2014) based on Internal Audit findings at CM Tucker and all staff have been informed of the change	Nov. 30, 2014	Barbara Glasgow/ Terry Mayers	BG TBM		
	Effectively immediately, cashiers are to discontinue the use of the DMH Imaging Coversheet and to itemize the reimbursement requests on the F-11A "SCDMH Invoice Voucher."					

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

C.M. Tucker Nursing Care Center –

Review of Patients' Personal Fund Accounts

February 18, 2015

State of South Carolina
Department of Mental Health

2414 Bull Street•P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

John H. Magill
State Director of Mental Health

Memorandum

DATE: February 18, 2015

TO: Versie J. Bellamy, MN, RN, Deputy Director
Division of Inpatient Services

Norma Jean Mobley, RPh, NHA
C.M. Tucker Nursing Care Center
Administrator – Roddey Pavilion

Frances Corley, RN, NHA
C.M. Tucker Nursing Care Center
Administrator – Stone Pavilion

FROM: Amanda Henry, Senior Auditor
Office of Internal Audit

RE: Review of Patient Personal Fund Accounts -
C.M. Tucker Nursing Care Center (CMTNCC)

BACKGROUND

The C.M. Tucker Nursing Care Center (CMTNCC) consists of two pavilions, Stone and Roddey. Patient personal fund accounts are maintained for patients at both pavilions. Patient funds are deposited into their personal funds bank account and detailed account information for each patient is maintained on SCDMH's Avatar financial system. Patients' cash withdrawals and deposits are posted to their individual accounts by the cashiers at Stone and Roddey pavilions. As of June 30, 2014 approximately 200 patient personal fund accounts with available balances totaling over $50,000 were maintained.

The review of patient personal fund accounts was initiated by a notification received from the Administrator of the Roddey Pavilion concerning a patient's funds.

AUDIT SCOPE

Of the 202 patient personal fund accounts, Stone maintains 50 and Roddey152. Sampling of these accounts consisted of the following:

- Stone Pavilion - Five accounts (10% of population) consisting of twenty-five transactions were selected for review of corresponding documentation
- Roddey Pavilion - Twenty-nine accounts (19% of population) consisting of 160 transactions were selected for review of corresponding documentation

The selected accounts were reviewed for proper approvals of transactions, required documentation and compliance with DMH policy and procedures. The transactions reviewed occurred during fiscal year 2014.

FINDINGS & RECOMMENDATIONS

Findings with recommendations are documented in the attached audit report. There were no findings for patient personal fund accounts reviewed for the Stone pavilion. The findings documented in the report pertain only to the accounts at the Roddey pavilion. We sincerely thank the mangement and staff for their cooperation, time and assistance during the audit.

cc.
Audit Committee
John Magill
Mark Binkley
David Schaefer
Doug Glover

C.M. Tucker Nursing Care Center

Review of Patient Personal Fund Accounts

Submit Original Receipts For Purchases Made by Staff for Patients

Receipts of cigarette purchases made by authorized staff for patients at the Roddey pavilion were reviewed. Eight receipts with "duplicate" indicated on the receipts were found. Invoice vouchers for those receipts are as follows:

- Voucher #1402092007 dated 8/13/2013 totaling $242.93 – two "duplicate" receipts
- Voucher #1409092004 dated 3/11/2014 totaling $486.85 – two "duplicate" receipts
- Voucher #1411092013 dated 5/28/2014 totaling $197.22 – four "duplicate" receipts

Based on the documentation, what appears to have happened was a cigarette purchase was made by staff for one patient each on 8/13/2013, 3/11/2014 and 5/28/2014. Each transaction, with the exception of one transaction on 3/11/2014 where the original receipt could not be found, had an original receipt with a unique identifying receipt transaction number. These three original receipts were duplicated by the store cashier for the additional cigarette purchases that were made for the other patients. Those "duplicate" receipts were submitted to the Roddey pavilion cashier by staff to support the cigarette purchases.

Recommendation

Only original receipts are to be submitted to the facility cashiers for purchases made by staff for patients. Per the Department of Financial Services (DoFS) policy and procedures #9.2.2 "Disbursement of Inpatients Personal Funds" designated staff are to submit original receipts for purchases made to the facility cashier. Management should review these procedures with the appropriate staff and ensure that they are followed. Management may want to consider occasionally reviewing a sample of receipts.

Management Response

This issue was addressed as part of the Internal Audit of Petty Cash dated July 17, 2014. The finding in that report addressed the verification of sundry items to the original receipts. As part of that verification, the appropriate staff was instructed to have all purchases verified on the original receipt by someone other than the requestor and the receiver and the cashiers were instructed to only accept original receipts and not copies or duplicates. In addition to the cashiers ensuring that only original receipts are turned in, the Business Office staff is also reviewing the vouchers as they process them for payment. This issue has been resolved as of September 1, 2014.

Determine If Cigarettes Were Purchased and If So Obtain Original Receipts

The SCDMH F-22 forms "Request for Patient Fund Withdrawal" for the Roddey pavilion were reviewed for proper completion and authorized signatures. Of the sixteen forms reviewed for SCDMH invoice voucher #1406092007, dated 12/17/13, four (25%) indicated cigarettes as the reason for the $37.00 withdrawal of the patient's funds. However, no receipts were attached to the forms to document these purchases.

Also, eleven (does not include the previous four) of the sixteen (46%) forms reviewed were for cash withdrawals in the amount of $37.00. A withdrawal of this exact amount for the same patients has been used to purchase cigarettes in other transactions that were reviewed. There were no indications on the F-22 forms that these funds were for cigarette purchases and no receipts were found. However, this may be an indicator that withdrawals documented as cash may actually be for cigarette purchases. If so, then the control of obtaining required receipts for proof of purchases has not been completed.

Recommendation

Management should determine if cigarettes have been purchased and if so obtain receipts for those purchases. Also, management should review with staff, policy and procedures for the handling of patient's funds and ensure that they are followed.

Management Response

Management could not determine if the previous purchases were for cigarettes. However, Management has taken the necessary steps to educate staff about the appropriate use of patient personal funds and following proper procedures. Both the cashiers and the Business Office have incorporated the review of any potential odd dollar amounts for "cash" using patient personal funds.

Complete Residential Personal Property Inventory Form

Non-consumable items purchased for patients were traced to the "Resident's Personal Property Inventory" form maintained in the patient's clinical records. One of the ten items traced could not be found on the inventory form.

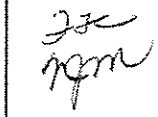
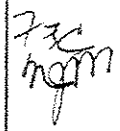
Recommendation

Non-consumable items which have been purchased with patient's funds must be entered on the "Resident Personal Property Inventory" form and kept with the resident's clinical record according to C.M. Tucker Policy and Procedure Directive 2.401. Management should review this policy and procedure with appropriate staff to ensure that proper procedures are followed and patient's items are appropriately inventoried.

Management Response

Facility Management will review C.M. Tucker Policy and Procedure Directive 2.401 with the appropriate personnel and begin performing quarterly audits of the "Resident Personal Property Inventory" form.

C.M. Tucker Nursing Care Center - Patient Personal Fund Accounts
Management Response and Monitoring

Audit Finding	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
Submit Original Receipts for Purchases Made by Staff for Patients	Previously addressed in Petty Cash Audit	Completed	Frances Corley Norma Jean Mobley		9/1/2014	This issue has been resolved as part of the Petty Cash Audit dated July 17, 2014.
Determine if Cigarettes Were Purchased and if so Obtain the Original Receipts	Appropriate staff have been educated regarding use of patient personal funds and following proper procedures. The recommendation regarding original receipts was previously address in the Petty Cash Audit.	2/28/2015	Frances Corley Norma Jean Mobley			The issue regarding orignal reciepts was resolved as part of the Petty Cash Audit dated July 17, 2014.
Complete Residential Personal Property Inventory Form	Facility Management will review C.M. Tucker Policy and Procedure Directive 2.401 with the appropriate personnel and begin performing quarterly audits of the "Resident Personal Property Inventory" form.	3/31/2015	Frances Corley Norma Jean Mobley			

Format Requested by the SCDMH Commission

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

Review of Selected Activities of Coastal Empire Community Mental Health Center

February 20, 2015

DMH South Carolina Department of Mental Health

State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:

Alison Y. Evans, PsyD, Chair
Joan Moore, Vice Chair
Beverly Cardwell
Jane B. Jones
Everard Rutledge, PhD
J. Buxton Terry
Sharon L. Wilson

2414 Bull Street•P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

John H. Magill
State Director of Mental Health

Memorandum

DATE: February 20, 2015

TO: Andrea Allen
Interim Executive Director
Coastal Empire Community Mental Health Center

FROM: Bryant Collins, CGAP, Senior Auditor BC
SCDMH Office of Internal Audit

RE: Review of Selected Activities for
Coastal Empire Community Mental Health Center

BACKGROUND

The Coastal Empire Community Mental Health Center serves approximately 3,323 clients for Allendale, Beaufort, Colleton, Hampton and Jasper counties. The annual budget is approximately $6.6 million. There are 96 individuals employed at the Center. The Center's last Internal Audit report was issued by our office on March 24, 2010.

AUDIT SCOPE

Our audit of the Center was conducted in accordance with the standard internal auditing procedures for community mental health centers. The scope included a review of selected activities for billing/accounts receivable, cash operations, accounts payable, computer services, and other general administrative activities we deemed appropriate. Our review consisted primarily of testing by sampling records to determine their reliability and the soundness of the Center's internal control procedures. In addition to testing and sampling records, we held discussions with the Center's staff and management to obtain an understanding of the control procedures.

FINDINGS & RECOMMENDATIONS

Our attached audit report contains findings and recommendations which should assist in strengthening internal controls and operational compliance. **The Center's only repeat finding was "Follow DoFS Policy for Self-Pay Clients Fee Reductions".** We sincerely thank all employees of the Coastal Empire Community Mental Health Center for their cooperation, time and assistance during the audit.

Cc: Audit Committee Members
John Magill
Geoff Mason
Mark Binkley
David Schaefer
Jeff Ham
Thomas S. Miller, DPM, Board Chair

COASTAL EMPIRE
MENTAL HEALTH CENTER
AUDIT REPORT

ACCOUNTS RECEIVABLE/BILLING

Follow DoFS Policy for Self-pay Clients Fee Reductions (Repeat 2000, 2006, and 2010)

As of November 2014, the Center had 383 clients receiving reductions in their self-pay balances. We examined records for 16 non-Medicaid self-pay clients who receive fee reductions ranging from 20% to 99%. Although the Center has made tremendous improvement in this area since the 2010 audit, a few deficiencies were still noted:

Five (31%) clients in our sample did not have current annual reviews on file in the SCDMH Electronic Medical Record, EMR. All five of these clients receive treatment at the Hilton Head Clinic.

Annual income for six (37.5%) clients was not computed correctly according to income documents on file in the EMR. Four of these clients receive treatment at the Hilton Head Clinic, one at the Allendale Clinic and one at the Ridgeland Clinic. Three of the six clients were the same clients that did not have annual reviews on file. Incorrect annual incomes for self-pay clients may result in incorrect reduction percentages and the failure to collect proper revenue for services rendered.

We recommend that Center personnel carefully follow DoFS policy and procedure 3.3 regarding documentation requirements and annual reviews for clients who receive self-pay fee reductions. We also recommend that intake personnel are properly trained to compute annual income from documents stated in the policy.

MANAGEMENT RESPONSE:

CECMHC's Management team is taking this finding very serious. We have issued verbal counseling to support staff that has been unable to keep their reviews 100% compliant. Support staff and Area Coordinators are working hard to ensure the financial reviews are correctly up to date per the DOFS Policy and Procedure 3.3. We are asking for all reviews to be updated by March 1, 2015.

Accounts Receivable will run a special audit using the EMR Signed Consent reports from Crystal to monitor compliance at each location.

Our Accounts receivable department is and will continue to run special audits per clinic on a quarterly basis to ensure compliance at each location. We also recognize the need to strengthen the efficiency of the Financial Review process. We are organizing a small group of management, support staff and administration to create a process that will eliminate audit findings with Financial Reviews. We anticipate a stronger process to be finalized by April 1st, training on April 23rd during our Support Staff meeting and implemented by May 1, 2015.

Contract Administration

Complete Financial Assessments to Justify Homeshare Clients' Minimum Stipend Payments

Six Homeshare Provider contracts were selected in our audit sample of contracts at the Center. For these contracts we examined stipend payments to providers in accordance to the stipend policy, 11-13, listed in the Homeshare Manual (Exhibit 1). Providers receive monthly stipends from the Homeshare client and SCDMH that total $1,339. The SCDMH stipend is the remainder of $1,339 less the client's stipend. The client stipend is 74% of their income unless they have excessive medical expenses, medication expenses, or other expenses as part of the Homeshare Program not exceeding $50.00 monthly. When excessive expenses exist for a client, a Financial Assessment Form (C-215) should be completed to document these expenses. The stipend policy also gives Center Directors the discretion to expand clients' expenses beyond expenses mentioned in the policy.

While examining payments to providers in the SCEIS Accounting System, we noticed that all client stipend payments were at a **minimum ($372),** thus the SCDMH stipend payments were at a **maximum ($967**) according to the stipend scale (Exhibit 2). To determine if this was an anomaly, we expanded our examination to include payments for all active provider contracts (25) at the Center. Client stipend payments were at a **minimum for all providers** who received stipend payments during the 2014 calendar year. Twenty-one of twenty-five (84%) providers received stipend payments.

We spoke with management regarding minimum provider stipend payments for each Homshare client. We also asked them about documentation justifying minimum stipend payments. Management stated that the Executive Director issued two documents approving amounts for the SCDMH stipend and the client stipend. They also stated that copies of these documents could be found in each client record in EMR. Documents justifying stipend payments were located in EMR for over 90% of the clients involved; however Financial Assessments Forms were not completed to document clients' excessive expenses. Financial Assessments Forms for Homeshare clients should be completed in accordance to the stipend policy. **The completion of financial assessments will give documented evidence of clients' financial statuses and their need to maintain additional income for other monthly obligations that are burdensome.**

We recommend that the Center complete Financial Assessments for Homeshare clients to justify their minimum stipend payments.

MANAGEMENT RESPONSE:

Per the recommendation of the Internal Audit, The Homeshare team leader has completed the C-215 forms for all the Homeshare clients and will be uploaded into EMR by March 1, 2015. Documents justifying stipend payments are being reviewed and uploaded into EMR by March 1, 2015. Future Homeshare clients will receive a stipend review using the C-215 form and if necessary documentation from the Executive Director.

Administration

Consider Revising the Board By-laws to Make the Attendance Standard More Attainable

We examined board minutes for seven meetings held from September 2013 to September 2014 to review board members attendance. By-laws for the Center's administrative board state in part, "Board members shall attend at least 75% of meetings during 12 previous consecutive months of service, serve on committees, appointed by the Chairperson and fulfill other specialized functions as appointed by the Chairperson". By-laws also state that the board shall hold meetings every other month. Seven (50%) of the fourteen board members did not meet the 75% attendance standard. Three of the seven board members attended five of seven meeting (71.4%) which is just below the 75% standard. In our opinion management should consider revising the attendance standard because more than one absence by a board member is below the standard considering the number of meetings held annually.

We recommend that management consider revising the board by-laws to make the attendance standard for board meetings more attainable.

MANAGEMENT RESPONSE:

On February 18, 2015 the Interim Director spoke with Coastal Empire CMHC Board Chair regarding the 2014 audit finding. The Board Chair has agreed to discuss attendance with all board members at the next board meeting on March 19, 2015. The board will provide us with the specific steps they need to take to increase attendance. If revisions of the by-laws are determined, change will be made according to the by-laws.

Coastal Empire Community Mental Health Center
Management Response and Monitoring

Audit Finding Area	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
ACCOUNT RECEIVABLE BILLING						
Follow DoFS Policy for Self-Pay Clients Fee Reductions (Repeat)	Correct and update all missing Financial review documents. Monitor using the EMR Consent report.	15-Apr-15	Pam Sullivan			Improve the efficiency of the Financial review process. Train support staff and implement.
CONTRACT ADMINISTRATION						
Complete Financial Assessments to Justify Homeshare Clients' Minimum Stipend Payments	C125 forms have been completed for all Homeshare clients. They will be uploaded by March 1, 2015.	1-Mar-15	Jerry Stewart			The ED will review and provide justification documents when necessary.
ADMINISTRATION						
Consider Revising the Board By-laws to Make the Attendance Standard More Attainable	The Board will discuss attendence and by-laws at the next March 19, 2015 meeting	19-Mar-15	Andrea Allen for the interim, then the new ED			If revisions of the by-laws are determined, change will be made according to the by-laws.

EXHIBIT 1

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH HOMESHARE MANUAL	POLICY: STIPENDS	
PROCEDURE: PROCESSING A STIPEND	DATE EFFECTIVE: September 12, 2013	NUMBER: 11-13
PREPARED BY: TLC COMMITTEE		Page 1 of 4 including 2 attachments

You will want to talk to your business office before you start the program to inform them about the program, the application fee outlined in policy 11-02, and below process. You will be sending your SCDMH Invoices to them and you want them to process the invoices correctly.

Providers are reimbursed for daily living expenses for the client placed in the home. A stipend cannot be paid until the Material Management Office (MMO) has awarded a contract meaning that the following activity has also occurred: Homeshare Provider has been trained, home study accomplished, obtained the necessary background documentation from the provider, and the provider has been placed on the Qualified Provider List (QPL). The QPL is also maintained on the SCDMH Contracts website: http://dmhhome/divisions/contracts/qpl_homeshare.doc

There are two types of stipend payment: SCDMH and Client. If client is not in home for the entire month, divide stipend by number of days in the month to determine partial stipend payment using below methodology to calculate client and state portion. There may be one invoice identifying the type of payment, client, time period, and amount. Two copies of the invoice will be made to send to each payer source-circling amount to be paid. Programs may use an individual approach to managing invoice payment depending on local resources as long as provider receives payment for service rendered and documentation supports such.

To figure out the client portion of the payment, multiply the client's monthly income by .74. If the client has excessive medication expenses/medical expenses or the client has expenditures as part of the homeshare program i.e. pre-burial not exceeding $50.00 per month and based on client financial resources, subtract those expenses from the monthly income before calculating. Upon review of the Financial Assessment Form (C-215), the Executive Director or designee of the Executive Director needs to approve all extraordinary expenses that reduce the client portion of stipend as evidenced by signing and dating C-215 form. Clients' monthly income should be reviewed every year around February due to possible cost of living increase with SSI. The Executive Director has discretion to expand extraordinary expenses beyond above as appropriate.

Processing a stipend

1) The stipend invoice is completed and submitted to the staff within 5 working days prior to the end of each month. Remember to identify the funding source whether SCDMH or Client and type of service, to circle the SCDMH payment and total the amount at the bottom.
   Per individual Homeshare program procedure:
   - ▶ stipend invoices are completed, signed, and submitted to staff by
   - ▶ providers at monthly Network Meeting, OR;
   - ▶ stipend invoices are completed by staff, signed by providers at the

EXHIBIT 1
(Continued)

- monthly Network Meeting, and then processed by staff
- in the case of an unsigned stipend invoice the provider will be
- responsible to contact staff to arrange an alternate time to sign.

2) For client stipend, Homeshare staff will complete, verify and forward to client or appointed financial manager (representative payee, conservator, and/or guardian, etc) for payment.

3) For SCDMH stipend, the staff will verify and submit the stipend invoices to the center business office 3 days prior to the end of the month. The center business office will process and submit stipend invoices to the SCDMH business office by the 1st or 2nd of each month. SCDMH Accounts Payable Office forwards invoices to the Comptroller General's Office (CGO) who issues a "warrant number" under which each invoice will be paid by the State Treasurer.

4) SCDMH will retrieve the checks from the CGO's to separate and mail to providers. Providers will receive their stipend payment approximately 4 to 6 weeks from the date SCDMH receives the stipend invoices from the center business office.

5) Circumstances that impact the timely processing and payment of stipend invoices:

- stipend invoice completion errors
- provider's failure to sign their invoice in a timely manner
- no contract filed with SCDMH contracts division
- holidays that fall on a Monday or Friday
- illness, leave, or resignation of a staff involved in the processing
- end of fiscal year/closeout

Other Financial Resources Available: Case services

- an average of $50.00 per client, per month, will be allocated in the Homeshare budget to be used when no other resources are available to pay for necessary expenses. Allocation will cover necessary expenses not covered by the client's financial resources e.g., dental, vision, clothing, medications, other special services or personal health/hygiene needs.

sle/5/6/2004
update 6/17/04
11-13 STIPENDS
08/28/2013 4:23 PM

EXHIBIT 2

HOMESHARE
STIPEND SCALE EXAMPLE

The stipend scale is based on the clients' reasonable ability to pay at the pro-rated amount of $372.00 or 74 percent of monthly income. Level of income will be based on financial resources, recurring medication expenses and/or specialized one-time needs to support future independence. Extraordinary expenses, also called non-discretionary expenses, are expenses that are due to circumstances beyond a client's control or expenses as part of being a homeshare participant. Below is an example of what you might expect to pay based on sample income.

Income	Client Stipend	SCDMHC Stipend
$500	$372	$967
$525	$389	$950
$550	$407	$932
$575	$426	$913
$600	$444	$895
$625	$463	$876
$650	$481	$858
$675	$500	$839
$700	$518	$821
$725	$537	$802
$750	$555	$784
$775	$574	$765
$800	$592	$747
$825	$611	$728
$850	$629	$710
$875	$648	$691
$900	$666	$673
$925	$685	$654
$950	$703	$636
$975	$722	$617
$1,000	$740	$599
$1,025	$759	$580
$1,050	$777	$562
$1,075	$796	$543
$1,100	$814	$525
$1,125	$833	$506
$1,150	$851	$488
$1,175	$870	$469
$1,200	$888	$451
$1,225	$907	$432
$1,250	$925	$414
$1,275	$944	$395
$1,300	$962	$377
$1,325	$981	$358
$1,350	$999	$340
$1,375	$1,018	$321
$1,400	$1,036	$303

EXHIBIT 2
(Continued)

$1,425	$1,055	$284
$1,450	$1,073	$266
$1,475	$1,092	$247
$1,500	$1,110	$229
$1,525	$1,129	$210
$1,550	$1,147	$192
$1,575	$1,166	$173
$1,600	$1,184	$155
$1,625	$1,203	$136
$1,650	$1,221	$118
$1,675	$1,240	$99
$1,700	$1,258	$81
$1,725	$1,277	$62
$1,750 and over	$1,339	$0

Above is an example of stipend payment. To figure out the client portion of the payment, multiply the client's monthly income by .74. If the client has excessive medication expenses/medical expenses or the client has expenditures as part of the homeshare program i.e. pre-burial not exceeding $50.00 per month and based on client financial resources, subtract those expenses from the monthly income before calculating. Upon review of the Financial Assessment Form (C-215), the Executive Director or designee of the Executive Director needs to approve all extraordinary expenses that reduce the client portion of stipend as evidenced by signing and dating C-215 form. Clients' monthly income should be reviewed every year around February due to possible cost of living increase with SSI. The Executive Director has discretion to expand extraordinary expenses beyond above as appropriate

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

Review of Selected Activities of Pee Dee Mental Health Center

July 8, 2015

DMH South Carolina Department of Mental Health

State of South Carolina
Department of Mental Health

2414 Bull Street•P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

John H. Magill
State Director of Mental Health

Memorandum

DATE: July 8, 2015

TO: Patrick M. Bresnan, MBA
Executive Director
Pee Dee Mental Health Center

FROM: Bryant Collins, CGAP, Senior Auditor BC
SCDMH Office of Internal Audit

RE: Review of Selected Activities for
Pee Dee Mental Health Center

BACKGROUND

The Pee Dee Mental Health Center serves approximately 5,750 clients for Florence, Darlington, and Marion counties. The annual budget is approximately $9.2 million. There are 136 individuals employed at the Center. The Center's last Internal Audit report was issued by our office on October 21, 2010.

AUDIT SCOPE

Our audit of the Center was conducted in accordance with the standard internal auditing procedures for community mental health centers. The scope included a review of selected activities for billing/accounts receivable, cash operations, accounts payable, computer services, and other general administrative activities we deemed appropriate. Our review consisted primarily of testing by sampling records to determine their reliability and the soundness of the Center's internal control procedures. In addition to testing and sampling records, we held discussions with the Center's staff and management to obtain an understanding of the control procedures.

FINDINGS & RECOMMENDATIONS

Our attached audit report contains findings and recommendations which should assist in strengthening internal controls and operational compliance. **The Center's only repeat finding was "Consider Reducing the Amount of Petty Cash on Hand". In their response management decided not to make any changes to the amount of petty cash available at this time.** We sincerely thank all employees of the Pee Dee Mental Health Center for their cooperation, time and assistance during the audit.

Cc: Audit Committee Members
John Magill
Geoff Mason
Mark Binkley
David Schaefer
Mallory Miller
Dr. Gregory V. Browning, Board Chair

PEE DEE
MENTAL HEALTH CENTER
AUDIT REPORT

Billing and Accounts Receivable

Follow DoFS Policy for Self-Pay Fee Reductions

As of April 2015 the Center had 230 clients who were receiving a reduction of their self-pay balances. We examined records for sixteen non-Medicaid self-pay clients who receive fee reductions ranging from 70% to 99%. The following problems were noted:

- Current Determination of Ability to Pay Reduction forms for five clients (31.25%) were not found in the SCDMH Electronic Medical Record (EMR). These forms should be updated annually because financial statuses of clients receiving reductions are always subject to change. Additionally, one of these clients did not have proof of income in the EMR.

- Supporting documentation to justify incomes was not found for five clients (31.25%) in the EMR. In some instances clients received two sources of income, but only one income source was located.

We recommend that the Center's intake personnel carefully follow DoFS policy and procedure 3.3 regarding documentation requirements for clients who receive self-pay fee reductions.

MANAGEMENT RESPONSE:

Staff have reviewed and will adhere to DOFS Policies 3.1, 3.2, and 3.3. Training on the policies will be on-going through various venues, i.e. staff development and FOCUS (administrative newsletter). Reports have been developed as a tickler and will be emailed to front office staff (no less than monthly) to advise of financial reviews due and past due. A generic note will be generated to document those clients who refuse to bring in proof of income supporting documentation.

Ensure Clients' Income Documents are Placed in the EMR in a Timely Manner

After notifying management of deficiencies found during our examination of self-pay clients with reductions, some missing clients' documents were promptly placed into the EMR.

We recommend that the Center's intake personnel place clients' documents into EMR in a timely manner.

MANAGEMENT RESPONSE:

Center's front office staff will place clients' documents into EMR in a timely manner. Front office staff will review and adhere to DOFS Policy 3.3. Proof of income from all payer sources will be scanned into EMR timely. Clinic Directors will spot check for documents during monthly audits of client records.

Contract Administration

Use Clients' 2015 Incomes to Calculate Their Portion of the Monthly Homeshare Provider Stipend Payments

Six Homeshare Provider contracts were included in our audit sample of contracts. While examining provider stipend payments for the calendar year, we noticed that clients' portion of monthly payments were incorrect according to totals on invoices in the SCEIS Accounting System. The majority of Homeshare clients' incomes are obtained via Social Security benefits or Supplemental Security Income (SSI). Documents in the EMR consisted of clients' Cost of Living Adjustment (COLA) for 2015 along with their new incomes; however 2014 incomes were used to make monthly calculations on providers' invoices. For audit purposes, we expanded our examination of payments to all active Homeshare Provider contracts (26) at the Center. Our examination of additional invoices revealed that 2014 incomes were used to calculate all clients' payments as of May 31, 2015.

We recommend that Center personnel use Homeshare clients' 2015 incomes to calculate their portion of monthly Homeshare Providers' stipend payments.

MANAGEMENT RESPONSE:

Pee Dee Mental Health has established a new document which will be completed annually that requires the current income for the client be provided to accurately calculate the client's portion of the Homeshare Providers stipend payment. Accounts Payable will not process payments to any Homeshare providers without the new document being completed, and will review the information provided on the form to ensure the accurate income is recorded for the client. In addition to the form, it is also required that the clinician provide a copy of the clients Social Security Income data information to ensure the income notated on the document is associated for the current year. Accounts Payable will follow up with any clinician if the document and Social Security Income data sheet is not provided annually as required prior to remitting payment.

Cash

Consider Reducing the Amount of Petty Cash on Hand (Repeat 2010)

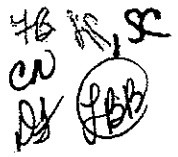
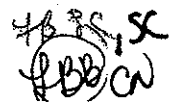
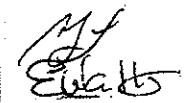
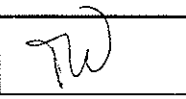
The Center has a total of $500 for petty cash and change funds at its main office and satellite offices. Center management has allocated $350 for petty cash purchases and $150 for five change funds. We examined petty cash transactions from July 2012 to April 14, 2015. Only six petty cash transactions were made during this time period. Purchases ranged from $14.96 to $163.13 with an average purchase of $47.85.

We continue to recommend that Center management consider reducing petty cash on hand.

MANAGEMENT RESPONSE:

At this time, Pee Dee Mental Health will not be making any changes to the value of funding identified for Petty Cash. Pee Dee Mental Health will continue to review the necessity of Petty Cash fund on an annual basis and make any adjustments deemed necessary at that time.

Pee Dee Mental Health Center
Management Response and Monitoring

Audit Finding Area	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
BILLING AND ACCOUNTS RECEIVABLE						
Follow DoFS Policy for Self-Pay Fee Reductions	Staff have reviewed and adhere to DOFS Policies 3.1, 3.2, 3.3. Training on the policies will be on-going through various venues, i.e. staff development and FOCUS (administrative newsletter).	6.30.15	Christie Nowlin, Sharon Montgomery, Faye Barnes, Leesa Campbell, Linda Brigman and Debra Floyd		6.30.15	Reports have been developed as a tickler and will be emailed to front office staff (no less than monthly) to advise of financial reviews due and past due. A generic note will be generated to document those clients who refuse to bring in proof of income.
Ensure clients' income documents are placed in the EMR in a timely manner	Center's front office staff will place clients' documents into EMR in a timely manner. Front office staff will review and adhere to DOFS Policy 3.3.	6.30.15	Christie Nowlin, Sharon Montgomery, Faye Barnes, Leesa Campbell, Linda Brigman		6.30.15	Proof of income from all payor sources will be scanned into EMR timely. Center Directors will spot check for documents during monthly audits of client records.
CONTRACT ADMINISTRATION						
Use clients' incomes to calculate their portion of monthly Homeshare Provider stipend payments	**Create new income verfication document**	**6.30.2015**	**Cathy Timmons and Edith Watts**		**6.30.2015**	**New document has been established requiring clinicians to provide current year income to determine clients portion of Homeshare expense.**
CASH						
Consider reducing the amount of petty cash on hand (Repeat 2010)	**None**	7.1.2015	Teresa Wilson		7.1.2015	Center will continue to review necessity of Petty Cash annually.

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

Review of Selected Areas of

G. Werber Bryan Psychiatric Hospital

February 29, 2016

DMH South Carolina Department of Mental Health

State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:

Alison Y. Evans, PsyD, Chair
Joan Moore, Vice Chair
Beverly Cardwell
Bob Hiott, MEd
Everard Rutledge, PhD
J. Buxton Terry
Sharon L. Wilson

2414 Bull Street•P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

John H. Magill
State Director of Mental Health

Memorandum

DATE: February 29, 2016

TO: Versie J. Bellamy, RN, MN
Deputy Director of Division of Inpatient Services

Stuart J. Shields, MSW, MHA
Director of G. Werber Bryan Psychiatric Hospital Adult/Forensic

FROM: Amanda Henry, Audit Manager I
SCDMH Office of Internal Audit

RE: Review of Selected Areas of
G. Werber Bryan Psychiatric Hospital

BACKGROUND

Within the Division of Inpatient Services (DIS) is G. Werber Bryan Psychiatric Hospital (BPH). BPH provides care and services to the acute and non-acute adult inpatient population. The Acute Adult division of BPH maintains a budget of approximately $29 million and has approximately 450 employees. The last audit of BPH was performed in 2010.

AUDIT SCOPE

The scope of the audit included review of fixed assets, staff scheduling, overtime analysis, personnel and other areas. We also interviewed management and staff of the hospital to gain an understanding of their responsibilities and processes within those areas.

SUMMARY

Findings with recommendations are documented in the attached audit report. Several concerns were noted with inventory of major moveable equipment, storage of surplus property and office papers. Additional concerns were also noted in the area of staff scheduling particular with the use of the obsolete scheduling system. We sincerely thank the management and staff for their cooperation, time and assistance during the audit.

cc.
Audit Committee
John Magill
Mark Binkley
Dave Schaefer
Doug Glover

G.Werber Bryan Psychiatric Hospital (BPH)

Review of Selected Activities

I. FIXED ASSETS

Annually Perform Inventory of Major Moveable Equipment

The last annual inventory of BPH major moveable equipment was completed by DoFS (Division of Financial Services) in April, 2009. According to the DoFS Fiscal Analyst who is responsible for performing the annual inventories, repeated requests had been made to Division of Inpatient Services (DIS) Materials Management division to perform the inventories but the requests were delayed due to various reasons. After Internal Audit's request for the inventory report, an inventory was then performed in June 2015.

The following are findings from the June 2015 inventory of 324 items totaling $777,821 at BPH.

- Thirty-nine (12%) items with a total cost $113,859 could not be found; cost of the items ranged from a high of $36,554 to a low of $1,007; acquisition years for items were from 1997 to 2015.
- Thirteen (33%) of the 39 missing items were computers; eight were laptops. acquired in years 2002 through 2013.

In addition to the missing items, Audit also noted that 55 acquired items on a July 2015 BPH inventory list generated by DoFS, had been assigned fixed asset decals but had not been assigned a location. Further inquiry by Audit determined that the location assignment had not been made because the necessary paperwork had not been received by DoFS from BPH. Two of the 55 items were acquired in 2013, one in 2014 and the remaining in 2015.

Update

Since the June inventory, one of the missing laptops has been located; however, nineteen (49%) of the 39 missing items have not been located. According to DIS-IT manager the item costing $36,554 was a security switch and was returned to the vendor and swapped out for another switch; however, no documentation was completed.

Recommendation

We recommend that management ensure that annually inventory of major moveable equipment is performed. Decals should be timely affixed to acquired assets and DoFS provided with the necessary paperwork.

Proper documentation should be submitted to DoFS concerning the location of the missing items found. Also, for missing items that cannot be found submit documentation with proper approvals for removal from the inventory list. If it is determined that the missing laptops and computers are due to theft, Public Safety should be contacted. Due to the potential of a privacy violation, the DIS Privacy Officer should also be notified.

MANAGEMENT RESPONSE

BPH Management will work closely with the DIS Materials Management Division and DoFS to ensure that annually inventory of major moveable equipment is performed and decals are timely affix to acquired assets. Continued research will occur in all storage areas to locate all items and proper documentation will be submitted for items that cannot be found so that they can be removed from the inventory. This process will be ongoing as we go through all of our storage locations one building at a time. If needed, Pubic Safety will be involved and the DIS Privacy Officer will be notified.

Remove and Properly Dispose of Items in the Fisher Auditorium, Shand and Davis Buildings and Cease Using Those Buildings for Storage

Internal audit became aware that decaled surplus property and other obsolete items belonging to BPH and other DIS facilities are being kept in the Fisher Auditorium, Shand and Davis buildings on the Crafts Farrow Campus. The following items were found in the auditorium.

Fisher Auditorium

- 170 computers
- 11 Ethernet Switch
- 1 Nortel WLAN Security Switch
- 30 leased copiers

Other items including microwaves, refrigerators, dryers, televisions, furniture, desks, chairs, beds, medical equipment, etc. were also found.

DIS-IT management stated that they were not aware that the computers were being stored in the auditorium.

Also, per the DMH Procurement personnel all copiers used by the agency are leased under a state contract for five years. Once the lease expires copiers are to be picked up by the vendor.

Shand and Davis Buildings

Numerous obsolete items such as hospital beds, file cabinets, desks, chairs and other furniture were found in both the Shand and Davis buildings.

Note: Due to the poor conditions of the buildings, items were only observed and not inventoried by Audit.

Recommendations

Management should remove and properly dispose of all items stored in these buildings and cease using these buildings as storage facilities. Contact vendors for removal of the leased copiers. DIS policy number LD 3 should be reviewed by management and appropriate personnel trained on proper accountability of state property.

MANAGEMENT RESPONSE

Management is in agreement that all appropriate DIS property stored in the Fisher Auditorium and the Shand and Davis buildings should be removed. In preparation to remove these items, a request will be submitted to the Department of Corrections to acquire a labor force; a request will be submitted to the Fixed Asset Management Section, Division of Financial Services to remove decaled items from the inventory that cannot be located; and a request will be submitted to the State Surplus Office to remove items in the building. Coordination will be made with Physical Plant Services to locate a dumpster near these buildings to dispose of all items not removed by State Surplus.

The projected completion date to have all items removed from the Fisher Auditorium is October 31, 2016. The projected date to have all items removed from the Shand Building is March 31, 2017. The projected date to have all items

removed from the Davis Building will be dependent on the approval of a Comprehensive Property Improvement Plan (CPIP) that will be submitted by February 10, 2017, which will be in line with the next submission cycle to build a storage facility to meet regulatory storage requirements for paper records and to store mission essential property.

DIS policy number LD 3 will be reviewed by management and appropriate personnel by March 31, 2016.

Remove and Properly Dispose or Store the Contents of the Boxes in the Barn-like Storage Building and Cease Using the Building for Storage

We examined a deteriorating "barn-like" storage building on the grounds of BPH. The building maintains a dirt floor and was close to full capacity with storage boxes containing papers from offices within BPH and possibly other DIS facilities. Due to the condition of this building only one box was opened by Audit and partially inspected. We found office letters with Personal Identification Information (PII) in the box.

Recommendation

Management should remove and properly dispose or store contents of boxes and cease using the building for storage. DIS Privacy Officer should be contacted concerning potential privacy and security concerns.

Office papers should be managed and properly destroyed by individual locations within BPH and other DIS facilities. Papers with PII should be shredded when no longer needed. Management should review with staff the proper management, storage and disposal of papers with private information. In addition, all BPH employees should obtain training or be re-trained on Privacy and Security requirements of PII and PHI.

MANAGEMENT RESPONSE

Management is in agreement that all boxes and property stored in the Barn-like Storage Building will be removed. In coordination with the DIS Privacy Officer and BPH staff, all appropriate paperwork will be shredded and records requiring continued storage will be temporarily relocated to the Davis Building pending the approval and construction of a storage building for DIS facilities. In preparation to remove these items, a request will be submitted to the Department of Corrections to acquire a labor force; a request will be submitted to the Fixed Asset

Management Section, Division of Financial Services to remove decaled items from the inventory that cannot be located; and a request will be submitted to the State Surplus Office to remove items in the building. Coordination will be made with Physical Plant Services to locate a dumpster near this building to dispose of all items not removed by State Surplus.

The projected completion date to have all items removed from the Barn-like Storage Building is June 30, 2016.

II. STAFF SCHEDULING

Consider Purchasing a New Scheduling System

The scheduling system currently being used is Res-Q Labor Management version 10.05.94. This system is over 20 years old and obsolete. The system is very labor intensive and data is manually input from paper sources. Certain reports to manage labor resources cannot be generated.

Recommendation

To efficiently and effectively manage staffing needs, maximize productivity and reduce cost which ultimately equates to better patient care, we recommend a new scheduling system be purchased. Consideration should also be given to the possibility of integration with the Time Management module of SCEIS.

MANAGEMENT RESPONSE

Management is in agreement that a new system is needed to replace Res-Q. Funding was requested and approved for FY 16 to procure a new system in DIS. The target date for implementation is 6-30-16.

Timely and Accurately Complete Staffing Summary Schedules

The DIS 4 Week Summary Schedules of staff for all lodges at BPH were reviewed for weeks 7/19 – 8/15/15 and 8/16 – 9/12/15. The schedules were reviewed for proper completion and timeliness of submission to DIS Central Timekeeping. The schedules are used by timekeeping as an input document and information is keyed into SCEIS for the scheduling of BPH staffs' work time or time off. The following errors were noted.

- Schedules are late coming into timekeeping
- BPH employees are listed but no time is scheduled

- BPH employees are listed with incomplete schedules
- No indication that some employees listed are Temporary or Agency employees
- Too many or too few "U" days are recorded (U days are scheduled days off)
- "U" day scheduled on a holiday

Because of the numerous errors occurring, timekeeping personnel consistently send numerous emails or make phone calls to staffing personnel who in turn request the corrections from nursing management.

Recommendation

We recommend that the Summary Schedules be timely and properly completed. Schedules received by timekeeping should have minimal errors.

MANAGEMENT RESPONSE

Management is in agreement that schedules need to be timely and properly completed. The new time, attendance and staff scheduling system has multiple tools to automate scheduling and eliminate errors. These include staffing templates, tracking of agency and contract staff, an interface to SCEIS, staff self-scheduling, real-time data reporting, and administrative rules which catch errors and enforce staffing policies (e.g., scheduling a "U" day on a holiday).

III. OVERTIME ANALYSIS

Consider Possible Improvements from Data Analysis of Behavioral Health Assistants Overtime

Reports from SCEIS were obtained which listed all BPH employees and their overtime hours worked and paid in calendar year 2014 and from January 1 through June 30, 2015. From the 2014 SCEIS report a sample of 25 Behavioral Health Assistants (BHA) who had the highest number of overtime hours worked in that calendar year (CY) were selected for documentation review. The sample included BHA A, B and C. No major errors were noted in the review of the overtime documentation and approvals.

The overtime hours from the SCEIS reports as well as other data acquired from the Res-Q scheduling system for the same time periods were analyzed. The following was concluded:

Per SCEIS data:

- Total overtime hours for 2014 were 18,162

- Total overtime hours for January through June 30, 2015 were 7,374
- Overtime hours worked per employee for 2014 ranged from 442 to 1196 with corresponding overtime pay from $8,582 to $23,296
- 12 of the 25 (48%) received in addition to their 2014 annual salary, overtime pay which equated to over 50% of their annual salary
- Most of the employees who worked the majority of overtime hours in 2014 were continuing to work the majority of overtime hours in 2015
- Most overtime hours are worked by BHA – C; 18 of 25 or 72%

NOTE: 3 of the 25 employees who worked overtime did not have a current EPMS

Per Res-Q data:

- Most overtime hours are worked during the evening and night shifts
- Majority of evening overtime hours were worked on Lodge B
- Majority of overtime worked was performed on the same lodge that the employee was assigned to for regular work
- Total of overtime hours per Res-Q does not equal overtime hours per SCEIS. No reconciliation of hours is performed.

Possible improvements derived from analysis:

1. Consider placing a cap on the total overtime pay. For example no more than 50% of pay can come from overtime hours worked.
2. Consider hiring additional permanent employees for evening shift on lodge B.
3. Reconcile overtime hours on Res-Q to SCEIS overtime hours.
4. Require management to maintain a current EPMS on all employees who work overtime. Complete an evaluation for employees who do not have a current one.

MANAGEMENT RESPONSE

Management is in agreement that BHA overtime improvements can be made with the use of data analysis.

1. The new time and attendance and staff scheduling system scheduled will limit OT use via administrative rules set up in the system. Managers will also have the ability to monitor OT hours and costs in real-time and adjust staffing as needed.

2. The system will optimize staffing for lodges based on definable variables, such as patient acuity, staff availability, current OT status, etc.

3. Res-Q will be replaced with a new time and attendance and staff scheduling system. It will eliminate the need to manually reconcile hand-written timesheets since hours will be captured by electronic timeclocks.

4. EPMS' for employees will be completed by 3/31/2016.

IV. PERSONNEL

Review Non-Exempt Classification of Nursing Staff

The jobs of the nursing staff at BPH are governed by the Fair Labor Standards Act (FLSA); a federal law which determines overtime pay eligibility. The exemption status of most of the nursing staff at BPH is "non-exempt" and therefore is eligible and due to receive overtime pay. However, in reviewing the requirements for determining the exemption status, it appears that their status may be considered exempt and would therefore be ineligible for overtime pay. Per FLSA an exempt employee must meet the following three tests:

1. Paid at least $23,600 per year (or $455 per week)
2. Paid on a salary basis
3. Performs exempt job duties

The first two tests have been met. The third test "performs exempt job duties" requires the employees to have specialized education and to use discretion and judgment while performing their work.

Recommendation

Management should meet with Human Resources and review the exemption status of the nursing staff to determine if it should be changed based on job duties performed.

MANAGEMENT RESPONSE

After review of the exemption status of nursing staff, it is determined that nursing categories to include; Directors of Nursing, Assistant Directors of Nursing, Unit/Lodge Nurse Managers will be considered "exempt" due to the level of their administrative job duties. At this time, all other nursing staff will remain in "non-exempt" status as their duties require overtime to support licensing, regulatory, accreditation and patient care requirements.

Update the Organization Unit Record in SCEIS

Changes occurred in the lettering of BPH lodges in January, 2015. BPH Lodge E was changed to F, D to G and C to H. The organizational record in SCEIS for BPH employees also contains the letter of the lodge. This record identifies where an employee primarily works and is integrated with other SCEIS functions such as time management, payroll and personnel administration.

Recommendation

We recommend that the records in SCEIS be updated to reflect the changes made in January, 2015.

MANAGEMENT RESPONSE

The Division of Inpatient Services Human Resource Department will submit the appropriate actions to the DMH Central Human Resource Department. The DMH Human Resource Department will update SCEIS to reflect the changes by the target date.

Consider Utilizing the Electronic Time and Attendance Capabilities in SCEIS

The time and leave management module in SCEIS includes electronic time and leave recording and should be used by all DMH employees. At present this module is not being fully utilized with BPH employees and others at facilities within DIS. Currently recording and approval of leave is a manual paper driven process which requires leave data to be input into SCEIS by DIS Central Timekeeping.

Recommendation

We recommend utilizing the time and leave management module in SCEIS. In utilizing the module, manual processing would be eliminated resulting in data accuracy and efficiencies in time and reporting.

MANAGEMENT RESPONSE

For services that provide 24 hour coverage, weekend coverage, extended hour shifts (i.e. Nursing Services, Environmental Services, Nutritional Services, Admissions, OD/ON); we do not recommend utilization of the SCEIS portal. At this time, shift changes, overtime hours, and dual employment records require input by a Time Administrator.

Currently the SCEIS Leave Management Module is partially utilized by DIS Central Timekeeping. Utilization of the SCEIS Leave Management Module would be beneficial for other disciplines where employees work routine schedules (Monday – Friday and observed holidays). It is recommended that Timekeeping and Human Resources begin utilizing this module with other disciplines following the development of a timeline and training.

Timely Complete EPMS Planning Stages and Annual Reviews

A sample of twenty personnel field folders were reviewed for completion and proper documentation of Employment Performance Management System (EPMS) annual reviews and planning stages. The following was noted.

- Annual reviews were not completed for 12 of the 20 (60%)
- Planning stages were not completed for 3 of the 20 (15%)

A SCEIS report listing all Bryan Patrick Hospital (BPH) employees, their last annual review date and evaluation rating was reviewed as of June 30, 2015. The following was noted:

- 30 of approximately 400 (8%) employees maintain a default evaluation rating Default evaluation ratings are automatically assigned to an employee when a supervisor fails to complete an evaluation by an employee's review date.

- Approximately 260 of the 400 (65%) employees' last annual review date indicated that their performance evaluations had not been completed timely. The last annual review date ranged from May 2010 through June 2015.

BPH management is notified monthly by Division of Inpatient Services (DIS) Human Resources (HR) of annual reviews that are due. DIS HR sends monthly notifications starting 90 days prior to the date the evaluation is to be completed.

Recommendation

BPH management should ensure annual reviews and planning stages are completed timely. It is important that employees understand their job responsibilities and are given on-going, objective feedback concerning their job performance.

Note: An audit of personnel field folders was performed in August 2015 by the DIS Quality Review Team. Deficits were noted with EPMS annual reviews and planning stages. For Bryan Adult, a total of 178 personnel field folders were reviewed. All sixteen folders reviewed for the medical staff were missing planning stages as well as

employee evaluations. Deficits were also noted with nursing staff (RN's, Nurse Managers and LPN's) and behavioral health assistants. DIS HR is assisting with correcting the deficits and a follow-up review is scheduled.

MANAGEMENT RESPONSE

DIS Human Resources will continue to distribute a monthly Excel EPMS report to the Bryan Psychiatric Hospital Facility Director. (The Excel report will now include a column indicating EPMS annual review ratings which have been received by the HR office and are complete.) DIS Human Resources will also continue to conduct routine auditing of Bryan Psychiatric Hospital employee field folders on a quarterly basis; providing results to the facility director. Two HR FTEs will continue to dedicate a portion of their job duties to the EPMS activities for Bryan Hospital to include management of submissions, tracking and reporting of EPMS activity/documentation for Bryan Psychiatric Hospital and as required by the DMH Human Resources office.

The Bryan Psychiatric Hospital will develop a facility tracking system for EPMS activity; utilizing the HR monthly report excel spreadsheet and designated support staff.

V. STATEMENT OF SERVICES RENDERED

Obtain Approval and Timely Submit Statement of Services Rendered Forms

The following was noted in the review of "Statement of Services Rendered "forms (F-163). These forms are used in documenting hours worked as an Officer of the Day and Night (OD/ON) and had been submitted to DIS Central Timekeeping for input into SCEIS for time worked.

- Most forms were not signed by an approving authority
- Forms are not being submitted timely – Example: Work completed from June – August, 2015 was submitted to timekeeping in October of 2015

Recommendation

We recommend that hours worked as an OD/ON be approved and submitted weekly to timekeeping.

MANAGEMENT RESPONSE

In November 2015, the process for approving and submitting the statement of services rendered changed but was not fully implemented until January 2016. Forms are now submitted weekly, signed by the medical director and submitted to DIS Central Timekeeping timely.

VI. PROCUREMENT

Monitor Procurement Card Statements to Ensure all Cardholders do not Exceed Their Monthly Spending Limit

We reviewed procurement card monthly statements for fiscal year 2015 for BPH cardholders. Cardholders are responsible for purchases at BPH and other DIS facilities. One instance in which a cardholder exceeded their monthly spending limit of $5,000 by $646.41 was found. This is a violation of DoFS procurement card policy #12.3 and should have been discovered by the procurement card liaison during their monthly reconcilements and reported to the Procurement Card Administrator.

Recommendation

Procurement card purchases should be carefully monitored to ensure all cardholders do not exceed their monthly spending limit. Exceptions should be reported to the Procurement Card Administrator.

MANAGEMENT RESPONSE

The one instance in fiscal year 2015 where a cardholder exceeded his monthly limit of $5,000 by $646.41 has been corrected as of 12/27/14 - 01/27/15 closing period. A software update in May 2015 allows the credit card liaison to monitor cardholders' balances on a daily basis to prevent the cardholder from exceeding their monthly limit. Purchases attempted above the daily limit will be declined.

VII. INFORMATION TECHNOLOGY

Timely Remove Terminated Employees Access to Information Systems

Access controls of information systems for BPH personnel were reviewed. Active user lists for the systems were obtained and compared to the payroll register of terminated employees. The following numbers of terminated employees maintain active user IDs.

- 2 - Network
- 16 - Avatar
- 3 - CIS
- 1 - Res-Q

Recommendation

Management should review all user IDs and ensure that only current employees have access to information systems. Terminated employees' access should be timely removed.

MANAGEMENT RESPONSE

Effective immediately, BPH supervisors will e-mail the DIS Help Desk when an employee separates from the facility. Upon receipt of the e-mail, DIS IT will immediately remove access to the network and subsequently notify the DIS Central Nurse Staffing Section to remove employees from Res-Q and SCDMH Central IT if a DP65 Form has been attached requesting an employee be removed from Avatar and CIS. DIS IT will routinely reconcile termination requests against termination reports.

G. Werber Psychiatric Hospital
Management's Response and Action Plan

Audit Finding	Action to Take	Date of Action	Individual Completing	Initials	Target Checked/Tested	Comments
Annually Perform Inventory of Major Moveable Equipment	Continue to work toward locating all items and submitting proper documentation to have items not located removed from inventory. If determined that missing laptops and computers are due to theft, PSO will be involved. Due to the potential of a privacy Notify DIS Privacy Officer	3/7/2016	Doug Glover & Frank Johnson		4/29/2016	
Remove and Properly Dispose of Items in the Fisher Auditorium, Shand and Davis Buildings and Cease Using Those Buildings for Storage	Obtain labor from the Department of Corrections; submit request to remove and dispose of items; Fisher Auditorium projected 10/31/16; and Shand, 3/31/17. Davis Building will be contigent on the approval of a CPIP that will be submitted by 2/10/2017.	3/7/2016	Doug Glover		Fisher Auditorium - 10/31/16; Shand - 3/31/17; Davis - 6/30/19	

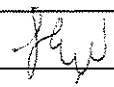
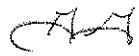
G. Werber Psychiatric Hospital
Management's Response and Action Plan

Audit Finding	Action to Take	Date of Action	Individual Completing	Initials	Target Checked/Tested	Comments
Remove and Properly Dispose or Store the Contents of the Boxes in the Barn-like Storage Building and Cease Using the Building for Storage	Arrange a meeting with appropriate BPH, Morris Village, and Crafts Farrow nursing staff to plan for removal and disposal of items. Shred all appropriate paperwork; relocate records requiring continued storage temporarily to Davis Building.	3/7/2016	Doug Glover & Frank Johnson		6/30/2016	
Consider Purchasing a New Scheduling System	Funding was approved FY 16 in to procure a new scheduling system.	6/30/2016	Mesa Foard & Patricia Handley		6/30/2016	
Timely and Accurately Complete Staffing Summary Schedules	The new time and attendance and staff scheduling system will address the timely and accurate completion of staffing summary schedules.	6/30/2016	Mesa Foard & Patricia Handley		6/30/2016	
Consider Possible Improvements from Data Analysis of Behavioral Health Specialists Overtime	The new time and attendance and staff scheduling system will limit OT use via administrative rules set up in the system. Managers will also have the ability to monitor OT hours and costs in real-time and adjust staffing as needed.	6/30/2016	Mesa Foard & Patricia Handley		6/30/2016	

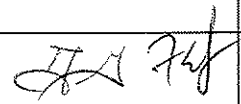
G. Werber Psychiatric Hospital
Management's Response and Action Plan

Audit Finding	Action to Take	Date of Action	Individual Completing	Initials	Target Checked/Tested	Comments
Review Non-Exempt Classification of Nursing Staff	It is determined that nursing categories to include: Directors of Nursing, Assistant Directors of Nursing, Unit/Lodge Nurse Managers will be considered "exempt" due to the level of their administrative job duties.	6/17/2016	Irene Thornley & Patricia Handley		6/17/2016	
Update the Organization Unit Record in SCEIS	DIS HR will submit the appropriate actions to DMH Central HR. DMH HR will update SCEIS to reflect the changes.	6/17/2016	Irene Thornley		6/17/2016	
Consider Utilizing the Electronic Time and Attendance Capabilities in SCEIS	Implement process for employees who work routine schedules (Monday-Friday and observed holiday). Train staff on use of the system.	7/16/2016	Irene Thornley & Roberta Richards		7/16/2016	

G. Werber Psychiatric Hospital
Management's Response and Action Plan

Audit Finding	Action to Take	Date of Action	Individual Completing	Initials	Target Checked/Tested	Comments
Timely Complete EPMS Planning Stages and Annual Reviews	DIS HR will continue to distribute a monthly Excel EPMS report to BPH Director. DIS HR will continue to to conduct roujtine auditing of BPH field folders on a quarterly basis. Two DIS HR FTEs will continue to dedicate a portion of their job duties t othe EPMS activites for BPH to include management of submissions, tracking and reporting of EPMS activity/documentatio n for BPH. BPH will develop a facility tracking system for EPMS.	6/30/2016	Irene Thornley & Stuart Shields		6/30/2016	
Obtain Approval and Timely Submit Statement of Services Rendered Forms	Corrected in January 2016	Jan-16	Lydia Weisser		Jan-16	
Monitor Procurement Card Statements to Ensure all Cardholders do not Exceed Their Monthly Spending Limit	A software update in May 2015 allows the credit card liaison to monitor cardholders' balances on a daily basis to prevent the cardhold from exceeding their monthly limit. Purchases attempted above the daily limit will be declined.	02/23/16	Doug Glover		02/23/16	

G. Werber Psychiatric Hospital
Management's Response and Action Plan

Audit Finding	Action to Take	Date of Action	Individual Completing	Initials	Target Checked/Tested	Comments
Timely Remove Terminated Employees Access to Information Systems	Inform BPH supervisors of the requirement to email DIS Help Desk when an employee separates from the hospital.	2/29/2016	Doug Glover & Frank Johnson		2/29/2016	

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

Review of Selected Activities of Catawba Community Mental Health Center

February 29, 2016

DMH South Carolina Department of Mental Health

State of South Carolina
Department of Mental Health

2414 Bull Street•P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

John H. Magill
State Director of Mental Health

Memorandum

DATE: February 29, 2016

TO: Paul J. Cornely, PhD, MPH
Executive Director
Catawba Community Mental Health Center

FROM: Bryant Collins, CGAP, Senior Auditor BC
SCDMH Office of Internal Audit

RE: Review of Selected Activities for
Catawba Community Mental Health Center

BACKGROUND

The Catawba Community Mental Health Center serves approximately 5,509 clients for Chester, Lancaster, and York counties. The annual budget is approximately $8.8 million. There are 109 individuals employed at the Center. The Center's last Internal Audit report was issued by our office on August 4, 2010.

AUDIT SCOPE

Our audit of the Center was conducted in accordance with the standard internal auditing procedures for community mental health centers. The scope included a review of selected activities for billing/accounts receivable, cash operations, accounts payable, computer services, and other general administrative activities we deemed appropriate. Our review consisted primarily of testing by sampling records to determine their reliability and the soundness of the Center's internal control procedures. In addition to testing and sampling records, we held discussions with the Center's staff and management to obtain an understanding of the control procedures.

FINDINGS & RECOMMENDATIONS

Our attached audit report contains findings and recommendations which should assist in strengthening internal controls and operational compliance. **The Center's only repeat finding was "Follow DoFS Policy for Self-Pay Clients Fee Reductions".** We sincerely thank all employees of the Catawba Community Mental Health Center for their cooperation, time and assistance during the audit.

Cc: Audit Committee Members
John Magill
Geoff Mason
Mark Binkley
David Schafer
Mallory Miller
Christopher T. Barton, Board Chair

AUDIT REPORT

CATAWBA COMMUNITY

MENTAL HEALTH CENTER

Billing and Accounts Receivable

Submit Outstanding Claims for Insurance and Medicaid in a Timely Manner

Aging Reports for Outstanding Claims Balances were generated from the Crystal Software for fiscal years 2014 and 2015. A summary of these reports were as follows:

FROM	TO	INSURANCE	MEDICAID	MEDICARE	OTHER
07/01/2013	06/30/2014	$12,973	$23,589	$ 486	0
07/01/2014	06/30/2015	22,462	26,469	1,418	0
Average	------	$17,718	$25,029	$ 952	0

Reports showed balances for insurance and Medicaid claims older than 360 days averaged $17,718 and $25,029 respectively for the last two fiscal years. Claims greater than one year are most likely uncollectible because of current filing requirements. At the Center we spoke to financial staff about these reports and we were informed that problems with the Client Information System, CIS, have not allowed them to bill and run monthly reports consistently to monitor outstanding claim balances particularly during the calendar year 2015.

We recommend that fiscal personnel at the Center submit outstanding claims for insurance and Medicaid in a timely manner due to filing requirements.

MANAGEMENT RESPONSE:

Our staff was behind in processing outstanding claims due to issues with CIS, ICD-A codes and Medicaid rejection code 953, which are rejections on dual eligible clients with Medicare. All issues have been addressed and staff will work the outstanding claims starting with the oldest claims first.

Follow DoFS Policy for Self-Pay Clients Fee Reductions (Repeat 2010)

As of November 17, 2015 the Center had 370 clients who were receiving a reduction of their self-pay balances. We examined records for sixteen non-Medicaid self-pay clients who receive fee reductions ranging from 40% to 99%. The following problems were noted:

- Current Determination of Ability to Pay Reduction forms for nine clients (56.25%) were not found in the SCDMH Electronic Medical Record (EMR). These forms should be updated annually because financial statuses of clients receiving reductions are always subject to change.

- Current proof of income was not located for one client (6.25%) in the EMR. Another client (6.25%) did not have acceptable proof of income documentation on file in the EMR.

- Income was not properly computed for six clients (37.5%) based on their proof of income in the EMR.

- Another report generated for the audit indicated that 54 of 370 clients (14.59%) clients receiving fee reductions in their self-pay balances had past due annual reviews. This was an improvement from the 2010 report when 22% of these clients had late reviews.

We recommend that Center personnel carefully follow DoFS policy and procedure 3.3 regarding documentation requirements and annual reviews for clients who receive self-pay fee reductions. We also recommend that intake personnel are properly trained to compute annual income from documents stated in DoFS policy 3.3.

MANAGEMENT RESPONSE:

Policy was sent out to all clinics to be reviewed. We will be providing additional training on the proper proof of income that can be used, and how to calculate the income based on that proof. We will be doing a self-audit for fee reductions twice a year instead of once a year. All intakes and annual reviews will be reviewed by the billing staff and those that have

reductions will require back up documentation for billing to review for accuracy.

Accounts Payable

Use the Standard Mileage Reimbursement Rate to Process Board Member's Travel Vouchers

In our initial sample review of accounts payable we examined travel vouchers for four of ten (40%) board members during fiscal year 2015. These vouchers pertained to mileage reimbursement for attending monthly board meetings. All four vouchers were processed using **four cents less than the standard mileage reimbursement rate.** To determine if this was coincidental, we examined eleven additional vouchers for mileage reimbursement to board members. These vouchers were for fiscal years 2013, 2014, and 2015. Ten of eleven vouchers, 90.9%, were processed using a mileage reimbursement rate **four cents less than standard rate**.

At the Center we questioned management about the mileage reimbursement rate for board members' travel. Management stated that they were following DoFS policy and procedure 11.3.2 which considers board members state employees for the purpose of filing for travel reimbursement. In conjunction with this policy, General Appropriations Act in Proviso 117.20J directs **a reimbursement rate of four cents per mile less than the standard business mileage rate when an employee chooses to use his or her personal vehicle when a motor pool vehicle is reasonably available.**

We discussed this issue with SCDMH Accounting Management after completing the audit field work. We both concurred that board members are not typical state employees since they do not have an option of selecting a vehicle from a motor pool like regular state employees.

In conclusion, we examined twenty-six vouchers for board members' mileage reimbursement at the other sixteen Community Mental Health Centers, CMHC's. Twenty-five, 96.15%, were processed using the standard mileage reimbursement rate.

We recommend that Center personnel use the standard mileage reimbursement rate to process board members' travel vouchers.

MANAGEMENT RESPONSE:

This action has been implemented as of January 2016.

Catawba Community Mental Health Center
Management Response and Monitoring

Audit Finding Area	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
BILLING AND ACCOUNTS RECEIVABLE						
Submit outstanding claims for for insurance and Medicaid in a timely manner due to filing requirements	Spoke to billing staff about processing claims and instructed them to start with the oldest claims first.	2/22/2016	Sandra Ramirez	SR	2/22/2016	Ongoing, monthly
Follow DoFS policy and procedure 3.3 regarding documentation requirements and annual reviews for clients who receive self-pay fee reductions (Repeat)	Policy was sent to the clinics for review. The reductions were removed on all clients with annual reviews past due. All intakes and annual reviews will be reviewed by the billing staff and those that have reductions will require back up documentation for billing to review for accuracy.	2/16/2016	Sandra Ramirez	SR	2/16/2016	
Properly train intake personnel to compute annual income from documents stated in DoFS policy and procedure 3.3 (Repeat)	**We will be providing additional training on the allowed documentation for proper proof of income, and how to calculate the income based on that proof**	5/31/2016	Sandra Ramirez			
ACCOUNTS PAYABLE						
Use the standard mileage reimbursement rate to process board members' travel vouchers	**Started using the standard rate in January 2016**	**1/27/2016**	**Sandra Ramirez**	SR	**1/27/2016**	**January Board mileage was paid at the standard rate**

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

Review of Selected Activities of Anderson-Oconee-Pickens Community Mental Health Center

August 26, 2016

DMH South Carolina Department of Mental Health

State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:

Alison Y. Evans, PsyD, Chair
Everard Rutledge, PhD, Vice Chair
Beverly Cardwell
Louise Haynes
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John H. Magill
State Director of Mental Health

Memorandum

DATE: August 26, 2016

TO: Kevin Hoyle, M.A., Executive Director
Anderson-Oconee-Pickens Community Mental Health Center

FROM: Bryant Collins, CGAP, Senior Auditor BC
SCDMH Office of Internal Audit

RE: Review of Selected Activities for
Anderson-Oconee-Pickens Community Mental Health Center

BACKGROUND

The Anderson-Oconee-Pickens (AOP) Community Mental Health Center serves approximately 6,127 clients for Anderson, Oconee, and Pickens counties. The annual budget is approximately $9.7 million. There are 140 individuals employed at the Center. The Center's last Internal Audit report was issued by our office on October 26, 2009.

AUDIT SCOPE

Our audit of the Center was conducted in accordance with the standard internal auditing procedures for community mental health centers. The scope included a review of selected activities for billing/accounts receivable, cash operations, accounts payable, computer services, and other general administrative activities we deemed appropriate. Our review consisted primarily of testing by sampling records to determine their reliability and the soundness of the Center's internal control procedures. In addition to testing and sampling records, we held discussions with the Center's staff and management to obtain an understanding of the control procedures.

FINDINGS & RECOMMENDATIONS

Our attached audit report contains findings and recommendations which should assist in strengthening internal controls and operational compliance. **There were no repeat audit findings.** We sincerely thank all employees of the Anderson-Oconee-Pickens Community Mental Health Center for their cooperation, time and assistance during the audit.

Cc: Audit Committee Members
John Magill
Geoff Mason
Mark Binkley
David Schafer
Mallory Miller
Dr. Hope Threadgill, Board Chair

AUDIT REPORT

ANDERSON-OCONEE-PICKENS

MENTAL HEALTH CENTER

Billing and Accounts Receivable

Submit Outstanding Medicaid Claims in a Timely Manner

A summary of Aging Reports for Outstanding Claim Balances were generated for fiscal years 2014, 2015 and 2016. Reports for 2014 and 2015 were generated on June 15th. The report for 2016 was generated on July 1st. Reports revealed Medicaid claim balances that were material and exceeded 360 days. **Claims greater than one year are most likely uncollectible because of current filing requirements**. A summary of balances from these reports were as follows:

FROM	TO	MEDICAID
07/01/2013	06/30/2014	$ 27,288
07/01/2014	06/30/2015	109,065
07/01/2015	06/30/2016	2,356*
Average	--------	$ 46,236

During the audit field work we spoke to financial staff about Medicaid claim balances from the reports. We were informed that some problems exist with billing for South Carolina Prime (Healthy Connections) clients in the Client Information System, CIS. These clients are dual eligible for Medicaid and Medicare. We were also informed that other data entry problems with CIS have contributed to these balances.

***Auditor's Note: Fiscal year 2016 just ended. A total of $167,904 in Outstanding Medicaid claims was in the 121-360 day category as of July 1, 2016. Future reports run for fiscal year 2016 will show an increase in Medicaid claims exceeding 360 days because the aging schedule will adjust accordingly.**

Recommendations:

1. **Submit Medicaid claims in a timely manner due to timely filing requirements.**

2. **Consult SCDMH Central Administration Management on improving the timely submission of outstanding Medicaid claims. Consultation should include conversations with Information Technology (IT) and the Division of Financial Services.**

3. **Write-off Medicaid claim balances for fiscal years 2014 and 2015.**

MANAGEMENT RESPONSE:

1. **We are currently submitting claims in a timelier manner and have put a process in place to resubmit denied claims in a timelier manner. We have further implemented a designated day of the week to focus strictly on claims follow-up.**

2. **We have submitted numerous help desk tickets to resolve any IT issues that deal with Medicaid/Insurance filing problems.**

3. **Medicaid claims that are too old to receive reimbursement were initially denied and are on file with Medicaid, will be resubmitted to get a 510 edit code (exceeds timely filing) and put on a spreadsheet to send to the Provider Services Representative at SCDHHS to see if we can get reimbursement. This is an agreement that SCDMH has with Medicaid FFS. Anything that does not fall under this category we will write-off by October 31, 2016.**

Complete Annual Reviews for Self-Pay Clients With Fee Reductions in Accordance to DoFS Policy and Procedure 3.3

As of June 15, 2016 the Center had 397 clients who were receiving a reduction of their self-pay balances. We examined records for sixteen non-Medicaid self-pay clients who receive fee reductions ranging from 20% to 99% in the SCDMH Electronic Medical Record (EMR). Records included income documentation, annual reviews, clinical service notes (tickets) and client intake information. No deficiencies were found while reviewing annual reviews for these sixteen clients, however, an additional report generated for the audit indicated that 65 of 397 clients (16.37%) receiving fee reductions in their self-pay balances had past due annual reviews.

Recommendation: **We recommend Center personnel carefully follow DoFS policy and procedure 3.3 regarding annual reviews for clients who receive self-pay fee reductions.**

MANAGEMENT RESPONSE:

Annual reviews were being completed however annual review letters are being distributed the month of a client's review. We will look at ways to send reminder letters out earlier so that annual reviews can be completed within a year. Clients will continue to be moved to full fee at the 12 month review if they do not bring in the proper documentation.

Train Intake Personnel to Properly Compute Annual Income for Self-Paying Clients with Fee Reductions

Although income documentation was being collected by intake personnel for self-pay clients in our review, annual income was not properly computed for four (25%) of the sixteen clients. The computation of annual income is an important component in determining the correct rate for self-pay clients who are eligible for fee reductions in DMH services.

We recommend that intake personnel are trained to properly compute annual income for self-pay clients who receive fee reductions.

MANAGEMENT RESPONSE:

We will conduct internal training to ensure that all intake staff are following DOFS policy 3.3, and only using the documents allowed in that policy. It appears we may have been using bank statements which showed employer deposits, however those indicate the net deposit to an account and not the gross income needed to compute the reduction.

Administration

Consider Revising the Board By-laws to Conform to the State Law on Board Membership

Article III of the Center' governing board's by-laws states in part, "The Board shall consist of fifteen (15) members, seven (7) whom shall come from Anderson County, five (5) Pickens County and three (3) from Oconee County as long as the number of members representing each county are proportional to its population. State Law 44-15-60 says that a community

mental health board shall be made up of not less than seven nor more than fifteen members. During the audit the Center had eleven board members. Two appointments were made to the board just prior to the audit exit conference, leaving two vacancies for a complete board.

We recommend that management consider revising the governing board's by-laws to conform to the state law on board membership so that flexibility is present in total board members required to serve.

MANAGEMENT RESPONSE:

This recommendation will be referred to the Board's Orientation Committee, which is responsible for reviewing the Center's by-laws annually. The Orientation Committee will review the recommendation and, in turn, make a recommendation to the full Board for approval regarding a change in language in the by-laws.

Anderson-Oconee-Pickens Community Mental Health Center
Management Response and Monitoring

Audit Finding Area	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
BILLING AND ACCOUNTS RECEIVABLE						
Submit outstanding Medicaid claims in a timely manner	Center to review claims submissions to make sure we are filing in a timely manner.	8/24/2016	Pam Garrison	PG	Ongoing	AOP is currently submitting claims in a timely manner and we have put in a process to focus on claims follow up.
Complete annual reviews for self-pay clients with fee reductions in accordance to DoFS Policy and Procedure 3.3	AOP will review DoFS policy and procedure 3.3 regarding annual reviews for clients who receive self-pay fee reductions	8/24/2016	Eric Turner		Ongoing	Annual review letters were bering distributed in the month of their review.AOP will send out letters so they can be completed timely.
Train intake personnel to properly compute annual income for self-pay clients with fee reductions	Center will review process to properly train intake staff to to compute annual income for self-pay patients.	8/24/2016	Eric Turner		Ongoing	AOP will conduct training to ensure that all intake staff are following DoFS policy 3.3.2.
ADMINISTRATION						
Consider revising the board by-laws to conform to the state law on board membership	AOP will review board's by-laws on board membership so that flexibility is present in total board required to serve.	9/26/2016	Kevin Hoyle		1/31/2017	This recommendation will be reviewed by the Orientation Committee and then to the board.

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

Physical Plant Services

Vehicle Management Section

February 14, 2017

DMH South Carolina Department of Mental Health

State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:

Alison Y. Evans, PsyD, Chair
Everard Rutledge, PhD, Vice Chair
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John H. Magill
State Director of Mental Health

Memorandum

DATE: February 14, 2017

TO: Ken Roey
Director of Physical Plant Services

FROM: Amanda Henry, Audit Manager I
SCDMH Office of Internal Audit

RE: Review of Vehicle Management

BACKGROUND

As of April 2016, DMH maintained a fleet of approximately 658 owned vehicles comprised mostly of passenger vans 311 or 47% and sedans 223 or 34%. Other types of vehicles included in the fleet are pickups, utility, and buses. The model year of the vehicles range from 1967 – 2016. DMH also leases approximately 100 vehicles which are located at DMH Centers and are comprised of passenger vans and sedans.

DMH separates vehicles into two areas; Division I and II. Division I vehicles are mostly located at the Division of Inpatient Services (DIS), Physical Plant Services (PPS), Public Safety (PS), and Administration. Division II vehicles are at the Centers.

Vehicle Management (VM), a section of Physical Plant Services (PPS), consists of three areas; Administration, Transportation and Maintenance. VM administers and maintains the fleet of vehicles used by Division I. VM also provides transportation for patients, lab work and mail for the agency.

Transportation Coordinators are located within Divisions I and II. They send to VM administration information concerning the mileage and daily usage of the owned vehicles as well as maintenance expenses.

Due to the age and high mileage of the fleet, in calendar year 2015 DMH purchased 89 new vehicles and 6 used. In 2016, 17 new vehicles and one used were purchased. The majority of vehicles purchased were passenger vans and sedans.

AUDIT SCOPE

The scope of the audit included review and reconciliation of DMH state owned vehicles to the state database, review of documentation for new vehicles purchased to ensure compliance with replacement criteria and proper approvals and the leased vehicle inventory and corresponding invoices. The Vehicle Fleet Maintenance program (VFM), the Accident Investigation Committee, transportation, maintenance and other areas deemed appropriate were also reviewed. The management and staff in all three areas of VM were interviewed to gain an understanding of their responsibilities and processes within those areas. Some of the transportation coordinators were also interviewed. Data was obtained from the State Fleet Management (SFM), VM and transportation coordinators.

SUMMARY

Findings with recommendations are documented in the attached audit report. We sincerely thank the management and staff for their cooperation, time and assistance during the audit.

cc.
Audit Committee
John Magill
Mark Binkley
Ken Roey

Physical Plant Services
Vehicle Management Section

I. VEHICLE MANAGEMENT SYSTEM

Consider Obtaining a Comprehensive Enterprise Wide Vehicle Management System

Currently Vehicle Management (VM) utilizes a Vehicle Fleet Maintenance (VFM) program that was developed in 2002 by DHEC and distributed as a standalone application to state agencies. VM obtained updates to this program in 2016 from a sole source provider. This VM system is outdated, mostly paper driven and requires manual input of data. Also, silos of information are being maintained throughout the agency because of the inadequacies of the system. For example, the transportation area of VM maintains a separate access data base concerning drivers, routes and mileage and the Centers maintain vehicle information mostly on excel spreadsheets. Basic functions such as compiling, analyzing and reporting vehicle information at times have been challenging and limited.

Recommendation

Management should consider obtaining a more comprehensive enterprise wide vehicle management system. Software and systems that are available today can begin automatically collecting data as soon as a driver logs into the system. These systems can analyze the captured data, identify trends and provide other beneficial information and reports to management. Access to vehicle information could then be made available to all personnel engaged in the management of vehicles and transportation thus reducing the need for information silos.

MANAGEMENT RESPONSE

Vehicle Management is currently using two different programs as noted above. One program deals with vehicle data and will be referred to as the Vehicle Maintenance Program (VMP). The second program deals with dispatch of vehicles for transporting clients and materials and will be referred to as the Vehicle Dispatch Program (VDP).

MANAGEMENT RESPONSE (cont'd)

Vehicle Maintenance Program (VMP).

The VMP in use was developed in 2002 and provided to DMH at no cost and has served our needs well. This program was recently updated to provide a security upgrade and some improved functionality. We have reviewed multiple off the shelf software applications, but none of them would provide the functionality required, and would require significant expense to modify for DMH needs.

In 2016 the Department Of Administration solicited bids for a new program to replace the program currently used by State Fleet Management (SFM). This process was put on hold after a number of vehicle management software vendors dropped out of the solicitation as they were unable to meet all needed requirements.

SFM has since engaged the current vendor in further discussion regarding use of an updated version of their existing program. If the new platform meets state security requirements it is likely they will move forward with updating to the newer version, to be followed by a broader roll-out to customer agencies. We will make a determination by December 2017 of whether it appears likely that DMH will be able to piggyback off the SFM solution or whether we should pursue our own replacement program which could potentially include the vehicle dispatch program described below.

Vehicle Dispatch Program (VDP)

The VDP in use is a simple access program which should be replaced. We are currently in the process of getting proposals for a web based tablet compatible program which provides real time information to the operator and captures relevant metrics such as actual pick up times and miles traveled. Our goal is to implement a small scale pilot in the spring of 2017, with a decision regarding full scale implementation to be made by the end of 2017.

II. VEHICLE INVENTORY

Reconcile Annually DMH's Owned Vehicle Inventory to the State Fleet Management's (SFM's) List

During the inventory of DMH's owned vehicles we noted that a reconciliation of these vehicles to the State Fleet Management's (SFM's) list of DMH owned vehicles had never been done. A reconciliation of vehicles was performed during the audit and all vehicles were accounted for. However, several errors were noted on DMH's inventory list as well as SFM's list. On DMH's list, there were numerous incorrect serial numbers and five vehicles being used by DMH were not listed. On the SFM's list, four vehicles had not been removed from the list that had been turned in to them by DMH. DMH's turn-in documents (TIDs) for those vehicles dated from 2010 to 2016. Also, two DMH vehicles were listed twice on the State's list and two vehicles that were in DMH's inventory were not on the State's list.

Recommendation

We recommend that all reconciling errors be corrected. Errors with the SFM's report should also be communicated to the SFM's office for correction. Also, to properly account for DMH's vehicles, Vehicle Management should reconcile annually DMH vehicles to the SFM's list and correct any errors found.

MANAGEMENT RESPONSE

All errors noted above have been corrected. We will be requesting a report on an annual basis from SFM to conduct reconciliations.

Annually Obtain a List of Leased Vehicles from SFM and Reconcile DMH Leased Vehicles to that List

DMH maintains a Standard State – Owned Vehicle Lease agreement with SFM. The most current agreement is dated June, 2006. According to the lease, SFM will provide annually to DMH a list of leased vehicles. The purpose of the list is for use in reconciliations and vehicle replacement or retention confirmations. Also, DMH is to sign and return a copy of the list of vehicles to SFM which constitutes a renewal of the agreement.

According to VM the list of leased vehicles has not been provided annually by SFM but is requested when needed. Also, reconciliation of DMH leased vehicles has never been performed by VM and has never been required.

Recommendation

VM should request from SFM that a list of leased vehicle be provided annually to DMH as stated in the lease agreement and a reconciliation of DMH leased vehicles should be performed annually by VM. Once the reconciliation is completed, the list should be reviewed and signed by Management and returned to SFM for renewal of the agreement.

MANAGEMENT RESPONSE

Per conversation with SFM, the entire lease agreement is being revised, with plans to send out the new agreements within the next 60 days. A list of currently leased vehicles was provided by SFM on 2/2/2017 and has been sent to all Centers for reconciliation, target completion date is 3/10/2017. Future reconciliations will be conducted on an annual basis.

III. VEHICLE UTILIZATION

Annually Run the Utilization Report and Identify Underutilized DMH Owned Vehicles. Obtain Justifications for Retainage of these Vehicles and Reassign if Needed.

Due to issues with the VFM program, VM could not run a utilization report for DMH owned-vehicles in 2015. According to VM the last report that was run was in 2014. The program issues were fixed in 2016 and a report was run in October of 2016. Utilization is determined by reviewing the compilation of miles and days driven for a vehicle in a year. Per Directive 870-06 "Effective usage for agency - owned and leased general purpose vehicles has been determined to be 9000 miles or 186 days per year." The following was noted: total vehicles owned were 667; of the total 356 vehicles or 53% did not meet effective utilization criteria. Of those 356 vehicles, 143 or 21% were in Division I and 213 or 32% were in Division II. VM is in the process of obtaining justifications. As of January 2017 only 92 of the 356 or 26% of the justification had been received.

Recommendation

Annually run the utilization report to review miles and days driven for each DMH owned vehicle. Identify underutilized vehicles and obtain justifications for those vehicles. Based on information provided by the justification and if possible, reassign vehicles within the agency. If the vehicle cannot be reassigned then it

would be considered surplus and should be turned in to the SC Surplus Property Office.

The report along with the justifications should also be reviewed and approved by Management to assist in right sizing the fleet, if needed.

MANAGEMENT RESPONSE

As of 2/10/2017, 90%+ of the justifications have been received and a total of 15 vehicles have been identified as surplus. Future utilization reviews will be conducted on an annual basis.

Annually Obtain from SFM a Utilization Report for Leased Vehicles and Review the Report for Underutilized Vehicles

VM currently does not obtain a utilization report from SFM concerning leased vehicles. DMH has approximately 100 leased vehicles. Most are leased by the Centers. In order to review the utilization of leased cars, Audit obtained, from five of the 11 centers who leased vehicles for fiscal year 2016, the miles and days driven for 75 leased vehicles. Only 26 out of the 75 or 43% of the leased vehicles met the DMH effective use criteria.

Recommendation

At least annually, VM should obtain and review a utilization report concerning all DMH leased vehicles from SFM. Justifications for retainage of underutilized leased vehicles should then be obtained from the Centers. If it is determined that the vehicle is no longer needed the lease should be terminated by the Center's and the vehicle returned to SFM.

This report along with justifications should also be reviewed and approved by Management to assist in right sizing the fleet if needed.

MANAGEMENT RESPONSE

The current SFM utilization reports only reflect annual mileage. We will work with the Centers to obtain daily usage data currently recorded on individual trip logs until a more complete data set can be obtained from SFM. Future utilization reviews will be conducted on an annual basis.

Summary Concerning Utilization Reporting

By obtaining utilization information on both owned and leased vehicles Management will have a whole picture of all vehicles used at the agency and the utilization rates. This information will assist them in their decision making process concerning the entire fleet of DMH vehicles and in optimizing the use of available resources.

IV. CONTROLS

Strengthen Access Controls to Vehicle Keys and Establish Policy and Procedures Concerning the Safeguarding of Vehicle Keys to Include an Annual Inventory

In the Vehicle Administrator office vehicle keys were observed being left on the Administrators desk and pinned to the bulletin board. In the Vehicle Maintenance Office vehicle keys were observed being left in the window sill for cars that were being washed by SCDC inmates. Also, in the Maintenance office one of the metal boxes used to store keys does not lock and is not permanently attached to the wall. The lock is broken on another box used to store keys. In the transportation area keys for vehicles are being maintained in a metal box that does not lock and the office is not locked so that the transportation drivers can obtain vehicle keys. The risk that unauthorized people could gain access to the vehicles is increased when keys are left unsecured.

There are no Policy and Procedures for the safeguarding of vehicles keys and no annual inventory of keys is performed.

Recommendation

We recommend that access controls to vehicle keys be strengthened. Keys should be stored in locking metal boxes attached to walls. Boxes where the lock is broken should be fixed.

Management should also establish policy and procedures concerning the safeguarding of the vehicle keys and train personnel on the established procedures. At a minimum, an annual inventory of keys should be performed.

MANAGEMENT RESPONSE

Lock boxes will be installed in all areas where vehicle keys are maintained and a Physical Plant Services directive will be issued which addresses the requirements for safeguarding vehicle keys, training and annual inventories.

Strengthen Controls Concerning Vehicle Pickup in Maintenance Area

Once repairs or maintenance of vehicles have been completed by the maintenance technicians on DMH owned vehicles, the vehicles are parked in the back of the maintenance area. The administrative assistant of maintenance calls the authorized driver and notifies him/her that the vehicle is ready to be picked up. At the time of pickup the authorized driver is to sign a book maintained in the maintenance office documenting that the vehicle is being picked up and by whom. However, this is not always done. The maintenance area and the authorized driver both maintain a vehicle key; therefore the vehicle can be picked up without maintenance being notified or the book signed. Because this can happen control is lost concerning the location of the vehicle.

Recommendation

We recommend that the Vehicle Maintenance strengthen controls concerning vehicles that are waiting to be picked after completion of the repairs and/or maintenance.

MANAGEMENT RESPONSE

We have reminded customer departments of the pickup procedures and will review any instances of non-conformance with the individual department heads. We are in the process of getting quotes for additional fencing which will add another layer of security for vehicles under repair.

Review Role Access to the Vehicle Fleet Maintenance (VFM) Program

All data concerning DMH owned vehicles is maintained through the Vehicle Fleet Maintenance (VFM) program. The role access that has been given to VM employees concerning this program should be re-evaluated. Nine employees have access up to the Supervisor role which is second to the highest access that can be given. The Supervisor role has complete authority to add, edit and delete over all modules in the VFM program. Access to the VFM program should be role based and only the access that is required to perform an employee's job duties should be allowed.

Recommendation

Roles access should be reviewed and only the minimum necessary access should be given.

MANAGEMENT RESPONSE

Role access is in the process of being reviewed and will be limited to the level of need required.

V. Vehicle Accident Investigation Committee

Increase Frequencies of Meetings of the Vehicle Accident Investigation Committee

The Vehicle Accident Investigation Committee was established to review all accidents involving all state owned vehicles. Its goal is to promote safe driving and reduce the number of accidents through proper training, development of safe procedures, and if needed referral of an employee to management for disciplinary actions.

According to documents reviewed as of July 2016, DMH's Vehicle Accident Investigation Committee last met on May 28, 2014. A total of 25 accidents were reviewed at the meeting; nine occurred in 2013 and 16 through April 18, 2014.

Further inquiry resulted in finding that a total of 100 accidents had occurred in the past two fiscal years; 47 in FY 2015 and 53 in FY 2016.

Recommendation

The Vehicle Accident Investigation Committee should meet more frequently as required by the State Fleet Safety Program. Per SCDMH's directive 872-06 the Vehicle Accident Investigation Committee is to convene as required. According to the State Fleet Safety program procedures, the committee should meet at least annually. As a general rule meetings should be called after an agency has experienced 3 or more vehicle accidents.

MANAGEMENT RESPONSE

The Vehicle Accident Investigation Committee has been meeting on a quarterly basis since July 2016 and has significantly increased its role in reaching out to other Departments and Centers in an attempt to highlight significant trends and promote safe driving behavior.

Physical Plant Services
Vehicle Management
Management Response and Monitoring

Audit Finding	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
Consider Obtaining a Comprehensive Enterprise Wide Vehicle Management System	*Vehicle Management is currently using two different programs as noted above. One program deals with vehicle data and will be referred to as the Vehicle Maintenance Program (VMP). The second program deals with dispatch of vehicles for transporting clients and materials and will be referred to as the Vehicle Dispatch Program (VDP).Vehicle Maintenance Program (VMP):* *The VMP in use was developed in 2002 and provided to DMH at no cost and has served our needs well. This program was recently updated to provide a security upgrade and some improved functionality. We have reviewed multiple off the shelf software applications, but none of them would provide the functionality required, and would require significant expense to modify for DMH needs.* *In 2016 the Department Of Administration solicited bids for a new program to replace the program currently used by State Fleet Management (SFM). This process was put on hold after a number of vehicle management software vendors dropped out of the solicitation as they were unable to meet all needed requirements.* *SFM has since engaged the current vendor in further discussion regarding use of an updated version of their existing program. If the new platform meets state security requirements it is likely they will move forward with updating to the newer version, to be followed by a broader roll-out to customer agencies. We will make a determination by December 2017 of whether it appears likely that DMH will be able to piggyback off the SFM solution or whether we should pursue our own replacement program which could potentially include the vehicle dispatch program described below.Vehicle Dispatch Program (VDP):* *The VDP in use is a simple access program which should be replaced. We are currently in the process of getting proposals for a web based tablet compatible program which provides real time information to the operator and captures relevant metrics such as actual pick up times and miles traveled. Our goal is to implement a small scale pilot in the spring of 2017, with a decision regarding full scale implementation to be made by the end of 2017*	Pilot new Vehicle Dispatch Program by June 2017, make decision on new enterprise programs by December 2017.	Tim Beaver	kpr		
Reconcile Annually DMH's Owned Vehicle Inventory to the State Fleet Management's (SFM's) List	*All errors noted have been corrected. We will be requesting a report on an annual basis from SFM to conduct reconciliations.*	Completed		kpr		
Annually Obtain a List of Leased Vehicles from SFM and Reconcile DMH Leased Vehicles to that List	*Per conversation with SFM, the entire lease agreement is being revised, with plans to send out the new agreements within the next 60 days. A list of currently leased vehicles was provided by SFM on 2/2/2017 and has been sent to all Centers for reconciliation, target completion date is 3/10/2017. Future reconciliations will be conducted on an annual basis.*	3/10/2017	Tim Beaver	kpr		
Annually Run the Utilization Report and Identify Underutilized DMH Owned Vehicles. Obtain Justifications for Retainage of these Vehicles and Reassign if Needed.	*As of 2/10/2017, 90%+ of the justifications have been received and a total of 15 vehicles have been identified as surplus. Future utilization reviews will be conducted on an annual basis.*	3/1/2017	Tim Beaver	kpr		
Annually Obtain from SFM a Utilization Report for Leased Vehicles and Review the Report for Underutilized Vehicles	*The current SFM utilization reports only reflect annual mileage. We will work with the Centers to obtain daily usage data currently recorded on individual trip logs until a more complete data set can be obtained from SFM. Future utilization reviews will be conducted on an annual basis.*	3/10/2017	Tim Beaver	kpr		

Physical Plant Services
Vehicle Management
Management Response and Monitoring

Strengthen Access Controls to Vehicle Keys and Establish Policy and Procedures Concerning the Safeguarding of Vehicle Keys to Include an Annual Inventory	*Lock boxes will be installed in all areas where vehicle keys are maintained and a Physical Plant Services directive will be issued which addresses the requirements for safeguarding vehicle keys, training and annual inventories.*	3/10/2017	Ervin Hinton	kpr		
Strengthen Controls Concerning Vehicle Pickup in Maintenance Area	*We have reminded customer departments of the pickup procedures and will review any instances of non-conformance with the individual department heads. We are in the process of getting quotes for additional fencing which will add another layer of security for vehicles under repair.*	6/1/2017	Ervin Hinton	kpr		
Review Role Access to the Vehicle Fleet Maintenance (VFM) Program	*Role access is in the process of being reviewed and will be limited to the level of need required.*	3/1/2017	Tim Beaver	kpr		
Segregate the Issuance and Deletion of Fuel Cards	*To be removed per exit conference.*					
Increase Frequencies of Meetings of the Vehicle Accident Investigation Committee	*The Vehicle Accident Investigation Committee has been meeting on a quarterly basis since July 2016 and has significantly increased its role in reaching out to other Departments and Centers in an attempt to highlight significant trends and promote safe driving behavior.*	Completed.		kpr		

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

Review of Selected Activities of Santee -Wateree Mental Health Center

February 2, 2018

DMH South Carolina Department of Mental Health

State of South Carolina
Department of Mental Health

2414 Bull Street•P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

John H. Magill
State Director of Mental Health

Memorandum

DATE: February 2, 2018

TO: Jeffery Ham
Executive Director
Santee-Wateree Mental Health Center

FROM: Amanda Henry, Audit Manager
SCDMH Office of Internal Audit

RE: Review of Selected Activities for
Santee-Wateree Mental Health Center

BACKGROUND

The Santee-Wateree Mental Health Center (SWMHC) serves over 4,000 clients per year from the counties of Lee, Sumter, Clarendon and Kershaw. The annual budget is approximately $9.2 million and employs approximately 118 individuals. The Center's last audit report issued was February of 2014.

AUDIT SCOPE

Our audit of the Center was conducted in accordance with the standard internal auditing procedures for community mental health centers. The scope included a review of selected activities for contracts, cash operations, accounts payable, computer services, billing and other general administrative activities we deemed appropriate. Our review consisted of testing by sampling records and review of documents. In addition, we held discussions with the Center's staff and management to obtain an understanding of their control procedures and processes.

FINDINGS & RECOMMENDATIONS

Our attached audit report contains findings and recommendations, which should assist in strengthening internal controls and operational compliance. **There were no repeat findings from our previous audit.**

We sincerely thank the entire staff of the Santee-Wateree Mental Health Center for their cooperation, time and assistance during the audit.

Cc:
Audit Committee
John Magill
Mark Binkley
Deborah Blalock
Dave Schaefer
Demetrius Henderson
Carolyn Bishop-McLeod - Board Chair

AUDIT REPORT

SANTEE-WATEREE

COMMUNITY MENTAL HEALTH CENTER

I. Administration

a. Contracts

Review the Contract and Either Stop Paying for Services Provided or Notify the Lessor to Adjust the Rent Payment to Exclude Services Paid by the Center

Santee -Wateree MHC maintains a contract between the Center (lessee) and Miles and Reynolds (lessor). This contract is a rental agreement for use of two houses as Community Residential Care Facilities (CRCF). According to the contract, the initial term was five years beginning July 1, 2011 and ending June 30, 2016. The contract was extended through an amendment until June 30, 2018. The Center is paying a monthly rent of approximately $4,500. In Article 6 of the contract titled Services, the following is stated:

- In section 6.1 as part of the rent payment the lessor will provide certain services such as security, grounds maintenance, electricity, water and sewer …, and any other service necessary to maintain and operate all building and site improvements….

- In section 6.2 the lessee shall have the option to make direct payment for utilities to the supplier. If the option is exercised, the lessee can directly pay for utilities, notify the lessor in writing and the basic rent shall be adjusted to exclude those services.

In our review, we found that the Center is paying for services such as ground maintenance and utilities in addition to the monthly rent with no adjustments made to the rent payment. Over $3,900 was paid for electricity and $5,000 for ground maintenance at the CRCF for fiscal year 2017.

We recommend that Center management review the contract and either stop paying for services that are provided through the rent payment, or notify the lessor that the rent payment should be adjusted to exclude services paid by the Center.

MANAGEMENT RESPONSE

The current lease and payment arrangement is a continuation of the process that has existed at the Center at least since 2011. Leadership involved with the negotiation of the existing lease are no longer employed at DMH to provide historical perspective.

The current Center Administrator has scheduled a meeting with the landlord to review lease obligations and to initiate the process of renegotiating the lease to address a reduction in rent to accommodate utility and maintenance costs carried by the Center.

Complete Written Performance Evaluation Report When Professional Service Contracts Expire

According to Division of Financial Services (DoFS) Policy 10.27, Administration and Monitoring of all Professional Services Contracts, a written performance evaluation report (UN-44) must be prepared when a Professional Services contract expires. The report should be retained in the contract monitor's file. From our review of the files, the following was noted.

- Of the 19 Homeshare Provider files reviewed, none maintained a UN-44.
- 2 of the 4 (50%) of the Professional Services Contracts for Physicians did not have a UN-44 in file.

We recommend that Performance Evaluation Reports be completed for expired Professional Services Contracts and reports maintained in the contract monitor file.

MANAGEMENT RESPONSE

UN-44 were not present in the contract files due to a series of staff changes in the department (3 supervisors since the previous audit) and incomplete training regarding contract file requirements. To address this issue, the Center will develop a master list of all contracts monitored locally with expiration/renewal dates and meet with assigned contract monitors to review performance (via UN-44) at least quarterly in order to ensure compliance with SCDMH policy.

Obtain Current Professional Liability Insurance Certificates

A review of 3 of 5 (60%) Professional Service Contracts for Physician Services found that the contract monitor files were missing current Professional Liability Insurance Certificates. The certificates for Jackson & Coker expired 5/1/2014, Locumtenens.com 8/3/2016 and Graeme Johnson, L.L.C., 8/03/2016.

We recommend current Professional Liability Insurance Certificates be obtained by the Contract Monitor and maintained in the contractor monitor files.

MANAGEMENT RESPONSE

Contract with Jackson & Coker, while still in force, has been dormant since 2014, and contract with Locumtenens.com since 2015. No services are being used through these agencies presently. Current contract psychiatry services are being provided through Liberty Healthcare. Center practice has been to update these certificates in conjunction with the process of bringing a contract physician on board. To address the audit deficiency, however, Center staff has contacted these agencies to obtain an updated copy.

Dr. Johnson's insurance certificate expiration coincided with a staff resignation in our contracts administration function, and oversight on the part of the replacement. To address the deficiency, the updated certificate has been requested from the doctor. The contract monitoring master list and quarterly review noted above will ensure future compliance. The Staff has been provided additional training.

Update Contract Monitor Information

A list of Center contracts, which includes contract monitors, was obtained by audit from the DoFS, Contract Office. The contract monitors on this list were not current. For example, one of the monitors listed is no longer employed at the Center. In addition, when audit asked Center personnel who the contract monitor was, they too were not certain.

For better contract administration, we recommend that the Center Administrator determine who are the current contract monitors, contact the Contract Office with this information and inform Center personnel.

MANAGEMENT RESPONSE

All current contracts held at the Center are being reviewed to clarify Contract Monitor assignment. The Center has developed a Contract Monitor assignment letter that is in compliance with DoFS policy and will place in each file and with DMH Procurement, as appropriate. Additionally, each assigned monitor will review Pathlore Course OLS095C.

Indicate on Invoices that the Approving Signature is the Contract Monitor

Invoices for payment to Graeme Johnson, L.L.C were reviewed for the approving signature of the contract monitor. The invoices were signed but there was no indication on the invoice that this was the contract monitor.

We recommend that the approving authority who signs the invoice for payment also indicate that they are the contract monitor.

MANAGEMENT RESPONSE

The Accounts Payable and Contracts department at the Center has obtained a stamp with language compliant with DoFS policy 10.27/10.28 that will certify that signature on invoices are those of the contract monitor or authorized designee. In the absence of the stamp, the Center will attach a UN-45 form.

b. Vehicles

Maintain Vehicles in Accordance with the Vehicle Maintenance Program

According to Directive 872-06 – Vehicle Maintenance Program, preventive maintenance should not exceed 5000 miles or twelve months. For two of the fifteen center owned vehicles the following was found.

- Mileage accumulated for one vehicle (#1751) prior to an oil change was 12,595.
- One vehicle (#1789) is past due 5 months for an oil change.

We recommend that preventive maintenance be completed in accordance with the vehicle maintenance program.

MANAGEMENT RESPONSE

The Center Administrator and Center IT will work with PPS staff to develop a monitoring system that will provide greater central visibility to fleet maintenance schedules and activities. The appearance of excessive mileage between oil changes noted for vehicle #1751 was due to a failure to record maintenance actually performed. The planned central monitoring system will provide management and staff with information to identify data entry or maintenance scheduling oversights.

Evaluate Vehicle Utilization and Determine if the Center Owned Vehicle Should Be Retained or Turned In

From the review of utilization records (January – August 2017) for Center owned vehicles, the following was found for vehicle #1287.

- January – April 2017 vehicle was driven only 564 miles
- Vehicle was not driven from May –August 2017

We recommend that Center management evaluate the utilization of the vehicle and determine if it should be retained or turned in to Vehicle Management.

MANAGEMENT RESPONSE

Vehicle #1287 is one of three vehicles assigned primarily to the Center's ACT program in Sumter. These vehicles are typically used for frequent but low mileage service. Vehicle #1287 is an older vehicle and was out of service for a period in early 2017. The vehicle was out of service again, due to mechanical problems during year-end closeout. The vehicle was repaired and returned to service once budget in the new fiscal year was available. Center Administrator and PPS staff have recently met with DMH PPS and Vehicle Management staff to review utilization and replacement strategies. We anticipate that consolidation of vehicles in Sumter with the new Sumter campus (reducing locations in Sumter from three to two) will reduce some logistical barriers to efficient vehicle utilization.

c. Storage Building

Increase Security of Storage Building by Maintaining an Access Log

SWMHC has a storage building located at the Camden Satellite office. This building is divided into two separate areas. In one area, clients' files are housed and in the other area supplies for the Center and miscellaneous items are maintained. Access is obtained to both areas through locked outside doors. The Center Physical Plant Services (PPS) personnel and the Administrator maintain keys to these buildings. An access log was not being maintained for this building.

We recommend increasing security of the building by maintaining an access log documenting who entered, time and date. The log should be maintained by PPS personnel and reviewed periodically by management.

MANAGEMENT RESPONSE

Center Administrator will maintain an access log in both storage outbuildings at the Camden satellite office and review it monthly.

Properly Secure Client Files and Remove Copier

Within the Client Files storage area the following was noted:

- Client files were found in unsecured boxes. Client files that were not in boxes had been left on open shelves. These files contain clients' personal identification information as well as other clinical information.

- A copier was found in this storage area. Per the Center Administrator several years ago, the Center was using this copier to image client files. The Center discontinued the imaging process in 2015; however, the copier had been not removed.

We recommend appropriately securing client files. We also recommend removing the copier and having the memory wiped so that no residual client information can be recovered.

Center management should check with DMH Records Management and determine if the client files may be imaged by them and possibly stored, if required, at their facility or appropriately shredded.

MANAGEMENT RESPONSE

Center staff has distributed all consumable supplies previously being stored centrally in the Camden storage building to the clinic locations, thus clearing shelf space to consolidate client files in storage at this location. The Center is pursuing modifying that section of the building with a lockable internal caged area that will provide greater security within the building. Any exposed records have been re-boxed and sealed. The equipment being used in the imaging project has been disabled, memory removed and is scheduled for removal and recycling.

The Center Administrator and Records Custodian will obtain clarification from DMH Records Management regarding retention requirements and potential relocation and imaging of old records centrally.

The Center's new central location in Sumter, to be completed mid-2018, has additional space designated for records storage and will provide a secure location for physical records that must remain on site.

II. CASH

Cash Receipts

Complete the Voided Receipt Report for Voided Receipts and Retain With the Receipt Book

During the review of voided cash transaction receipts, we noted that the voided receipt reports were not being completed and retained in the receipt book as required by policy. According to DoFS Policy 5.3, if it is necessary to void a receipt, a Voided Receipt report (**UN-14**) must be completed and submitted with the applicable day's deposits. The cashier and another person,

such as the cashier's supervisor, who verifies that the receipts have been properly voided and retained in the receipt book, must sign the report.

We recommend that the voided receipt report be completed and retained with the receipt book for voided receipts.

MANAGEMENT RESPONSE

The Center has requested Cashier Training from the DMH Business Office to ensure that all appointed cashiers and supervisors are fully trained in cashiering responsibilities of the agency. The Business Office has agreed to provide the training in early 2018. Accounts Receivable, Office managers and the Records Custodian have reviewed the procedures with all front office staff to ensure that all cashiers follow the correct procedure.
Center Administrator will review all returned receipt books with Accounts Receivable Supervisor to verify compliance with DoFS policy and identify additional training needs.

Properly Use Petty Cash Funds and Timely Enter Petty Cash Transactions into SCEIS

During our review of transactions for the petty cash maintained at the Human Resource office, we noted the following.

- A disbursement of $50.26 from petty cash was made July 20, 2017 to pay a water bill to the City of Bishopville
- This transaction was not entered into SCEIS until October 13, 2017

According to DoFS policy 5.2.2 "Disbursements from Petty Cash Funds" petty cash should be used only for small essential purchases and should not be used when the transaction can be processed through accounts payable.

We recommend that usage of Petty Cash be according to policy and petty cash transactions timely posted into SCEIS.

MANAGEMENT RESPONSE

The Center has implemented proactive procedures that will forestall the circumstances that resulted in an "emergency" use of Petty Cash funds to pay a utility bill. For reasons that are unclear, the Center has failed to receive water bills from the City of Bishopville in time to process through normal process in Accounts Payable. Center AP staff are now contacting the city during on the first business day of each month (when bills are generated) to obtain a scanned copy. This

provides sufficient time to process the utility bill through routine channels and for the City to receive the payment by the due date.
The Petty Cash Fund cashier has created electronic tracking of reimbursement requests in order to prompt timely follow up with Accounts Payable on delays in receiving timely reimbursement.

Initial the Change Fund Log Verifying the Balancing of the Change Fund

We reviewed the CAF change fund log from June - August 2017. The cashiers document the balancing and verifying of the CAF change fund in this log. We noted that the primary cashier had balanced the change fund daily. However, the secondary cashier verifying the count did not initial the change fund log for most of June and all of July and August.

We recommend that the cashier verifying the balancing of the change fund indicate this by initialing the change fund log.

MANAGEMENT RESPONSE

The deficiency in the change fund verification has been addressed with the office staff at the clinic where the failure occurred. All staff at that location will be required to attend the Cashier training when scheduled. Additionally, the Center Administrator will monitor compliance with this requirement weekly for three months until assured of consistent compliance and at least quarterly thereafter.

III. Human Resources

Timely Complete EPMS Planning Stages and Annual Reviews

A sample of twenty four personnel field folders were reviewed for completion and proper documentation of Employment Performance Management System (EPMS) annual reviews and planning stages. Of those folders, reviewed 20 of 24 or approximately 80% did not have a current EPMS planning stage or an annual review.

We recommend that management ensure annual reviews and planning stages are completed timely. It is important that employees understand their job responsibilities and receive on-going, objective feedback concerning their job performance.

MANAGEMENT RESPONSE

Center HR has created an electronic EPMS records and a database to facilitate notification and tracking of EPMS due dates and completion. Further, Center HR

is providing all rating supervisors with information regarding timely EPMS status of staff and pursuing completion by the due dates.

IV. Representative Payee

Decrease Balance in the Representative Payee Account and Consider Discontinuing Providing This Service

SWMHC leases two homes in Bishopville, SC. The Center staffs and operates a CRCF program (Emerald House) in these homes. There are ten clients residing in the houses, five in each home. At the time of the audit, the CRCF Administrator maintained Representative Payee accounts for the ten residents. We reviewed those ten accounts and noted that one maintained a balance greater than $2,000 and received Supplemental Security Income (SSI) benefits. According to the Social Security Administration (SSA), total resource balances cannot exceed $2,000 or benefits may stop.

We recommend that the CRCF Administrator review the account and the monies be appropriately spent to decrease the balance below the $2,000 threshold.

Due to the risks involved in maintaining these accounts, we also recommend that the Center consider discontinuing providing representative payee services.

MANAGEMENT RESPONSE

The CRCF Administrator initiated the transfer of representative payee services for the ten CRCF residents to Mental Health America in late October. The process of establishing/changing this service typically takes three to four months.

V. Accounts Receivable

Enter Service Tickets into EMR in a Timely Manner

A report was generated and reviewed for service tickets entered >= 30 days into the Electronic Medical Record (EMR) system. The following was noted:

Days Late	#Tickets	Amount
30-59	247	$36,288.57
60-89	118	$13,367.00
90-119	3	$247.00
120 or more	11	$2,679.01
Total	**379**	**$52,581.58**

Because service tickets are not entered into EMR in a timely manner, there is an increased risk of loss of revenue.

We recommend entering service tickets into the EMR system in a timely manner.

MANAGEMENT RESPONSE

Clinical management is initiating a process for direct supervisors to review each clinician's Clinical Note Completion Status (formerly tickets) on a weekly basis. The supervisors will address deficiencies directly to reduce risk of lost revenue and report to the Center's Clinical and Executive directors. As a further safeguard, Center Quality Assurance will monitor overall Center status on a monthly basis to provide analysis of the Center's performance and efficiency and to identify trends and training needs.

Santee Wateree MHC

Managment Response and Monitoring

	Audit Finding	Action to Take	Target Date	Individual Responsible	Initials	Date Completed	Comments
1	**Review the Contract and Either Stop Paying for Services Provided or Notify the Lessor to Adjust the Rent Payment Excluding Services Paid by the Center**	Advise landlord of lease obligations and initiate renegotiation for renewal.	2/28/2017	Susan Anderson			
2	**Complete Written Performance Evaluation Report When Professional Service Contracts Expire**	Meet quarterly with contract monitors to evaluate performance and record via UN-44	04/01/2018 and ongoing	Susan Anderson			
3	**Obtain Current Professional Liability Insurance Certificates**	Obtain current professional liability certificates from service providers.	2/28/2018 and ongoing	Diana Fludd			
4	**Update Contract Monitor Information**	Assign and document in files and with Procurement contract monitors for all contracts monitored at the Center.	2/28/2018 and ongoing	Susan Anderson			
5	**Indicate on Invoices that the Approving Signature is the Contract Monitor**	Attach UN-45 to invoices requiring monitor signature or stamp.	2/28/2018 and ongoing	Diana Fludd			
6	**Maintain Vehicles in Accordance with the Vehicle Maintenance Program**	Develop monitoring "dashboard" to provide wider visibility of fleet usage and maintenance. Meet monthly with vehicle coordinator to review utilization and service.	0/31/18 vehicle monitoring tool. 02/28/2018 and ongoing for monthly meetings	Susan Anderson			

Santee Wateree MHC

Managment Response and Monitoring

7	**Evaluate Vehicle Utilization and Determine if the Center Owned Vehicle Should Be Retained or Turned In**	Meet monthly with vehicle coordinator to review utilization. Evaluate needs with program managers	02/28/2018 and ongoing	Susan Anderson			
8	**Increase Security of Storage Building by Maintaining an Access Log**	Establish and maintain Access Log at storage location. Submit report to Management monthly	2/15/2018 and ongoing	Gene Holloman			
9	**Properly Secured Client Files and Remove Copier**	Provide additional locked area in facility for records storage. Clarify retention requirements and if central records transfer procedures. Evaluate relocation of records to new Sumter facility when complete. Copier has been removed.	8/1/2018	Susan Anderson			
10	**Complete the Voided Receipt Report for Voided Receipts and Retain With the Receipt Book**	Provide additional Cashier and Front Office training. Review returned receipt books for DoFS compliance.	02/28/2018 and ongoing	Jacqueline Caudle			
11	**Properly Use Petty Cash Funds and Timely Enter Petty Cash Transactions into SCEIS**		2/1/2018	Diana Fludd and Dorothy Jackson			
12	**Initial the Change Fund Log Verifying the Balancing of the Change Fund**	Provide additional Cashier and Front Office training. Verify compliance weekly for 2 months and at least quarterly thereafter	2/28/2018	Susan Anderson			

Santee Wateree MHC

Managment Response and Monitoring

13	**Timely Complete EPMS Planning Stages and Annual Reviews**	IN addition to DMH Directive 855-06 (3-250), HR has established an electronic database whereby electronic notification of EPMS and follow up in 30 days	2/1/2018	Dorothy Jackson			
14	**Decrease Balance in the Representative Payee Account and Consider Discontinuing Providing This Service**	Complete already initiated process of transfering rep payee services to another provider.	4/30/2018	Ella Fortune			
15	**Enter Service Tickets into EMR in a Timely Manner**	Supervisors monitor clinicans completion status weekly and report to clinical directors. QA monitors Center performance monthly.	3/1/2018	Jeffery Ham			

OFFICE OF INTERNAL AUDIT

AUDIT REPORT

Review of Selected Activities of Spartanburg Area Mental Health Center

May 4, 2018

DMH South Carolina Department of Mental Health

State of South Carolina
Department of Mental Health

2414 Bull Street•P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

John H. Magill
State Director of Mental Health

Memorandum

DATE: May 4, 2018

TO: Roger C. Williams, LMSW, CT, QMHI-S
Executive Director
Spartanburg Area Mental Health Center

FROM: Amanda Henry, Audit Manager
SCDMH Office of Internal Audit

RE: Review of Selected Activities for
Spartanburg Area Mental Health Center (SAMHC)

BACKGROUND

The Spartanburg Area Mental Center serves annually approximately 5,400 clients in Spartanburg, Cherokee, and Union counties. The Center maintains an annual budget of approximately $10.2 million and currently there are 115 employees. The Center's last Internal Audit report was issued on June 21, 2011.

AUDIT SCOPE

Our audit of the Center was conducted in accordance with the standard internal auditing procedures for the mental health centers. The scope included a review of selected activities for billing/accounts receivable, cash operations, accounts payable, computer services, and other general administrative activities we deemed appropriate. Our review consisted primarily of testing by sampling records to determine their reliability and the soundness of the Center's internal control procedures. We also held discussions with the Center's staff and management to obtain an understanding of the control procedures and processes.

FINDING & RECOMMENDATION

Our attached audit report contains a finding and recommendation, which should assist in strengthening internal controls and operational compliance. **There were no repeat findings from our previous audit.**

We sincerely thank the entire staff of the Spartanburg Area Mental Health Center for their cooperation, time and assistance during the audit.

cc:
Audit Committee
John Magill
Mark Binkley
Deborah Blalock
Rev. Dewitt Clyde – Board Chair

AUDIT REPORT

SPARTANBURG AREA

MENTAL HEALTH CENTER

Vehicles

Review Proper Fueling of State Vehicles with Employees

The fuel exception report for state vehicles used by Center employees was reviewed for fiscal year 2017 and through February of 2018. According to State Fleet Management, state vehicles are to be fueled with unleaded fuel unless the vehicles require a higher octane fuel. We noted the following exceptions for the Center vehicles that do not require higher octane fuel.

- Unleaded supreme fuel was used 31 times by the same employee to refuel state vehicles in FY 2017 and seven times in 2018.
- Unleaded plus fuel was used seven times by seven different employees to refuel state vehicles in FY 2017 and three times by two different employees in 2018.

Due to the frequency of use of higher-octane fuel by one employee, we recommend that management review with the employee proper fueling of state vehicles and consider discipline measures. Also, the policy for properly fueling a state vehicle should be reviewed with all center employees who operate state vehicles.

MANAGEMENT RESPONSE

The employee in question has been given a notice of employee counseling. She has met with her supervisor, the center director and the vehicle manager to review the situation and to stress the importance of compliance.

The vehicle manager has started to include a monthly reminder about fuel and vehicle operations. Fuel reports will now be reviewed monthly and reports of non-conformance will be provided to the employee's supervisor. Notice of repeated violations will be provided to the Center Administrator and Executive Director.

Spartanburg Area MHC

Managment Response and Monitoring

	A	B	C	D	E	F	G	H
1		**Audit Finding**	**Action to Take**	**Target Date**	**Individual Responsible**	**Initials**	**Date Completed**	**Comments**
2	1	**Review Proper Fueling of State Vehicles with Employees**	Monthly review of gasoline charges and monthly reminder of appropriate gasoline use	5/1/2018	Paula Gilliam, vehicle manager	PG	5/1/18	
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Executive Director
Roger C. Williams, 5/1/18