



# MICHIGAN

OFFICE OF THE AUDITOR GENERAL

## AUDIT REPORT



THOMAS H. MCTAVISH, C.P.A.  
AUDITOR GENERAL

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

– Article IV, Section 53 of the Michigan Constitution

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Michigan  
*Office of the Auditor General*  
**REPORT SUMMARY**

*Performance Audit*

Report Number:  
391-0300-12

*Caro Center*

*Bureau of State Hospitals and Behavioral  
Health Administrative Operations  
Department of Community Health*

Released:  
March 2013

*The Caro Center is an inpatient psychiatric hospital that provides treatment for adults with mental illness, including those that are not guilty by reason of insanity, that are court ordered, or that are incompetent to stand trial. The mission of the Center is to provide the highest quality mental health services guaranteed by the Mental Health Code in a safe and supportive environment that maximizes individual growth and successful transition to the community. The Center provides services for patients from 45 counties. As of March 31, 2012, the Center had 143 patients.*

**Audit Objective:**

To assess the efficiency of the Center's use of selected resources.

**Audit Conclusion:**

We concluded that the Center's use of selected resources was moderately efficient. We noted two reportable conditions (Findings 1 and 2).

**Reportable Conditions:**

The Center had not implemented a comprehensive process to assign and monitor the cost and completion of work orders (Finding 1).

The Center did not ensure that it was fully refunded for all returned medications (Finding 2).

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**Audit Objective:**

To assess the effectiveness of the Center's efforts to safeguard selected State and patient assets.

**Audit Conclusion:**

We concluded that the Center's efforts to safeguard selected State and patient assets were moderately effective. We noted five reportable conditions (Findings 3 through 7).

**Reportable Conditions:**

The Center did not effectively monitor procurement card transactions to ensure that purchases were proper and authorized. Also, the Center did not ensure that procurement card account information was properly safeguarded (Finding 3).

The Center did not have effective controls over its inventories (Finding 4).

The Center needs to improve its controls over patients' personal property (Finding 5).

The Center did not maintain an inventory control program or periodically inventory its noncontrolled medications (Finding 6).

The Center did not conduct all of the preventive maintenance inspections required by its preventive maintenance system. Also, the Center did not ensure that information maintained in the preventive maintenance system was accurate (Finding 7).

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**Audit Objective:**

To assess the effectiveness of the Center's efforts to evaluate the services it provided to patients.

**Audit Conclusion:**

We concluded that the Center's efforts to evaluate the services it provided to patients were effective. Our audit report does not include any reportable conditions related to this audit objective.

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**Audit Objective:**

To assess the effectiveness of the Center's efforts to investigate and resolve complaints.

**Audit Conclusion:**

We concluded that the Center's efforts to investigate and resolve complaints were moderately effective. We noted two reportable conditions (Findings 8 and 9).

**Reportable Conditions:**

The Department of Community Health (DCH) Office of Recipient Rights (ORR) staff located at the Center had not established an effective process to ensure that all potential patient rights violations were identified (Finding 8).

The Center did not ensure that staff entered all administrative report forms and incident reports into the Center's complaint database (Finding 9).

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**Agency Response:**

Our audit report contains 9 findings and 11 corresponding recommendations. The Center's preliminary response indicates that it agrees with the recommendations.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: <http://audgen.michigan.gov>



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THOMAS H. MCTAVISH, C.P.A.  
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March 5, 2013

Mr. James K. Haveman, Jr., Director  
Department of Community Health  
Capitol View Building  
Lansing, Michigan

Dear Mr. Haveman:

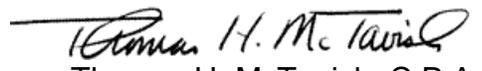
This is our report on the performance audit of the Caro Center, Bureau of State Hospitals and Behavioral Health Administrative Operations, Department of Community Health.

This report contains our report summary; description of agency; audit objectives, scope, and methodology and agency responses and prior audit follow-up; comments, findings, recommendations, and agency preliminary responses; various exhibits, presented as supplemental information; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agency's response subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a plan to comply with the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

  
Thomas H. McTavish, C.P.A.  
Auditor General



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BUREAU OF STATE HOSPITALS AND  
BEHAVIORAL HEALTH ADMINISTRATIVE OPERATIONS  
DEPARTMENT OF COMMUNITY HEALTH**

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## Description of Agency

The Caro Center is an inpatient psychiatric hospital, operated under the jurisdiction of the Department of Community Health (DCH), that provides treatment for adults with mental illness\*. Patients include those that are not guilty by reason of insanity, court ordered, and incompetent to stand trial (see Exhibit 7).

The mission\* of the Center is to provide the highest quality mental health services guaranteed by the Mental Health Code in a safe and supportive environment that maximizes individual growth and successful transition to the community.

The Center, located in Tuscola County, originated as the Michigan Farm Colony for Epileptics in 1914 and has since provided services for DCH. The Center provides services for mentally ill patients from all 15 Upper Peninsula counties and 30 Lower Peninsula counties (see Exhibit 1). As of May 2012, the Center had bed capacity for 242 patients. Over the last 10 fiscal years, the Center had an average daily census of 166 patients (see Exhibit 2). The Center's campus has 37 buildings, consisting of 3 occupied residential units, 2 unoccupied residential units, 2 buildings for clinical support services, 11 buildings for operations, 12 closed buildings, and 7 houses/apartments for contractual staff. Several of the closed buildings are in disrepair.

The Center is accredited by the Joint Commission\* and is certified as a provider of inpatient psychiatric hospital services in the Medicare program.

For fiscal year 2010-11, the Center had operating expenditures of \$37.7 million, of which 86% were personnel costs (see Exhibits 3 and 4). As of March 31, 2012, the Center had 354 employees and 143 patients (see Exhibits 5 and 6).

\* See glossary at end of report for definition.

## Audit Objectives, Scope, and Methodology and Agency Responses and Prior Audit Follow-Up

### Audit Objectives

Our performance audit\* of the Caro Center, Bureau of State Hospitals and Behavioral Health Administrative Operations, Department of Community Health (DCH), had the following objectives:

1. To assess the efficiency\* of the Center's use of selected resources.
2. To assess the effectiveness\* of the Center's efforts to safeguard selected State and patient assets.
3. To assess the effectiveness of the Center's efforts to evaluate the services it provided to patients.
4. To assess the effectiveness of the Center's efforts to investigate and resolve complaints.

### Audit Scope

Our audit scope was to examine the records and processes related to selected activities at the Caro Center. Selected activities included hospital operations, excluding patient care; administrative operations; human resources; and the Office of Recipient Rights (ORR). We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Our audit procedures, conducted from April through September 2012, generally covered the period October 1, 2009 through March 31, 2012.

Our audit was not directed toward examining patient care or clinical decisions made by Center staff concerning patient treatment identified within a patient's individual plan of service or expressing an opinion on those clinical decisions and, accordingly, we

\* See glossary at end of report for definition.

express no opinion on patient care or on those clinical decisions. Also, our audit report includes supplemental information presented as Exhibits 1 through 7. Our audit was not directed toward expressing an opinion on this information and, accordingly, we express no opinion on it.

### Audit Methodology

We conducted a preliminary review to gain an understanding of the Caro Center's operations and internal control\* in order to establish our audit objectives and methodology. Our preliminary review included interviewing Center staff; observing operations; reviewing selected policies and procedures and the Mental Health Code; examining patient case file documentation; analyzing the Center's expenditure and procurement card\* records; and touring the Center's buildings.

To accomplish our first audit objective, we interviewed Center staff and reviewed DCH and Center policies and procedures related to pharmacy operations, work orders, and human resources. Also, we analyzed and reviewed data related to medication refunds and purchases, work orders, human resource activities (overtime, hiring, and promotion), expenditures, and food costs. In addition, we judgmentally selected for review 40 work orders from a population of 696 work orders that took the Center 30 days or more to complete. Because we judgmentally selected the sample, the results cannot be projected to the entire population. Further, we conducted interviews with Center, DCH, and Department of Technology, Management, and Budget staff related to operating facility buildings efficiently and safely.

To accomplish our second objective, we interviewed Center staff and reviewed DCH and Center policies and procedures related to commodities and other items subject to inventory, items received and distributed by the warehouse, purchases, pharmacy operations and medications, preventive maintenance, and keys. Also, we analyzed and reviewed data related to procurement card purchases, inventory, items received and distributed by the warehouse, tools, food, patients' personal property, medication inventories, and preventive maintenance. In addition, we judgmentally selected for review 62 of the 3,621 procurement card purchases that occurred during our audit period. Because we judgmentally selected the sample, the results cannot be projected to the entire population.

\* See glossary at end of report for definition.

To accomplish our third objective, we interviewed Center staff; observed performance improvement team meetings and other Center team meetings; and reviewed policies, procedures, the Center's performance improvement plan, the Joint Commission Accreditation Manual related to performance improvement, and the Center's self-assessment of accreditation requirements. Also, we reviewed the Center's process to collect, analyze, and evaluate performance related data.

To accomplish our fourth objective, we interviewed Center and ORR staff and reviewed DCH, Center, and ORR policies and procedures related to investigating and resolving complaints. Also, we analyzed and reviewed Center and ORR data and documentation related to administrative report forms\*, incident reports\*, and sentinel events\*.

When selecting activities or programs for audit, we use an approach based on assessment of risk and opportunity for improvement. Accordingly, we focus our audit efforts on activities or programs having the greatest probability for needing improvement as identified through a preliminary review. Our limited audit resources are used, by design, to identify where and how improvements can be made. Consequently, we prepare our performance audit reports on an exception basis.

#### Agency Responses and Prior Audit Follow-Up

Our audit report contains 9 findings and 11 corresponding recommendations. The Center's preliminary response indicates that it agrees with the recommendations.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require DCH to develop a plan to comply with the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

\* See glossary at end of report for definition.

We released our prior performance audit of the Caro Center, Bureau of Hospitals, Centers, and Forensic Mental Health Services, Department of Community Health (391-0900-05), in November 2006. Within the scope of this audit, we followed up 15 of the 18 prior audit recommendations. The Center complied with 6 of the 15 prior audit recommendations. We repeated 2 audit recommendations in Findings 5 and 7, and we rewrote 7 prior audit recommendations for inclusion in Findings 1, 2, 3, 4, 6, 7, and 9 of this audit report.

COMMENTS, FINDINGS, RECOMMENDATIONS,  
AND AGENCY PRELIMINARY RESPONSES

## EFFICIENCY OF USE OF SELECTED RESOURCES

### COMMENT

**Audit Objective:** To assess the efficiency of the Caro Center's use of selected resources.

**Audit Conclusion:** We concluded that the Center's use of selected resources was moderately efficient. Our audit disclosed two reportable conditions\* related to the work order process and medication refunds (Findings 1 and 2).

### FINDING

1. Work Order Process

The Center had not implemented a comprehensive process to assign and monitor the cost and completion of work orders. As a result, the Center did not complete work orders timely and the Center could not ensure that work orders were completed efficiently or that materials were used for their intended approved project. The Center expended \$2.5 million for maintenance during our audit period.

Building managers or their designees used an electronic work order system to submit requests for repairs. The data from the Center's work order system indicated that, during our audit period, maintenance supervisory staff disapproved 205 work orders, maintenance staff completed 6,211 work orders, and 869 work orders were outstanding as of May 22, 2012.

Our review disclosed:

- a. The Center's maintenance staff did not always document the description of work performed for completed work orders. We judgmentally selected 40 completed work orders. We reviewed documentation describing the work requested and completed to determine the reasonableness of the time charged to the work order. Due to insufficient documentation describing the work requested or completed, the Center could not support that the time charged to the work order was reasonable for 15 (38%) of 40 completed work orders. During our audit period, labor accounted for approximately 73% or \$1.8 million of the maintenance expenditures.

\* See glossary at end of report for definition.

- b. The Center's work order process did not ensure accountability of materials that were intended to be used by staff to complete work orders. As a result, the Center could not support that it always used materials for the intended approved project. During our audit period, expenditures for materials accounted for approximately 13% or \$300,000 of total maintenance expenditures. We noted:
- (1) The Center did not require materials used to be documented on the completed work orders. As a result, for 14 (35%) of 40 judgmentally selected completed work orders, the Center could not ensure that materials purchased were used for the intended approved project.
  - (2) The Center did not ensure that staff documented the related work order number on the supply requisition forms that staff used to request materials from the warehouse. In addition, the Center did not require work order numbers to be included on the request to purchase form used by staff to request the purchase of materials needed to complete a work order (see part a. of Finding 3). Including the work order number on the supply requisition and request to purchase forms would provide information that could be used to help ensure that supplies and materials were used for the intended approved project.
- c. The Center did not ensure that staff completed work orders on a timely basis. Not completing work orders timely could potentially impact the safety of patients and staff.

Our review of 6,211 completed work orders disclosed that 385 (6%) of the work orders took over 60 days to complete. Although 94% of the work orders were completed within 60 days, we noted that some work orders for items that could impact patient daily activities and/or safety, such as fixing water leaks, replacing anti-slip strips in a patient's shower, and adjusting fire exit doors that were hard to get open, took over 90 days to complete.

- d. The Center did not ensure that outstanding work order information contained in the electronic work order system was complete and accurate. As a result, the Center could not use the electronic work order system as an effective

management tool. We judgmentally selected 58 of 869 work order requests shown in the work order system as outstanding as of May 22, 2012. The Center informed us that 48 (83%) of the 58 should have been canceled or were already completed and that the work order system was not updated. The Center monitors work orders at least quarterly by identifying new work orders and work orders completed during the quarter. However, the Center's process did not include a detailed review of outstanding work orders to verify that they were outstanding and to determine the reason. In addition, the Center informed us that the maintenance supervisor reviewed each work order request and prioritized the request; however, the priority level was not documented in the work order system.

- e. The Center did not ensure that it recorded all emergency repairs in the electronic work order system. The Center stated that staff did not consistently record emergency repairs in the electronic work order system, in part, because of staffing limitations and work load. Center hospital policy 3.07 requires that staff enter emergency work orders into the work order system. Recording emergency repairs would allow the Center to ensure that staff completed the requested work and that follow-up activity, if necessary, is documented and formally requested.

### **RECOMMENDATION**

We recommend that the Center implement a comprehensive process to assign and monitor the cost and completion of work orders.

### **AGENCY PRELIMINARY RESPONSE**

The Center agrees that there are opportunities for improvement in its overall work order process. However, the Center indicated that work orders are generally completed in a timely and efficient manner as demonstrated by 94% of work order requests being completed within 60 days. The Center also indicated:

- a. The Center agrees that time spent on work orders can be more thoroughly documented. The Center informed us that it will modify its policy to ensure that additional requirements are documented on the work orders, including a description of the work needed, identification of staff assigned, time spent completing the work, etc. However, the Center stated that maintenance staff

are Center employees and annual overall labor costs for maintenance will remain unaffected.

- b. The Center agrees that work orders did not always clearly document the materials required to complete the necessary work. The Center informed us that it will modify its policy to ensure that work orders contain a listing of materials and that supply requisitions are cross-referenced to work orders. In addition, the Center indicated it will require the review and approval of supply requisitions and request to purchase forms by the maintenance supervisor to ensure that materials used to complete the work orders are appropriate and reasonable.
- c. The Center disagrees and feels that work orders are generally completed in a timely and efficient manner as demonstrated by the 94% of work order requests being completed within 60 days. In addition, the Center informed us that it does not necessarily consider that a work order request taking over 60 days to complete is an automatic indication that the work order request was completed untimely. However, the Center agrees that work orders that could potentially affect patient safety should be dealt with timely.
- d. The Center agrees that outstanding work order information in the electronic work order system was not always complete and accurate. The Center informed us that it will modify its policy to include a documented quarterly review of all outstanding work orders to ensure that the work order system is complete and accurate.
- e. The Center agrees that not all emergency repairs were recorded in the electronic work order system. The Center informed us that it will revise its work order policy to require that all emergency work orders completed after hours be forwarded to the maintenance supervisor for entry into the electronic work order system. The Center stated that this will ensure that the work order was appropriately completed and allow for any necessary tracking or follow-up.

## **FINDING**

### **2. Medication Refunds**

The Center did not ensure that it was fully refunded for all returned medications. We noted that the Center had not pursued collection of an estimated \$8,000 of refunds outstanding.

The Center uses a vendor to coordinate the return of expired, recalled, damaged, and unneeded medications to the pharmaceutical suppliers and manufacturers. The vendor verifies the medications to be returned and generates a list that includes the quantity of each medication returned and the estimated refund amount.

Our review of the vendor's list for the medications returned between August 1, 2009 and October 1, 2011 disclosed that the Center had received refunds for returned medications totaling approximately \$27,000. However, based on the vendor's list and the estimated refund value, the vendors still owed the Center approximately \$8,000. Because the Center was unaware of this difference, it had not initiated any follow-up efforts.

## **RECOMMENDATION**

We recommend that the Center ensure that it is fully refunded for all returned medications.

## **AGENCY PRELIMINARY RESPONSE**

The Center agrees that it did not have adequate controls in place to ensure that the vendor's tentative manifest was reconciled to the final return manifest.

The Center informed us that Department of Community Health (DCH) vendor representatives coordinate the return of medications and determine an estimated refund amount, which is later finalized by the vendor and returned to the Center on a final return manifest. The Center indicated that the vendor then consolidates return manifests for all DCH hospitals and centers and issues the refund in total to the DCH central office.

The Center indicated that the Bureau of State Hospitals and Behavioral Health Administrative Operations (BSHBHAO) will work with DCH Accounting and determine what, if any, additional reconciliation procedures could be performed to aid in the distribution of return revenues to the respective hospital or center.

## **EFFORTS TO SAFEGUARD SELECTED STATE AND PATIENT ASSETS**

### **COMMENT**

**Audit Objective:** To assess the effectiveness of the Center's efforts to safeguard selected State and patient assets.

**Audit Conclusion:** **We concluded that the Center's efforts to safeguard selected State and patient assets were moderately effective.** Our audit disclosed five reportable conditions related to procurement cards, inventory controls, patient personal property, medication controls, and preventive maintenance (Findings 3 through 7).

### **FINDING**

#### **3. Procurement Cards**

The Center did not effectively monitor procurement card transactions to ensure that purchases were proper and authorized. Also, the Center did not ensure that procurement card account information was properly safeguarded. As a result, the Center could not support that purchases were for intended approved purposes or in accordance with State policies.

For the period October 1, 2009 through June 14, 2012, the Center had 7 procurement cards. The Center's procurement card activity totaled 3,621 purchases and approximately \$665,000. We reviewed 62 judgmentally selected procurement card purchases totaling approximately \$29,000.

Our review of procurement card purchases disclosed:

- a. The Center did not provide sufficient documentation, such as the related work order number, to support that 9 (15%) of the 62 purchases totaling \$5,749 were used for intended approved purposes.

Department of Technology, Management, and Budget (DTMB) Administrative Guide procedure 510.17 indicates that the procurement card is to be used for State purposes and that cardholders should obtain and attach all documents to transaction reports.

- b. The Center could not locate the procurement card log for 3 (5%) of the 62 procurement card purchases totaling \$1,607. DCH requires that cardholders sign and date the procurement card log. The procurement card log provides support that the cardholder verified that purchases were appropriate and accurate.
- c. The Center did not retain documentation of supervisory reviews of procurement card purchases for 6 (10%) of the 62 purchases. DCH and the Center's procurement card procedures require the cardholder's supervisor to review procurement card billing information and authorize payment of the procurement card bill on a biweekly basis. Timely review of procurement card purchases could identify misuse of cards.
- d. The Center did not ensure that it safeguarded procurement card account information. For 4 (6%) of the 62 purchases, we noted that the procurement card account numbers were displayed on the receipt or other documentation. The Center should remove procurement card account numbers from all documents to prevent someone from inappropriately obtaining and using the account numbers.

The Procurement Card Program Cardholder Manual and DTMB Administrative Guide procedure 510.17 require the cardholder to maintain security of the account number, expiration date, and security code at all times.

## **RECOMMENDATIONS**

We recommend that the Center effectively monitor procurement card transactions to ensure that purchases are proper and authorized.

We also recommend that the Center ensure that procurement card account information is properly safeguarded.

## **AGENCY PRELIMINARY RESPONSE**

The Center agrees that there are opportunities for improvement in its overall procurement card processes:

- a. The Center agrees that additional documentation, such as work orders, could further support that procurement card purchases were used for intended purposes. The Center informed us that current procurement card procedures do not require a related work order number to document purchases. The Center indicated that each of the 9 purchases followed DTMB Administrative Guide procedures and had a completed purchase request form that indicated the purpose of the purchase in the justification section. The Center also indicated that each of the 9 purchases had sales receipts, invoices, and other documentation to support the purchase. The administrative manager or the hospital director reviewed and approved each purchase. The Center informed us that it will determine if additional documentation, such as a work order number, would further enhance procurement card purchases' documentation.
- b. The Center agrees that it could not locate 2 procurement card logs related to 3 procurement card purchases. The Center indicated that, for the instances cited, the responsibility of maintaining the procurement card log belonged to an accounting supervisor who left the Center in September 2011 and that current Center staff were unable to locate the appropriate log. DCH indicated that BSHBHAO management will reiterate to Center staff the importance of maintaining all supporting documentation for procurement card purchases.
- c. The Center agrees that it could not provide documentation that the cardholders' supervisors completed their biweekly reconciliation of these procurement card purchases. The Center indicated that, for the instances cited, the responsibility of maintaining the procurement card documentation belonged to an accounting supervisor who left the Center in September 2011 and that current Center staff were unable to locate the documentation in the files. DCH indicated that BSHBHAO management will reiterate to Center staff the importance of maintaining all supporting documentation for procurement card purchases.

- d. The Center acknowledges that security of the procurement card account numbers and expiration dates is critical. The Center informed us that, subsequent to the audit, cardholders were instructed to review supporting documentation to ensure that all associated card numbers and other identifying information are obliterated from the receipt prior to record storage. The Center indicated that it will include this in a policy statement and ensure that a procedure is in place.

## **FINDING**

### **4. Inventory Controls**

The Center did not have effective controls over its inventories. As a result, the Center could not ensure that necessary commodities were available and that its inventories were properly safeguarded against waste, misuse, loss, and theft.

The Center's inventory included over 2,000 different commodities, including food, cleaning supplies, maintenance supplies and materials, patient clothing, tools, and various pieces of equipment. During the period October 1, 2009 through March 31, 2012, the Center expended \$2.2 million on its various commodities.

Our review disclosed:

- a. The Center did not maintain accurate and complete inventory records. Accurate inventories help to ensure that the necessary commodities are available, to ensure patient and staff safety, and to protect against loss and theft. We noted:
  - (1) The Center's warehouse inventory records were not accurate for 25 (74%) of the 34 judgmentally selected items we reviewed. For example, the inventory records indicated that there were 4 microwaves in the warehouse; however, the Center could not locate any microwaves in the warehouse. In addition, we observed that items such as room air conditioners and refrigerators were located in the warehouse but were not included in the Center's inventory records.

The State of Michigan Financial Management Guide (FMG) prescribes guidelines for establishing, maintaining, and ensuring the accuracy of a supplies and materials inventory control program and requires agencies to record in departmental accounting records all equipment items that have an acquisition value of \$5,000 or greater. Further, the FMG suggests that equipment with a value of less than \$5,000 that is susceptible to theft may be inventoried and included in the department's records. Center warehouse policy 4.06 regarding inventory identifies items such as, but not limited to, digital video disc (DVD) players, radios, televisions, and appliances as susceptible to theft.

- (2) The Center's inventory records for tools assigned to maintenance staff did not match our physical count. The Center could not locate 12 (2%) of the 498 tools that had been assigned to the five maintenance staff that we reviewed. Missing tools included screwdrivers, wrenches, a hand planer, and a pipe cutter. In addition, we identified that the five staff had a total of 52 tools that were not included in the inventory records for tools assigned to maintenance staff.

Center maintenance policy 4.21 requires that the Center maintain a list of all tools assigned to maintenance staff and update the list as tools are added or removed.

- (3) The Center's inventory records for the tool crib did not match our physical count for 11 (28%) of the 39 tools judgmentally selected and reviewed.

Center warehouse policy 4.09 requires that the Center maintain a list of all items contained in the tool crib.

- b. The Center did not ensure that warehouse staff properly documented the receipt and distribution of inventory items. We noted:

- (1) For 6 (15%) of the 39 judgmentally selected purchase transactions reviewed, the packing slips did not include the warehouse employee's initials. Initialing the packing slip helps to ensure that the Center verified that it received all the items purchased.

Center warehouse policy 4.06 requires warehouse staff to initial and date the request to purchase form and packing slips.

- (2) For 13 (46%) of the 28 judgmentally selected transactions reviewed, the Center did not have documentation to support that the items removed from inventory were received by the requestor. Documentation supporting receipt of inventory items by the requestor helps to protect against loss and theft.

Center warehouse policy 4.06 requires the individual requesting the item from inventory to sign a supply requisition form to verify receipt of the item.

### **RECOMMENDATION**

We recommend that the Center establish effective controls over its inventories.

### **AGENCY PRELIMINARY RESPONSE**

The Center agrees that there are opportunities for improvement in its controls over inventories:

- a.(1) The Center agrees that there have been delays in getting commodity inventory updated in the inventory records. The Center indicated that a significant decrease in staffing since November 2010 caused delays in the updating of inventory records on a timely basis. The Center informed us that an additional accounting staff member was hired in October to assist with this function and help the Center maintain more accurate and complete inventory records. The Center informed us that accounting staff are currently updating inventory records.
- a.(2) The Center agrees that inventory records for tools assigned to five maintenance staff did not match the physical count. The Center will modify maintenance policy 4.21 to incorporate a periodic documented inventory of maintenance staff tools.

- a.(3) The Center agrees that inventory records for the tool crib did not match the physical count; however, a large portion of these tools are low in monetary value and the effort to account for every low-value small tool (including screwdrivers, wrenches, pipe cutters, and hand planers) is substantial. The Center indicated that, subsequent to the audit, maintenance staff completed an inventory of all tools maintained in the tool crib. In addition, the Center indicated that its management will review policy 4.09 to determine if modifications are necessary.
- b.(1) The Center agrees that it did not ensure that it properly documented the receipt of commodities purchased by the Center and received by warehouse staff. The Center indicated that it is reviewing warehouse policy 4.06 to determine the procedural changes that are necessary to address this issue. The Center indicated that revisions will be made if necessary to ensure that receipt of purchases is appropriately documented.
- b.(2) The Center agrees that it did not ensure that it properly documented receipt of the distributed commodities by the requestor. The Center indicated that it is reviewing warehouse policy 4.06 to determine the procedural changes that are necessary to address this issue. The Center indicated that revisions will be made if necessary to ensure that requestor receipt is appropriately documented.

## **FINDING**

### 5. Patient Personal Property

The Center needs to improve its controls over patients' personal property. Effective controls over patients' personal property would help the Center ensure that it properly safeguards patients' personal property and would minimize the Center's liability for lost, damaged, or stolen personal property.

Section 330.1728 of the *Michigan Compiled Laws* indicates that patients are entitled to receive, possess, and use personal property while at the facility. In addition, Section 330.1730 of the *Michigan Compiled Laws* indicates that State facilities must have policies and procedures related to patient accounts, ensuring that patients have easy access to their money and enabling them to spend their money.

Our review of patient purchases and inventory records disclosed:

- a. The Center did not ensure that it obtained patient and Center staff signatures as required by policy. Signatures by patients and Center staff provide support that the patients and Center approved and received purchases. We noted:
  - (1) The Center did not document that the patients actually received the items purchased for 12 (75%) of 16 patient purchases totaling approximately \$1,500. Seven of the 12 patient fund release authorization forms had been signed by the patients indicating they had received the items prior to the actual purchase of the items, and 5 patient fund release authorization forms did not include the patients' signatures indicating they had received the items purchased.
  - (2) The Center did not ensure that 1 (6%) of 16 patient fund release authorization forms included a signature by an appropriate Center staff member supporting that the patient had received the items purchased.

Center hospital procedure 2.56:1 requires that the patient and staff sign the patient fund release authorization form to acknowledge the receipt and delivery of items.

- b. The Center did not record all purchases of patients' personal property on the personal inventory forms. We noted that, for 7 (44%) of 16 personal property purchases, staff did not record the purchase on the patients' personal property inventory forms. For example, the Center did not include items such as iPod nanos, shoes, and a watch. The value of the 7 items not recorded on the patients' personal inventory forms totaled \$600.

Center hospital procedure 2.56:1 requires staff to record nonexpendable items, such as books, clothing, jewelry, compact discs, etc., on the patients' personal inventory forms.

- c. The Center did not properly inventory patients' personal property upon admission. During a tour of the Center's warehouse, we observed a pallet of items wrapped up and set aside. The Center informed us that the pallet

contained a patient's personal property and included items such as books, clothes, a dresser, a lamp, pots and pans, a radio, and a rocking chair. The Center indicated that staff had not inventoried the items. As a result, the patient and appropriate Center staff were not aware that the patient's personal property was in the warehouse.

Center hospital procedure 2.56:1 requires the warehouse to inventory patients' personal property stored at the warehouse.

- d. The Center could not support that staff returned patients' personal property upon discharge. Our review of personal property inventory logs for 5 recently discharged patients disclosed that signatures supporting that the patients received their personal property were missing for all 5 (100%) of the patients.

We noted items such as a laptop computer, an MP3 player, DVDs, and clothing on the patients' personal inventory forms which the patients, staff, or a witness did not sign indicating that the Center returned the items to the patients. Obtaining the appropriate signatures provides assurance that the Center returned personal property to the patients.

Section 330.1728(7) of the *Michigan Compiled Laws* and *Michigan Administrative Code* R 325.14306(8) require that any personal property in the possession of a facility at the time the patient to whom the property belongs is released be returned to the patient.

We noted a similar condition in our prior audit. In response to that audit report, the Center indicated that it agreed with our prior audit recommendation and that it had developed a comprehensive policy related to patient property.

## **RECOMMENDATION**

We again recommend that the Center improve its controls over patients' personal property.

## **AGENCY PRELIMINARY RESPONSE**

The Center agrees that there are opportunities for improvement in its controls over patients' personal property:

- a.(1) The Center informed us that management has reiterated to staff the importance of patients signing the acknowledgements only after they have received their items. The Center informed us that, as of July 2012, when a patient fund release form is prematurely signed acknowledging receipt of an item(s), the signature is blacked out. Staff are then required to put two Xs on the form: one to indicate where the patient needs to sign to acknowledge receipt of the item(s) and the second for nursing staff or a designee to sign and date.

In addition, the Center indicated that 3 of the 5 patient fund release forms were for clients who were unable to sign for themselves. The Center stated that, should this become an issue again, nursing staff will be required to document receipt of any purchases on behalf of the patients and note why the patients are unable to sign themselves.

- a.(2) The Center informed us that it reiterated to nursing staff during the October 2012 nurse council meeting the requirement to sign the patient fund release form to support that the patients received their item(s).
- b. The Center informed us that it reiterated to staff the necessity of inventorying all nonexpendable items as required by policy 2.56:1. In addition, the Center indicated that it made clarifications to the policy which it believes will further enhance existing procedures. The Center also indicated that all nursing staff will be trained on the revisions.
- c. The one patient's personal property noted in this finding was received in April 2012 from a group home several years after the patient was admitted to the Center. The Center informed us that, due to the excessive quantity of property received, the Center did not have enough storekeeping staff resources to complete the inventory at the time of arrival. The Center indicated that the patient's personal property has subsequently been inventoried in the patient's presence.

- d. The Center informed us that it reiterated to staff the current requirements for obtaining documentation that the patient received all personal property at the time of discharge. In addition, the Center indicated that it made clarifications to the policy which it believes will further enhance existing procedures. The Center also indicated that all nursing staff will be trained on the revisions.

## **FINDING**

### **6. Medication Controls**

The Center did not maintain an inventory control program or periodically inventory its noncontrolled medications\*. These medications accounted for \$3.95 million (98%) of the Center's \$4.03 million total medication costs during fiscal years 2009-10 and 2010-11. Without such a program, the Center could not properly account for the noncontrolled medications it purchased.

To accommodate patients' medication needs, the Center operates an on-site pharmacy that orders, receives, and stocks hundreds of different prescriptions and over-the-counter medications, including both controlled\* and noncontrolled medications. Noncontrolled medications included drugs such as Seroquel and Zyprexa, which are psychotropic medications\*.

The FMG (Part II, Chapter 12, Section 100) requires agencies maintaining warehouses or stock centers to establish and maintain an inventory control program. Also, the FMG requires agencies to verify the accuracy of inventory systems by completing a physical count of the inventory and comparing it with the inventory balances.

DCH and the Center implemented the Mediware\* system beginning in August 2011. The Center currently uses Mediware to determine medications dispensed to individual patients. DCH and the Center indicated that Mediware should be fully operational, specifically the inventory component, during April 2013 and, once fully operational, the Mediware system should provide the Center with the ability to maintain a perpetual inventory system of noncontrolled medications.

\* See glossary at end of report for definition.

## **RECOMMENDATION**

We recommend that the Center maintain an inventory control program and periodically inventory its noncontrolled medications.

## **AGENCY PRELIMINARY RESPONSE**

The Center agrees that it did not maintain an inventory control program or periodically inventory its noncontrolled substances during the audit period. DCH indicated that, over the past several years, it has been implementing a new pharmacy system at all of the State hospitals. DCH informed us that the pharmacy component of the new system has been implemented at all hospitals; however, the vendor continues to work with DTMB on the implementation of the inventory control component (WORxPO). DCH indicated that an implementation schedule has been developed for all of the facilities, and the Center has been identified as the pilot site. DCH informed us that the tentative date to go live for the inventory component is mid-March 2013. DCH indicated that, once this component has been implemented, the Center will be able to track all pharmaceuticals as they are received and subsequently dispensed by the pharmacy to the various areas within the Center that have responsibility for administering medications.

## **FINDING**

### **7. Preventive Maintenance**

The Center did not conduct all of the preventive maintenance inspections required by its preventive maintenance system. Also, the Center did not ensure that information maintained in the preventive maintenance system was accurate. As a result, the Center could not ensure that all equipment was properly maintained, functioning correctly, or safe for usage.

The Center established a preventive maintenance plan that includes schedules for inspecting the Center's equipment and conducting various inspections and tests of its mechanical, electrical, security, and plumbing systems. Each month, the Center provides the maintenance staff with a schedule of inspections that the staff are to complete during the month.

Our analysis of preventive maintenance records disclosed:

- a. The Center's preventive maintenance system indicated that the Center did not complete 356 (11%) of 3,256 preventive maintenance assignments for the period October 1, 2009 through April 30, 2012. Center staff informed us that the assignments were not completed primarily due to a lack of staff. They also stated that staff did not need to complete some assignments as they were the result of inaccuracies within the preventive maintenance system. For 11 (28%) of 40 preventative maintenance assignments randomly selected, we noted that the information contained in the preventive maintenance system was inaccurate. For example, the Center informed us that some items were no longer in service and should have been reported as inactive in the system. The Center also informed us that other items required preventive maintenance every four years; however, the system indicated a yearly requirement.
- b. The Center did not inspect respirators, for use by maintenance staff, on a monthly basis for 11 (34%) of 32 months reviewed. Center maintenance policy 4.25 requires respiratory protection equipment inspections monthly.

We noted a similar condition in our prior audit. In response to that audit report, the Center indicated that it agreed with our prior audit recommendation, that it met with the individuals responsible for completing preventive maintenance inspections, and that an internal monitoring system would be developed to track and monitor inspections.

## **RECOMMENDATIONS**

We again recommend that the Center conduct all of the preventive maintenance inspections required by its preventive maintenance system.

We also recommend that the Center ensure that information maintained in the preventive maintenance system is accurate.

## **AGENCY PRELIMINARY RESPONSE**

The Center agrees that it did not adequately review information in the preventive maintenance system to ensure that data maintained in the system was accurate and that all necessary preventive maintenance inspections were completed:

- a. The Center agrees that the process for addressing the preventive maintenance schedule requires revisions. The Center indicated that the maintenance supervisor will review the preventive maintenance plan on a monthly basis and ensure that monthly scheduled tasks are prioritized and completed as necessary. The Center informed us that any adjustments to the preventive maintenance plan due to inaccuracies in frequency of inspections or removal due to obsolete equipment will be fully documented. The Center indicated that the maintenance supervisor will report the status of all preventive maintenance to the administrative leadership team on a quarterly basis.
- b. The Center informed us that the maintenance supervisor will develop a documented monthly review of all confined space equipment inspections, which includes the respirators. The Center indicated that administrative support staff will track inspections to ensure compliance.

## **EFFORTS TO EVALUATE SERVICES**

### **COMMENT**

**Audit Objective:** To assess the effectiveness of the Center's efforts to evaluate the services it provided to patients.

**Audit Conclusion:** **We concluded that the Center's efforts to evaluate the services it provided to patients were effective.** Our audit report does not include any reportable conditions related to this audit objective.

## EFFORTS TO INVESTIGATE AND RESOLVE COMPLAINTS

### **COMMENT**

**Background:** The Center receives complaints related to its operations from patients and related parties, Center staff, and the community. For purposes of the audit, we considered sentinel events, allegations of suspected abuse of patient rights received by the Office of Recipient Rights (ORR), and information included in administrative report forms and incident reports to be complaints. The Center is required to resolve these types of complaints and inform ORR of incident reports, sentinel events, and complaints related to suspected patient rights violations.

**Audit Objective:** To assess the effectiveness of the Center's efforts to investigate and resolve complaints.

**Audit Conclusion:** We concluded that the Center's efforts to investigate and resolve complaints were moderately effective. Our audit disclosed two reportable conditions related to ORR and complaints (Findings 8 and 9).

### **FINDING**

#### 8. Office of Recipient Rights (ORR)

The DCH ORR staff located at the Center had not established an effective process to ensure that all potential patient rights violations were identified. As a result, ORR staff could not ensure that they fulfilled ORR's mission of ensuring that the highest standard of rights protection is available to recipients of public mental health services in Michigan.

The Center investigated all deaths and critical events. However, to ensure the highest standard of rights protection to the patients at the Center, ORR policy required ORR staff to perform an independent preliminary review of the circumstances surrounding patient deaths to determine if an investigation was warranted because of suspected rights violations. If ORR initiated an investigation, policy required that ORR staff document the results and conclusions in the investigation report. If the preliminary review by ORR staff did not identify suspected rights violations and an investigation was not initiated, policy required ORR staff to complete a review of recipient death form. For serious injuries, ORR policy required that ORR staff perform an independent review of the incident to determine if a patient's rights were potentially violated.

Our review disclosed:

a. ORR staff did not provide adequate documentation supporting the rationale for not investigating 4 (50%) of the 8 patient deaths that occurred during the audit period. We noted:

(1) For 2 (25%) of the 8 patient deaths, ORR could not locate the review of recipient death forms.

(2) For 2 (25%) of the 8 patient deaths, ORR staff did not document their rationale for determining that an investigation was not warranted.

DCH ORR procedure 02-03-02 required ORR to complete a review of recipient death form when it determined that there was no cause to suspect that a violation of the recipient's rights caused or contributed to the recipient's death. However, this form did not require ORR to document the rationale for determining that an investigation by ORR was not warranted. Without an adequately completed review of recipient death form, ORR was unable to support its determination that patient rights were not violated.

b. ORR staff did not fully review the one serious injury to a patient that occurred during our audit period.

An altercation between two patients resulted in a patient losing an eye. ORR staff investigated the techniques used to separate the patients but did not adequately review the circumstances surrounding the injury to the patient's eye. ORR staff stated that policy did not require an investigation because the eye injury was not the result of an apparent or a suspected rights violation.

c. ORR staff did not provide documentation supporting that it completed 5 (63%) of the 8 review of recipient death forms timely. We noted:

(1) For 2 (25%) of the 8 patient deaths, ORR did not date the review of recipient death forms.

(2) For 1 (13%) of the 8 patient deaths, ORR did not complete the review of recipient death form until 60 days after the patient's death.

- (3) For 2 (25%) of the 8 patient deaths, ORR could not locate the review of recipient death forms (as noted in part a.(1) of this finding).

Section 330.1778 of the *Michigan Compiled Laws* requires that ORR initiate investigations of apparent or suspected recipient rights violations in a timely and efficient manner. In addition, DCH ORR procedure 02-03-02 required that ORR staff perform an immediate preliminary review of all deaths.

- d. ORR staff did not include all patient deaths or serious injuries in the ORR database. As a result, ORR management could not track or monitor to ensure that ORR staff reviewed and resolved patient deaths and serious injuries timely. We noted that ORR management was not aware that staff did not fully review the eye injury and that staff did not complete the preliminary reviews of patient deaths timely.

DCH ORR procedure 02-02-03 required that staff log all complaints into the ORR database to ensure that staff reviewed and properly resolved all complaints. However, DCH ORR procedures did not require that staff log all deaths and serious injuries into the ORR database.

- e. DCH ORR did not ensure that its procedures provided specific guidance to ORR staff. ORR procedure 02-02-03 required ORR staff to perform an investigation if an apparent or a suspected rights violation occurred. However, the ORR Procedures Manual did not define apparent or suspected rights violation and did not provide specific guidance to assist ORR staff in performing an investigation or determining if a rights violation occurred.

## **RECOMMENDATION**

We recommend that the DCH ORR staff located at the Center establish an effective process to ensure that all potential patient rights violations are identified.

## **AGENCY PRELIMINARY RESPONSE**

DCH ORR agrees that there are opportunities for improvement in the processes to ensure that all potential patient rights violations are identified and reviewed:

- a. DCH ORR agrees that a review of recipient death form should be thoroughly completed and retained to support the rationale used to determine that further investigation was not warranted. DCH ORR policy 02-03-02 requires that ORR staff review the circumstances surrounding the death and determine if there were any apparent or suspected rights violations that may have caused or contributed to the death. DCH ORR indicated that ORR staff complete a review of recipient death form which allows for comments from the reviewers but does not require the reviewers to explicitly document their rationale for not conducting an investigation. ORR acknowledges that documentation was not available to support that ORR completed its preliminary review for 2 deaths. DCH ORR management indicated that it will review existing policy and determine what, if any, changes to existing policy are necessary to further enhance the necessity of appropriate documentation.
- b. DCH ORR agrees that one serious injury investigation should have been broadened from looking at intervention techniques used by Center staff once the incident occurred to reviewing if there was any act of omission or commission by Center staff that caused or contributed to the injury. DCH ORR management indicated that it will review existing policy and determine what, if any, changes are necessary to ensure that serious injuries to patients are fully reviewed for potential patient rights violations.
- c. DCH ORR agrees that it did not always document that ORR staff performed an immediate preliminary review of all deaths. DCH ORR management indicated that it will review existing policy and determine what, if any, changes are necessary. In addition, in the interim, DCH ORR management informed us that it will reiterate to ORR staff the importance of completing their reviews timely and the importance of adequate documentation.

- d. DCH ORR agrees that the ORR database does not report and track the status of serious injuries or patient deaths. Instead, the ORR database is designed to track and monitor the status of "rights complaints." ORR management informed us that it will review and determine if system capabilities would allow for additional tracking.
- e. DCH ORR acknowledges that its procedures may not provide "specific" guidance; however, DCH ORR indicated that all DCH ORR staff are required to attend 48 hours of initial training within 90 days of hiring, as well as 24 hours of annual training in recipient rights. DCH ORR indicated that this extensive training enables ORR staff to become proficient in identifying "apparent or suspected" rights violations.

## **FINDING**

### 9. Complaints

The Center did not ensure that staff entered all administrative report forms (ARFs) and incident reports into the Center's complaint database. As a result, the Center could not use the database as an effective management tool to help ensure that all ARFs and incident reports were properly and timely resolved.

The Center used ARFs or incident report forms to document specific incidents, allegations, and complaints involving patients or hospital operations. Center policy requires that staff enter information from these forms into the complaint database.

During our audit period, there were over 5,000 ARFs and completed incident reports in the complaint database. We judgmentally selected 25 ARFs and 25 incident reports for review. Our review noted that 10 (40%) of the 25 ARFs and 7 (28%) of the 25 incident reports were not entered into the complaint database. Some of these reports related to issues that ORR investigated or were part of a human resource action and were maintained by the Center's director. Subsequent to their resolution, staff should have entered these reports into the complaint database.

## **RECOMMENDATION**

We recommend that the Center ensure that staff enter all ARFs and incident reports into the Center's complaint database.

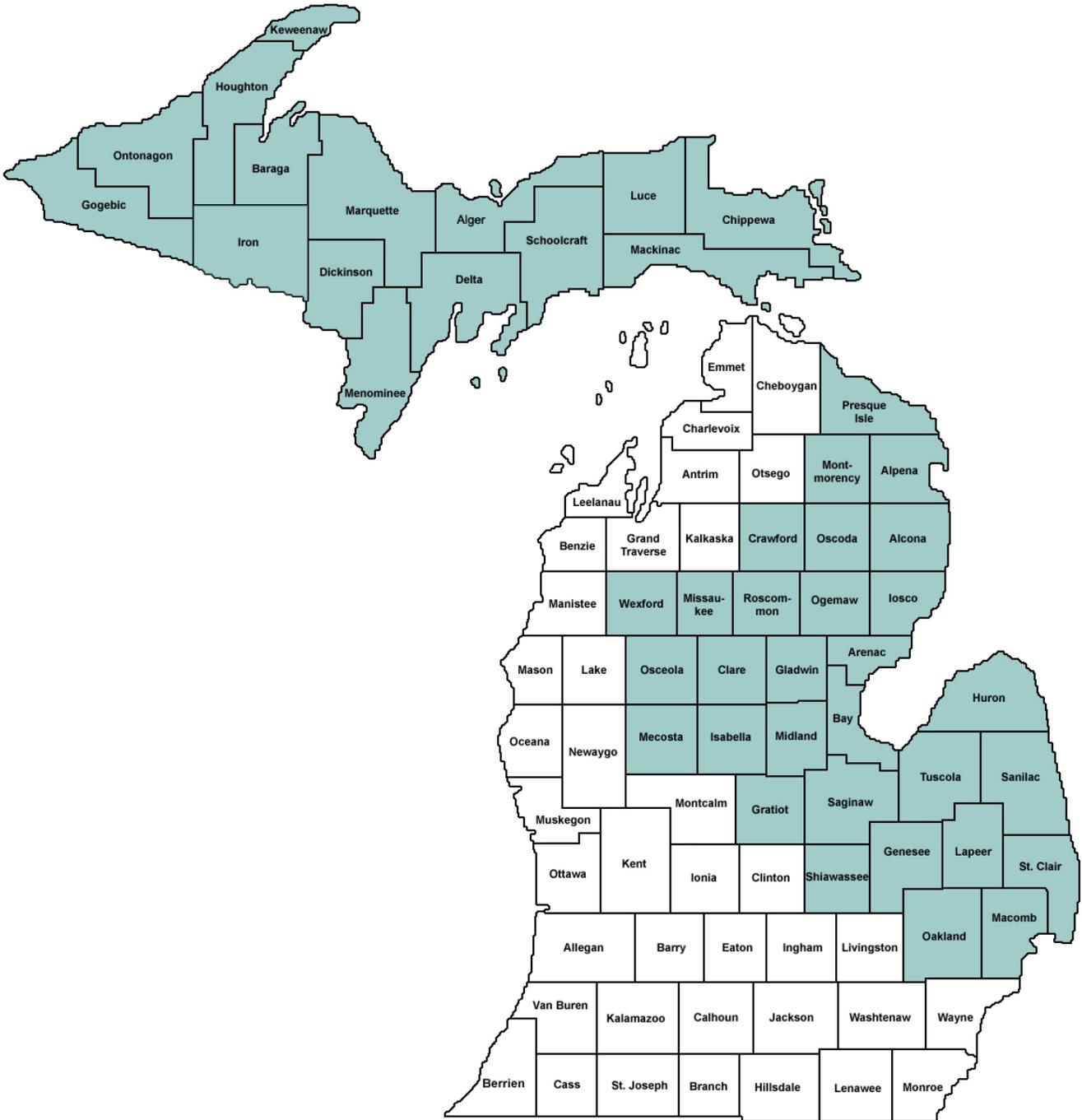
## **AGENCY PRELIMINARY RESPONSE**

The Center agrees that all ARFs and incident reports were not appropriately entered into the complaint database as required by Center policy.

The Center informed us that it initiated a performance improvement focus team to address the process for data submission in order to ensure that all ARFs and incident reports are entered into the database in a timely and accurate manner. The Center also informed us that two hospital policies were revised to ensure that the tracking mechanism is maintained. The Center indicated that staff will receive training on the revised policies to ensure compliance.

# SUPPLEMENTAL INFORMATION

CARO CENTER  
Map of Service Area  
As of September 30, 2012



Shaded counties represent the service area for the Caro Center.  
Source: Caro Center.

CARO CENTER  
Patient Admissions, Discharges, and Average Daily Census Data  
For Fiscal Years 2001-02 through 2010-11

Fiscal Year	Admissions	Discharges	Average Daily Census
2001-02	277	295	170
2002-03	241	213	169
2003-04	275	252	201
2004-05	246	272	185
2005-06	160	164	175
2006-07	176	177	158
2007-08	124	128	159
2008-09	110	127	151
2009-10	106	107	147
2010-11	74	74	145
10-Year Average	179	181	166

The average daily census was calculated by dividing the number of patient days by 365. Because of the varying lengths of time that patients were treated at the Center, the average daily census may not increase or decrease at a rate consistent with the yearly difference between admissions and discharges.

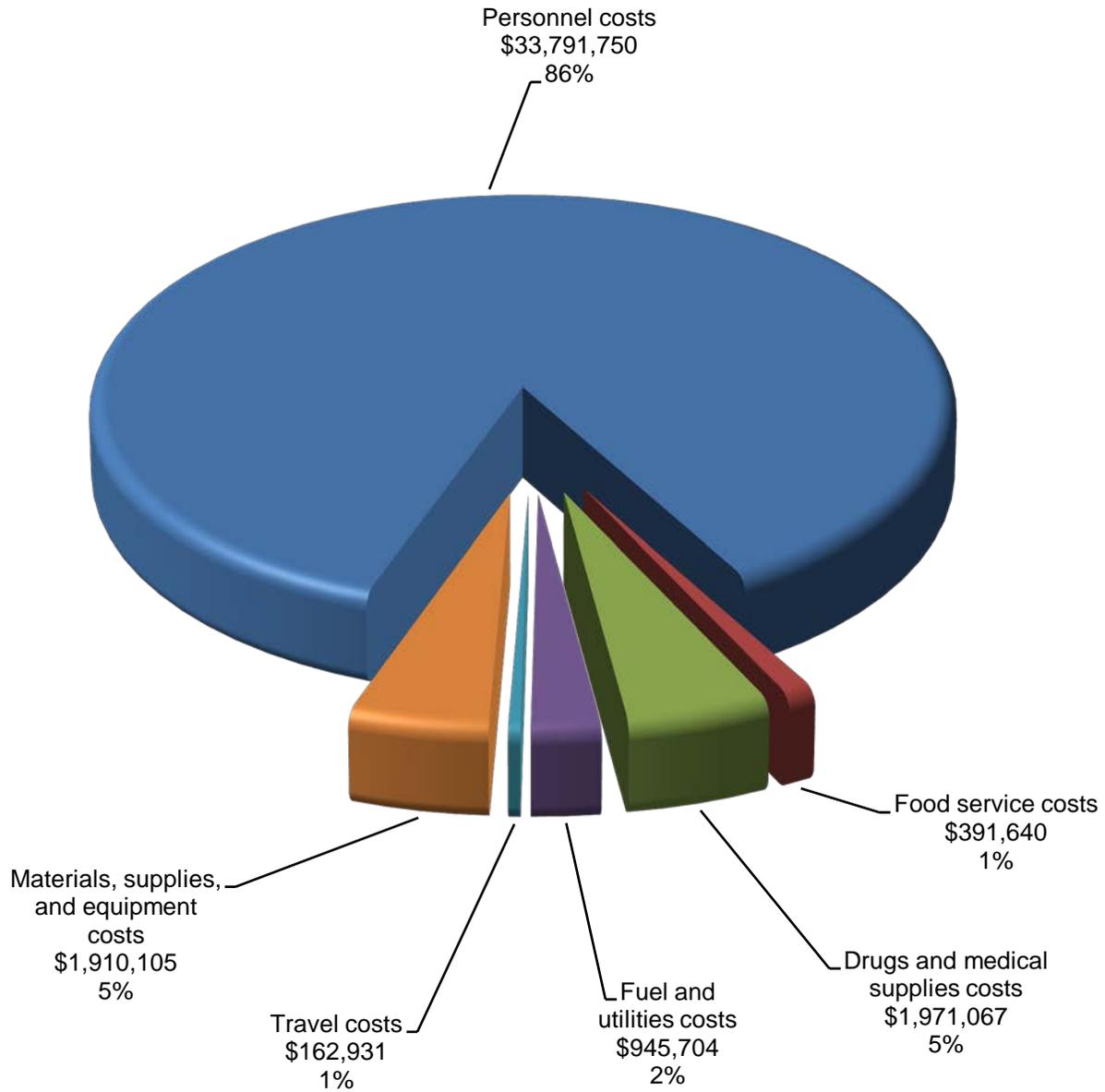
Source: Caro Center.

CARO CENTER  
Expenditures and Average Cost Per Patient  
For Fiscal Years 2006-07 through 2010-11

	Fiscal Years					Five-Year Average
	2006-07	2007-08	2008-09	2009-10	2010-11	
Average number of patients	158	159	151	147	145	152
Personnel costs	\$ 32,411,385	\$ 33,233,222	\$ 33,926,198	\$ 37,026,023	\$ 32,361,920	\$ 33,791,750
Average cost per patient	\$ 205,135	\$ 209,014	\$ 224,677	\$ 251,878	\$ 223,186	\$ 222,778
Food service costs	\$ 391,239	\$ 427,078	\$ 361,171	\$ 415,921	\$ 362,789	\$ 391,640
Average cost per patient	\$ 2,476	\$ 2,686	\$ 2,392	\$ 2,829	\$ 2,502	\$ 2,577
Drugs and medical supplies costs	\$ 1,797,713	\$ 2,054,105	\$ 1,864,071	\$ 2,142,152	\$ 1,997,292	\$ 1,971,067
Average cost per patient	\$ 11,378	\$ 12,919	\$ 12,345	\$ 14,572	\$ 13,774	\$ 12,998
Fuel and utilities costs	\$ 943,524	\$ 1,030,992	\$ 1,077,501	\$ 906,036	\$ 770,465	\$ 945,704
Average cost per patient	\$ 5,972	\$ 6,484	\$ 7,136	\$ 6,164	\$ 5,314	\$ 6,214
Travel costs	\$ 136,488	\$ 155,481	\$ 152,663	\$ 175,488	\$ 194,533	\$ 162,931
Average cost per patient	\$ 864	\$ 978	\$ 1,011	\$ 1,194	\$ 1,342	\$ 1,078
Materials, supplies, and equipment costs	\$ 1,295,262	\$ 1,729,213	\$ 1,676,550	\$ 2,885,400	\$ 1,964,100	\$ 1,910,105
Average cost per patient	\$ 8,198	\$ 10,876	\$ 11,103	\$ 19,629	\$ 13,546	\$ 12,670
Total agency costs	\$ 36,975,611	\$ 38,630,091	\$ 39,058,154	\$ 43,551,020	\$ 37,651,099	\$ 39,173,195
Average cost per patient	\$ 234,023	\$ 242,957	\$ 258,663	\$ 296,265	\$ 259,663	\$ 258,314

Source: Caro Center.

CARO CENTER  
Five-Year Average Expenditures by Category  
Fiscal Years 2006-07 through 2010-11



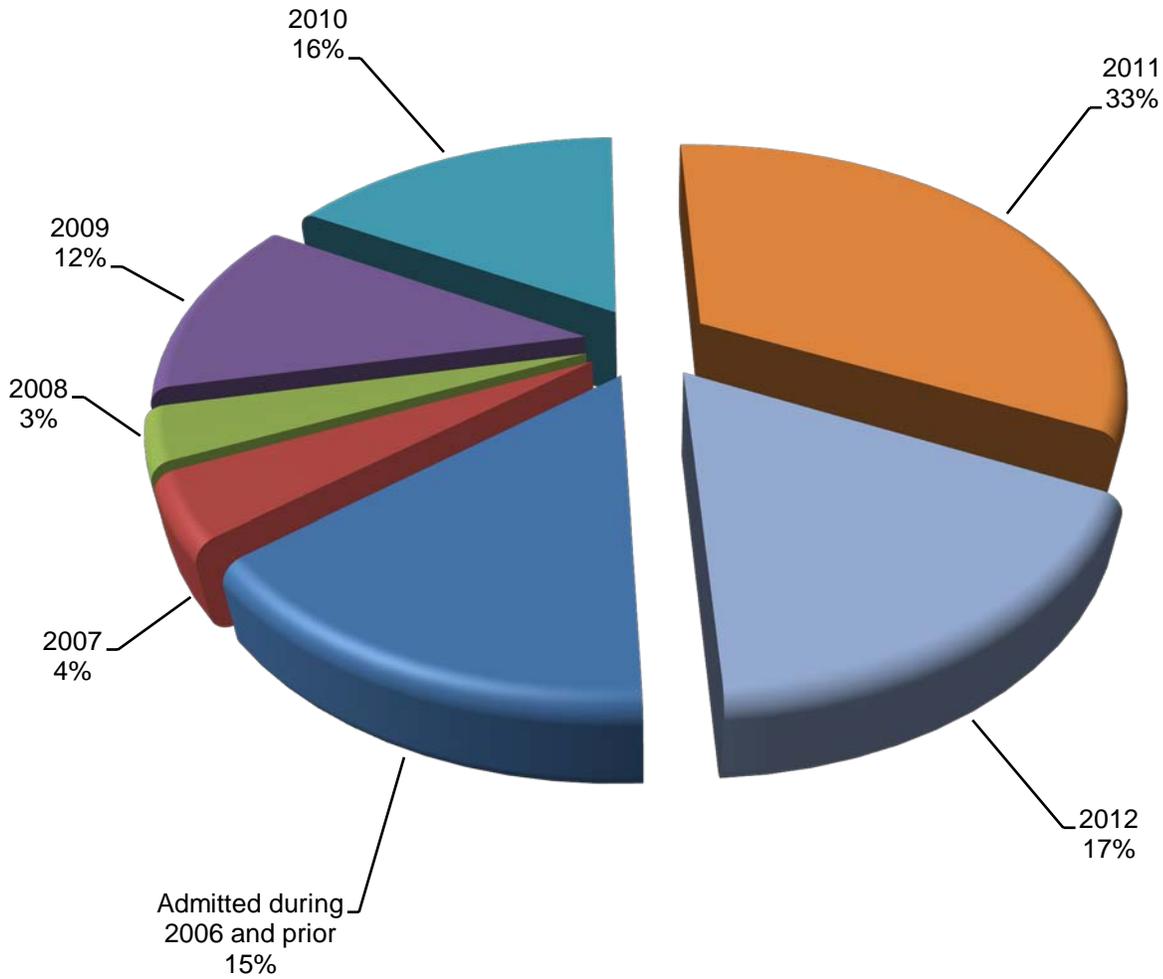
Source: Caro Center.

CARO CENTER  
Patient Census Breakdown  
As of March 31, 2012

	Number of Patients	Percentage of Total
Patient Location:		
Cottage 15	43	30.1%
Cottage 16	44	30.7%
Cottage 27 physically frail and fragile	24	16.8%
Cottage 27	32	22.4%
Total	<u>143</u>	<u>100.0%</u>
Admission Dates:		
1997	3	2.0%
1998	1	0.7%
2000	1	0.7%
2001	1	0.7%
2002	4	2.8%
2003	1	0.7%
2004	1	0.7%
2005	6	4.2%
2006	3	2.1%
2007	6	4.2%
2008	5	3.5%
2009	17	12.0%
2010	23	16.1%
2011	47	33.0%
2012	24	16.8%
Total	<u>143</u>	<u>100.0%</u>
Gender:		
Male	91	63.6%
Female	52	36.4%
Total	<u>143</u>	<u>100.0%</u>
Legal Status:		
Court ordered	59	41.3%
Not guilty by reason of insanity	74	52.0%
Incompetent to stand trial	5	3.5%
Maintenance court order	4	2.8%
Voluntary admission	1	0.7%
Total	<u>143</u>	<u>100.0%</u>

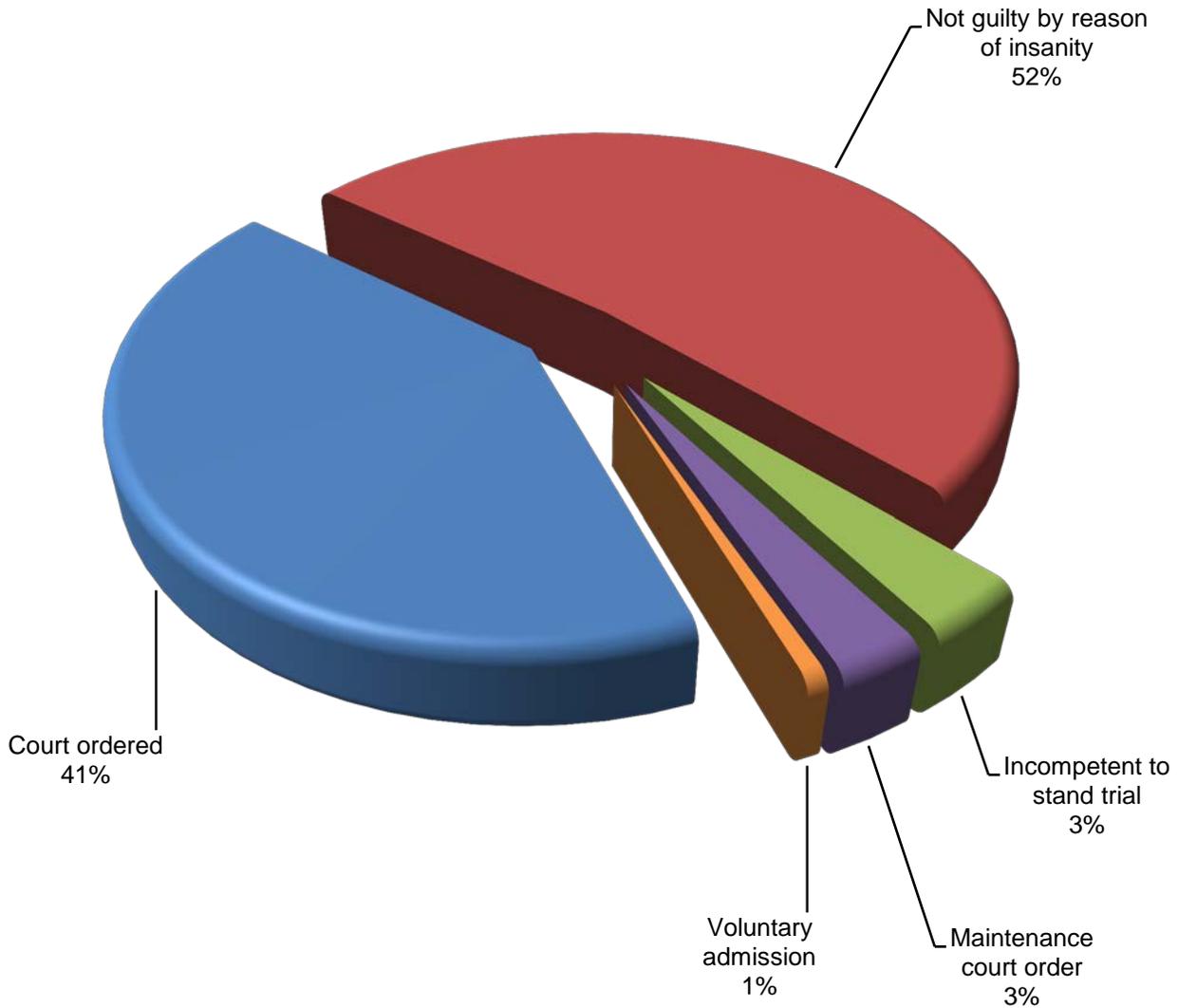
Source: Caro Center.

CARO CENTER  
Admission Years for Patients  
For Patients Hospitalized as of March 31, 2012



Source: Caro Center.

CARO CENTER  
Legal Status for Patients' Hospitalization  
For Patients Hospitalized as of March 31, 2012



Source: Caro Center.

# GLOSSARY

## Glossary of Acronyms and Terms

administrative report form (ARF)	A mechanism to document, investigate, follow up, and recommend corrective action for unusual events or conditions that impact the Center's operations.
BSHBHAO	Bureau of State Hospitals and Behavioral Health Administrative Operations.
controlled medication	A drug or other substance, or immediate precursor, included in Schedule I, II, III, IV, or V of the federal Controlled Substances Act (i.e., Title 21, section 801, et seq., of the <i>United States Code</i> , which controls the manufacture, distribution, and dispensing of controlled substances).
DCH	Department of Community Health.
DTMB	Department of Technology, Management, and Budget.
DVD	digital video disc.
effectiveness	Success in achieving mission and goals.
efficiency	Achieving the most outputs and the most outcomes practical with the minimum amount of resources.
FMG	State of Michigan Financial Management Guide.
incident report	A mechanism to document and report events of an unusual nature involving patients. Events requiring an incident report include but are not limited to patient deaths, serious injuries to patients, manual holds, known or suspected abuse or neglect of a patient, patient suicide attempts, unauthorized leave of absence, etc.

internal control	The plan, policies, methods, and procedures adopted by management to meet its mission, goals, and objectives. Internal control includes the processes for planning, organizing, directing, and controlling program operations. It includes the systems for measuring, reporting, and monitoring program performance. Internal control serves as a defense in safeguarding assets and in preventing and detecting errors; fraud; violations of laws, regulations, and provisions of contracts and grant agreements; or abuse.
Joint Commission	An independent, not-for-profit organization that accredits and certifies more than 19,000 health care organizations and programs in the United States. Joint Commission accreditation and certification are recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.
Mediware	A pharmacy management system that provides software and hardware solutions. The system has the ability to interface with other systems and modules and, as a result, streamline workflow, automate inventory controls for medicines, and provide accurate and efficient medication management for the general safety of patients.
mental illness	A substantial disorder of thought or mood that significantly impairs an individual's judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.
mission	The main purpose of a program or an entity or the reason that the program or the entity was established.

noncontrolled medication	A drug or other substance, or immediate precursor, that is not included in Schedule I, II, III, IV, or V of the federal Controlled Substances Act (i.e., Title 21, section 801, et seq., of the <i>United States Code</i> , which controls the manufacture, distribution, and dispensing of controlled substances).
ORR	Office of Recipient Rights.
performance audit	An audit that provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.
procurement card	A credit card issued to State employees for purchasing commodities and services in accordance with State purchasing policies.
psychotropic medication	A drug that acts primarily upon the central nervous system where it alters brain function, resulting in changes in perception, mood, consciousness, cognition, and behavior. Common types of psychotropic drugs include antidepressants, anti-anxiety agents, antipsychotics, and mood stabilizers.
reportable condition	A matter that, in the auditor's judgment, is less severe than a material condition and falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the audit objectives; all instances of fraud; illegal acts unless they

are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.

sentinel event

An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. Risk thereof includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.







