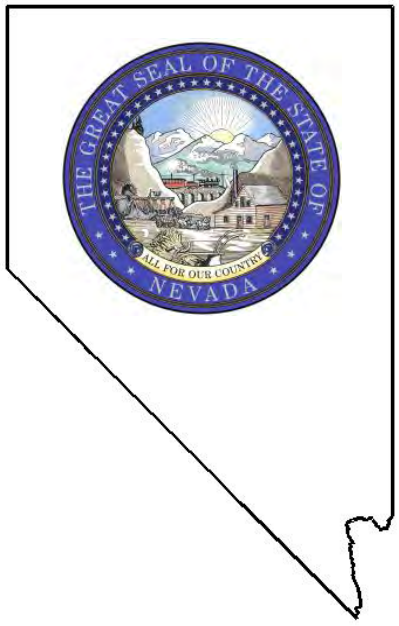
STATE OF NEVADA

Legislative Counsel Bureau
Audit Division
Audit Report Summaries
2017-2018



Eightieth Nevada Legislature

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MEMORANDUM

TO: Members of the Senate Committee on Finance
Members of the Assembly Committee on Ways and Means

FROM: Rocky Cooper, Legislative Auditor RC

DATE: February 1, 2019

SUBJECT: **Audit Report Summaries**

This document contains summaries of audits issued during the past biennium from January 1, 2017, through December 31, 2018. The table of contents references both the summary page and the agency's corresponding page in the Executive Budget. Each section contains one-page highlights of the audits performed, followed by additional information regarding agency action on recommendations. The complete audit reports are available on the Audit Division's website at www.leg.state.nv.us/audit/. After an audit report has been issued, the following steps help ensure our audit recommendations are adequately implemented:

- Agencies are required to prepare a plan of corrective action 60 days after an audit report is issued detailing the anticipated steps to implement the audit recommendations.
- A status report is prepared by the Governor's Finance Office, Internal Audit Division, after it reviews the status of the audit recommendations 6 months after the 60 day plan of corrective action.
- The Audit Subcommittee of the Legislative Commission may also require agencies to attend meetings of the Subcommittee to discuss progress towards successful implementation of recommendations.

The involvement of the Legislature is an important part of the audit follow-up process that helps ensure corrective action is taken. Consequently, this involvement has contributed to continuing financial benefits. The audit report summaries in this document identify over $15 million in monetary benefits, cost savings, and revenue enhancements. Including measurable financial benefits from prior years' recommendations that impact the current biennium, we estimate financial benefits totaling more than $44 million were realized over the past biennium. These savings would not have been possible without the support and involvement of the Legislature.

LEGISLATIVE COUNSEL BUREAU
AUDIT DIVISION
AUDIT REPORT SUMMARIES

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LEGISLATIVE COUNSEL BUREAU
AUDIT DIVISION
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Finance/Admin

Audit Highlights

Highlights of performance audit report on the Hearings Division issued on January 17, 2018. Legislative Auditor report # LA18-09.

Background

The mission of the Hearings Division is to provide fair and independent dispute resolution hearings in a timely and cost-efficient manner while providing due process to all parties. The Division is committed to providing fair and impartial hearings in accordance with the highest standards of ethics, professionalism, efficiency, and accountability.

The Division is responsible for conducting all hearings in disputed workers compensation cases, Victims of Crime Program appeals, state bid award disputes, and Department of Education disciplinary disputes. In addition, the Division conducts hearings via inter-agency agreements with several state agencies.

As of November 2016, all 45 of the Division's authorized full-time equivalent positions were filled. The Division is primarily funded through transfers from the Fund for Workers Compensation and Safety Administration by the Department of Business and Industry's Division of Industrial Relations. Expenditures for fiscal year 2016 totaled almost $4.6 million.

Purpose of Audit

The purpose of this audit was to determine if the Division has: (1) adequate controls to protect personally identifiable information and sensitive health information; and (2) adequate controls related to performance measures, accounts receivable and revenue tracking, and employee performance evaluations. The scope of our audit focused on activities in certain areas from fiscal year 2014 through 2016.

Audit Recommendations

This audit report contains two recommendations to improve the protection of sensitive information and seven recommendations to improve controls over performance measures, accounts receivable and revenue tracking, and employee evaluations.
The Hearings Division accepted the nine recommendations.

Recommendation Status

The Hearings Division's 60-day plan for corrective action is due on April 12, 2018. In addition, the six-month report on the status of audit recommendations is due on October 12, 2018.

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Hearings Division

Department of Administration

Summary

The Division's controls related to the protection of personally identifiable information and sensitive health information need improvement. The Division collects Social Security numbers unnecessarily from applicants for workers compensation employer representative licensure and maintains that information on its hearings management system. Additionally, the Division has not worked with the Department of Administration's Enterprise Information Technology Services (EITS) to review the security of its server.

The Division's controls related to certain financial and administrative practices need strengthening. Specifically, the Division's policies and procedures for performance measures, including data collection, calculation, and supervisory review, are too vague. In addition, there is currently no process to ensure hearings conducted under agreements with some agencies are properly billed and collected. The Division's controls do not ensure that revenues are sufficiently reviewed and reconciled to the state's accounting system. Finally, the Division did not evaluate employee performance as required by state law.

Key Findings

The Division collects and maintains nonessential personal information in hardcopy format, including Social Security numbers. Furthermore, the Division stored unencrypted Social Security information of 435 workers compensation employer representative licensees on its hearings information management system. This information is accessible to six Division employees who do not need the information to carry out their assigned duties. (page 4)

The Division has not adequately protected information in its hearings case management information system. This information is critical for the Division to meet its mission to provide hearings in a timely and cost-efficient manner. The Division uses its own server for its hearings management system. Although EITS set up and installed the server, Division staff stated the security settings for the server have not been reviewed by EITS. A security review of the Division's server will help reduce the risk of a third-party security breach. (page 5)

Due to the Division's lack of supporting records, we could not determine the accuracy of its three performance measures. Furthermore, the Division's policies and procedures are not sufficient and are not followed. In addition, descriptions of the measures in the Executive Budget are not clear or accurate. The Division can provide better information to decision makers by improving its performance measures. (page 6)

The Division does not have an adequate process to ensure it bills and collects amounts due for conducting hearings for state agencies. We found problems with 13 of 50 (26%) of the cases tested: 9 cases were not billed and 4 cases totaling $995 were billed but not collected. These problems occurred because the Division does not have adequate policies and procedures to help ensure all appropriate services are billed and collected. (page 10)

The Division's revenue collection practices need improvement. For example, the Division did not deposit revenue timely. Staff deposited 19 of 29 receipts tested an average of 4 days late. Also, management did not reconcile check logs with the state's accounting system on a monthly basis to verify all receipts were deposited and recorded correctly. In addition, the Division does not have procedures regarding revenue collection for the workers compensation representative licensing process, which has led to different practices between the Las Vegas and the Carson City offices. (page 11)

The Division did not evaluate employees' performance as required by state law. We examined 32 employee records for evidence of required probationary period evaluations and for evidence of required annual evaluations. In fiscal years 2015 to 2016 there were 69 employee evaluations due, but 56 evaluations were not conducted by the Division. Also, 7 of the 13 evaluations conducted were past due by more than 30 days. Without the required evaluations, management does not have documentation to ensure that promoted employees are fulfilling their new duties satisfactorily, to terminate employees who are not performing adequately, or to acknowledge those employees whose performance exceeds standards. (page 12)

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MEMORANDUM

To: Rocky Cooper, CPA, Legislative Auditor
Legislative Counsel Bureau

From: Paul Nicks, Acting Director
Governor's Finance Office

Date: October 12, 2018

Subject: Legislative Audit of the Department of Administration, Hearings Division

On January 17, 2018, your office released an audit report on the Department of Administration, Hearings Division (division). The division subsequently filed a corrective action plan on April 13, 2018. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the division to comply with audit findings.

There were nine recommendations contained in the report. The extent of the division's compliance with the audit recommendations is as follows:

Recommendation 1

Discontinue collecting Social Security numbers from applicants for workers compensation employer representative licensure and delete the Social Security number field from the hearings management system.

Status – Fully Implemented

Agency Actions – The division discontinued the collection of Social Security numbers from applicants for workers compensation employer representative licensure and deleted the Social Security number field from the hearings management system. We reviewed the hearings management system's electronic contact form and hard-copy forms and determined Social Security numbers are no longer collected or maintained.

Recommendation 2

Ensure that the Department of Administration's Enterprise Information Technology Services (EITS) periodically reviews the hearings management system server's security settings.

Status – Fully Implemented

Agency Actions – The division's hearings management system's server security settings are reviewed weekly during EITS office security scans. EITS reviews the security scan results and provides a copy of the results on a weekly basis to the division.

Recommendation 3

Review performance measures to determine whether the measures are clearly defined and the correct information is measured.

Status – Fully Implemented

Agency Actions – The division revised its performance measures to clearly define each measure, and ensure that the correct information is measured. We reviewed the revised performance measures and inquired about the review process. The division reports the director of the Department of Administration approved these measures which are being reviewed quarterly by the Senior Appeals Officer.

Recommendation 4

Develop policies and procedures on the methodology used to obtain each performance measure and distribute to all affected staff. The procedures should include how the supporting data is collected, how the measures are calculated, who reviews the calculations, and how long the supporting data and calculations are retained.

Status – Fully Implemented

Agency Actions – The division revised its performance measures methodology and created a performance measures section in its Policies and Procedures Manual. The revised methodology which will be used going forward includes: how the supporting data is collected, how the measures are calculated, who reviews the calculations, and how long the supporting data and calculations are retained. The performance measures methodology was distributed to all affected staff. We reviewed the updated methodology and observed the step by step online process which will be used by the division in calculating future performance measures with no exceptions noted.

Recommendation 5

Create policies and procedures to address accounts receivable to ensure collection of money for all billable hearings.

Status – Fully Implemented

Agency Actions – The division updated the Policies and Procedures Manual and created a section called "Accounts Receivables (A/R)" to provide policy guidelines and ensure collection of money for all billable hearings. We reviewed the A/R policies and procedures and sampled four billing documents and determined the division is following the requirements of the newly created A/R policies and procedures.

Recommendation 6

Comply with policies and procedures related to collecting revenue.

Status – Fully Implemented

Agency Actions – The division revised the policies and procedures related to collecting revenue and distributed it to affected staff. We reviewed the revenue policies and procedures, and check receipt logs, and determined the division is properly logging all checks received, and the checks were sent to the Administrative Services Division in Carson City for deposit in accordance with NRS 353.250.

Recommendation 7

Update policies and procedures to include administering workers compensation licenses, including the collection and deposit of fees, in both the Carson City and Las Vegas offices.

Status – Fully Implemented

Agency Actions – The division updated the workers' compensation license and revenue sections of its Policies and Procedures Manual to include administering workers compensation licenses, collecting, and depositing fees in both Carson City and Las Vegas offices. We reviewed the updated policies and procedures and workers compensation licenses' documentation with no exceptions noted.

Recommendation 8

Develop a system to monitor due dates and conduct timely employee performance evaluations.

Status – Fully Implemented

Agency Actions – The division updated its personnel and payroll policies and procedures manual. A system to monitor due dates and conduct timely employee performance evaluations was also developed by designating the Administrative Assistant IV as the timekeeper to track employee's evaluation schedule due dates online. We reviewed the electronic system for scheduling employee evaluations for compliance with the established evaluation schedule. We noted an evaluation was not completed for one of the employees since 2014. Subsequent follow-up with staff disclosed it was an oversight and the employee's next evaluation is due on October 20, 2018, and an evaluation meeting has already been scheduled between the employee and his supervisor.

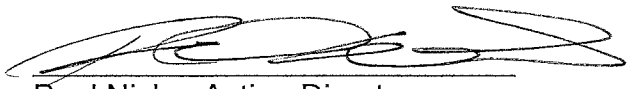
Recommendation 9

Update the Division's policies and procedures to include evaluations for new hires and recently promoted employees in compliance with NRS 284.340.

Status – Fully Implemented

Agency Actions – The division updated the personnel and payroll section of its Policies and Procedures Manual which details the policy for evaluations of new hires, recently promoted employees, and permanent employees. We reviewed the updated policies and procedures and determined it complies with NRS 284.340.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.



Paul Nicks, Acting Director
Governor's Finance Office

cc: Mike Willden, Chief of Staff, Office of the Governor
Patrick Cates, Director, Department of Administration
Michelle Morgando, Administrator and Senior Appeals Officer, Hearings Division
Steve Weinberger, CPA, Administrator, Division of Internal Audits

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October 19, 2018

Members of the Audit Subcommittee
of the Legislative Commission
Legislative Building
Carson City, Nevada 89701-4747

In January 2018, we issued an audit report on the Hearings Division (Division) of the Department of Administration. The Division filed its plan for corrective action in April 2018. NRS 218G.270 requires the Governor's Finance Office to issue a report within 6 months after the plan for corrective action is due outlining the implementation status of the audit recommendations.

Enclosed is the six-month report prepared by the Governor's Finance Office on the status of the nine recommendations in the audit report. As of October 12, 2018, the Finance Office indicated all nine recommendations were fully implemented. Therefore, we have no questions for agency officials.

Respectfully Submitted,

Rocky Cooper, CPA
Legislative Auditor

RC:sy
cc: Michael J. Willden, Chief of Staff, Office of the Governor
Paul Nicks, Acting Director, Office of Finance, Office of the Governor
Steve Weinberger, CPA, Administrator, Division of Internal Audits, Office of the Governor
Patrick Cates, Director, Department of Administration
Michelle L. Morgando, Esq., Senior Appeals Officer, Hearings Division, Department of Administration

(NSPO Rev. 1-18)
(O) 1578E

Audit Highlights

Highlights of performance audit report on the Victims of Crime Program issued on January 17, 2018. Legislative Auditor report # LA18-10.

Background

The Victims of Crime Program was established in 1969 by the Nevada Legislature. The Program is responsible for assisting eligible victims who suffer injuries from violent crimes that occur in Nevada. The Program provides payment of crime related medical expenses, counseling, lost income, and other approved benefits. The mission of the Program is to provide financial assistance to victims of crime in a timely, cost efficient, and compassionate manner.

The State Board of Examiners is the governing authority of the Program and adopts rules and regulations to formulate standards for the payment of compensation to victims of crime. The Hearings Division's Senior Appeals Officer serves as the Program Coordinator. The Program has office locations in Las Vegas and Carson City. As of November 2016, all seven of the Program's authorized full-time equivalent positions were filled.

The Program is funded primarily from court assessments and a federal grant. Expenditures for fiscal year 2016 totaled $6.1 million.

Purpose of Audit

The purpose of this audit was to (1) determine whether the Program has adequate controls to protect personally identifiable information and sensitive health information; and (2) determine if the Program has adequate controls related to performance measures, subrogation and revenue tracking, and employee performance evaluations. The scope of our audit focused on activities in certain areas from fiscal years 2014 through 2016.

Audit Recommendations

This audit report contains two recommendations to improve the protection of sensitive information and five recommendations to improve controls over performance measures, receipts, subrogation tracking, and employee evaluations.

The Program accepted the seven recommendations.

Recommendation Status

The Program's 60-day plan for corrective action is due on April 12, 2018. In addition, the six-month report on the status of audit recommendations is due on October 12, 2018.

Victims of Crime Program

Department of Administration

Summary

The Program's controls related to the protection of personally identifiable information and sensitive health information are weak. Documents containing sensitive information were not stored in a secure manner. Additionally, the Program's policies do not address document security until time of shredding. Furthermore, the Program has not reviewed the security of the contractor's server and the contract does not address protecting the server from unauthorized access by outside parties. The documents on the server contain sensitive information such as victims' personal information, medical records, and Social Security numbers.

Program controls related to certain administrative and financial practices need strengthening. First, the Program's policies and procedures regarding performance measures need improvements to ensure reported results are reliable. In addition, the Program needs to improve its process of recovering funds from victims when appropriate. Finally, the Program's controls related to reconciling revenues and evaluating employee performance can be strengthened.

Key Findings

Documents containing sensitive information are stored in an insecure manner. Boxes containing victim medical records and various other documents that are waiting to be shred are located in an open area that is accessible by all Program employees and janitorial staff provided by the building owner. These documents contained medical information and applications that include victim name, address, date of birth, crime information, and Social Security numbers. (page 4)

The Program's contractor stores victim data on its server at the contractor's office in Las Vegas. According to Program staff, neither the Program nor Enterprise Information Technology Services have reviewed the contractor's server security settings. Additionally, the contract does not address protecting the victims' data from unauthorized access by an outside party. Weak security controls may leave some information unprotected and vulnerable to third party security breaches. (page 5)

The Program's controls over collecting information and calculating performance measures do not provide assurance that the performance measures are accurate and reliable. The Program did not retain underlying records to support its reported performance measure numbers. Additionally, staff could not re-create the reports to match the numbers reported to the Department of Administration. In addition, there is no evidence that anyone reviewed the measures to ensure consistency with the budget instructions. (page 8)

The Program has not developed adequate policies to help ensure reliable and consistent reporting of performance measures. The Program's policies and procedures do not indicate how measures are calculated, who calculates the measures, how often they are calculated, who reviews the calculations, and to whom the measures are reported. The State Administrative Manual requires agencies to develop written procedures on how performance measures are calculated, including where data are obtained and which reports are used. (page 10)

The Program is entitled to and has the right to seek reimbursement from victims for money paid by the Program if victims obtain any recoveries. The Program refers to this reimbursement as a subrogation. However, there is no process in place to track known subrogation opportunities so there is no assurance that all subrogations are paid to the Program. Similar programs in other states we contacted have developed methods to track and recover subrogation funds. (page 10)

The Program's revenue collection and tracking processes need improvement. Staff are not adhering to some revenue collection and tracking procedures, such as performing reconciliations. While we did not detect evidence of fraud, the Program increases the risk that money could be lost or stolen, or errors could go undetected when it does not follow its internal control policies and procedures. The Program receives checks for restitution, subrogation, reimbursements, and donations. In fiscal year 2016, this amounted to $162,500 in receipts. (page 12)

The Program continues to have problems completing timely employee evaluations. In fiscal year 2015 and fiscal year 2016, 16 employee evaluations were due, but only 9 (56%) were conducted by the Program. Furthermore, seven of the nine evaluations conducted were past due by an average of 109 days. One employee's file did not contain any evaluations conducted since 2011. (page 13)

Brian Sandoval
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MEMORANDUM

To: Rocky Cooper, CPA, Legislative Auditor
Legislative Counsel Bureau

From: Paul Nicks, Acting Director
Governor's Finance Office

Date: October 12, 2018

Subject: Legislative Audit of the Department of Administration, Victims of Crime Program (Program).

On January 17, 2018, your office released an audit report on the Department of Administration, Victims of Crime Program (Program). The Program subsequently filed a corrective action plan on April 13, 2018. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the Program to comply with audit findings.

There were seven recommendations contained in the report. The extent of the department's compliance with the audit recommendations is as follows:

Recommendation 1

Update policies and procedures to ensure crime victims' confidential and sensitive information is protected. These policies and procedures should include document security until time of shredding.

Status – Fully Implemented

Agency Actions – The Program updated its Confidentiality Policy and distributed it to all affected staff. The Program also purchased a secure locked container to keep all documents secure until time of shredding. All documents that are awaiting pickup are kept in locked drawers until picked up. We observed the process and interviewed staff regarding access to confidential information and noted no exceptions..

Recommendation 2

Amend the contract to address periodic external security reviews of the contractor's server and protection from unauthorized access to victims' information by an outside party.

Status – Fully Implemented

Agency Comments – The Program reports their contractor has partnered with an outside company to perform periodic security reviews of the contractor's server to protect from unauthorized access to victims information by an outside party.

Auditor's Comments – The Program reported the recommendation was partially implemented in their six month's response letter. Subsequently, EITS reviewed the security scans provided by the outside company and stated that it satisfies the requirements of this recommendation. We reviewed the security scan and communications between EITS and VOC and noted no exceptions. Therefore, this recommendation is deemed fully implemented.

Recommendation 3

Develop policies and procedures on the methodology used to obtain each performance measure and distribute it to all affected staff. The procedures should include how the supporting data is collected, calculated, reviewed, and retained.

Status – Fully Implemented

Agency Actions – The Program developed policies and procedures on the methodology used to obtain each performance measure and distributed it to all affected staff. The procedures include: how the supporting data is collected, calculated, reviewed, and retained. We reviewed the Program's performance measures and noted no exceptions.

Recommendation 4

Create policies and procedures for identifying, tracking, and collecting subrogation recovery funds.

Status – Fully Implemented

Agency Actions – The Program created the Subrogation and Civil Suit Recoveries policies and procedures that includes the statutory provisions of NRS 217.240. We reviewed the tracking sheet, check log, deposits, and sample letters sent to attorney's requesting payments be sent to VOC following any collections made on behalf of the clients. The Program appears to be in compliance with the requirements of NRS 217.240.

Recommendation 5

Comply with policies and procedures related to collecting revenue.

Status – Fully Implemented

Agency Actions – The Program revised the policies and procedures related to collecting revenue and distributed it to affected staff. We reviewed the revenue policies and procedures, and check receipt logs. We noted one check out of eight reviewed was not deposited timely. Subsequent discussions with the Program Manager disclosed the person in-charge was a new temp employee who forgot to send the check to the Administrative Services Division in Carson City for deposit. The new employee according to the Program has since been retrained.

Recommendation 6

Conduct employee evaluations timely, and update policies and procedures to include a periodic review by the Program Coordinator of scheduled evaluations to ensure they are completed timely.

Status – Fully Implemented

Agency Actions – The Program developed new "Employee Evaluation and Work Performance Standard Policy" that requires a periodic review by the Program Coordinator of scheduled evaluations to ensure they are completed timely. We discussed the new policy with the Program Coordinator, and Manager and reviewed the electronic evaluation scheduling system for compliance with the established evaluation schedules with no exceptions noted.

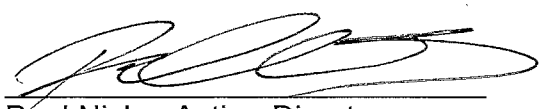
Recommendation 7

Update the Program's policies and procedures to include evaluations for new hires and recently promoted employees in compliance with NRS 284.340.

Status – Fully Implemented

Agency Actions – The Program updated the personnel and payroll section of its Policies and Procedures Manual which details the policy for evaluations of new hires, recently promoted employees, and permanent employees. We reviewed the updated policies and procedures and determined it complies with NRS 284.340. In addition, the Program is current with its employee performance evaluations.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.



Paul Nicks, Acting Director
Governor's Finance Office

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October 19, 2018

Members of the Audit Subcommittee
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Carson City, Nevada 89701-4747

In January 2018, we issued an audit report on the Victims of Crime Program (Program) of the Department of Administration (Department). The Program filed its plan for corrective action in April 2018. NRS 218G.270 requires the Governor's Finance Office to issue a report within 6 months after the plan for corrective action is due outlining the implementation status of the audit recommendations.

Enclosed is the six-month report prepared by the Governor's Finance Office on the status of the seven recommendations in the audit report. As of October 12, 2018, the Finance Office indicated all seven recommendations were fully implemented. However, the Finance Office did not fully address the implementation of Recommendation No. 2, which is shown below.

Recommendation Number	
2	Amend the contract to address periodic external security reviews of the contractor's server and protection from unauthorized access to victims' information by an outside party.

The Finance Office's report indicates the Program's contractor has partnered with an outside company that performs security scans on the contractor's server. The Department's Enterprise Information Technology Services has reviewed the scans and is satisfied that they meet the requirements for external security reviews. However, Program management states in August 2018 that the contract would be amended to require security scans in approximately 6 months.

Therefore, we will review the Program's contract amendment after approval by the Board of Examiners to determine whether it includes appropriate measures to fully implement this recommendation. Because we plan to monitor the Program's progress on this recommendation, we do not have any questions at this time.

Respectfully Submitted,

Rocky Cooper, CPA
Legislative Auditor

RC:sy
cc: Michael J. Willden, Chief of Staff, Office of the Governor
Paul Nicks, Acting Director, Office of Finance, Office of the Governor
Steve Weinberger, CPA, Administrator, Division of Internal Audits, Office of the Governor
Patrick Cates, Director, Department of Administration
Michelle L. Morgando, Esq., Coordinator, Victims of Crime Program, Department of Administration

(NSPO Rev. 1-18) (O) 1578E

Audit Highlights

Highlights of performance audit report on the Department of Taxation, Information Security issued on October 29, 2018. Legislative Auditor report # LA18-23.

Background

The mission of the Department of Taxation (Department) is to provide fair, efficient, and effective administration of tax programs for the State of Nevada in accordance with applicable statutes, regulations, and policies.

The Department has four offices located in Carson City, Henderson, Las Vegas, and Reno.

For fiscal year 2017, the Department had 429 authorized employees statewide, with 27 filled positions comprising the Information Technology (IT) unit.

The Department collects 17 taxes and administers the collection and distribution of more than $6 billion annually. The revenue collected by the Department provides funding to all levels of Nevada government, including school districts, cities, counties, and the State.

Purpose of Audit

The purpose of our audit was to determine if the Department has adequate information security controls in place to protect the confidentiality, integrity, and availability of its information and information systems. Our audit focused on the systems and practices in place during fiscal year 2018.

Audit Recommendations

This audit report contains 17 recommendations to improve the security of the Department's information systems.

The Department accepted the 17 recommendations.

Recommendation Status

The Department's 60-day plan for corrective action is due on January 29, 2019. In addition, the six-month report on the status of audit recommendations is due on July 29, 2019.

Information Security

Department of Taxation

Summary

The Department needs to strengthen information system controls to ensure adequate protection of information systems and the data processed therein. By taking action to address control weaknesses, the Department can better protect its physical resources, minimize security vulnerabilities, and ensure continuation of mission-critical services.

Control weaknesses included: (1) inadequate protection of server and telecommunications rooms to prevent unauthorized access and maintain optimum temperatures; (2) building access cards not routinely monitored; (3) inadequate monitoring of the status of security updates on laptop computers; (4) not adequately managing network users, including not disabling accounts of former employees; (5) incomplete backup and recovery documentation; (6) incomplete IT contingency planning; and (7) noncompliance with annual security awareness training requirements.

Key Findings

The Department needs to provide better protection for four of its five server and telecommunications rooms. For example, three rooms housing servers and networking equipment were not secured from unauthorized access. In addition, two rooms lacked controls to maintain optimum temperatures. As a result, network infrastructure is at risk of being stolen, damaged, or improperly accessed. (page 4)

The Department's building card access system, which controls access to the building's main entrances, is not routinely monitored. We identified 23 building access cards that needed to be deactivated. The Department needs sufficient measures in place to issue, replace, activate, and deactivate building access cards. (page 6)

The Department did not monitor the status of security updates on its 113 laptop computers to assist in protecting against security vulnerabilities. During our audit, most laptops had not received security updates. Staff in the Department's IT unit utilize a systems management application to update its laptops twice a month. However, after a scheduled update, we found only 2 of 66 laptops had successfully received the updates. (page 7)

The Department did not ensure Virtual Private Networking (VPN) accounts of former staff were disabled when employees transferred or terminated. A VPN allows users to connect to the Department's network resources through the Internet. We identified 33 of 120 VPN accounts that needed to be deactivated after employees transferred or terminated. Seven of the 33 accounts remained enabled for over 1 year after employees had left the Department. (page 8)

The Department does not review user access privileges for two of its four mission-critical applications that collect and distribute tax monies. In one application with 406 accounts, we identified 50 active accounts whose access was no longer appropriate based on the employees' status. Fourteen of the 50 accounts remained active for over 12 months after employees had left the Department and access should have been terminated. In addition, the Department does not maintain a current list of authorized users for these two applications. Without a current list of authorized users and annual evaluation of system access privileges, the Department is unable to periodically review if user access is appropriate. (page 9)

Background checks were not always completed for the Department's contractors. There was no evidence showing 6 of the Department's 12 contractors had background checks conducted. These contractors had specific responsibilities that gave them access to the Department's critical systems. State security standards indicate contractors who work for or provide IT services to the State and are identified as sensitive, require background checks. (page 10)

The Department does not have adequate documentation of its backup and recovery process. Without adequate documentation of its existing backup and recovery process, the Department cannot develop comprehensive recovery procedures for each system, application, and associated data. Clearly documented procedures bring more predictability to the backup and recovery process and ensure the consistent protection of Department data. (page 11)

The Department does not have a complete IT contingency plan. An IT contingency plan should contain sufficient information and instruction to enable management to assure its ability to continue its critical business services and operations. Without a current IT contingency plan, the Department cannot prioritize and categorize recovery of its critical systems. (page 12)

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January 25, 2019

Susan Brown, Director
Governor's Finance Office
209 E. Musser Street, Room 302
Carson City, NV 89701-4298

Dear Ms. Brown,

Pursuant to NRS 218G.250, the Department of Taxation submits the following Corrective Action Plan for audit LA 18-23.

Recommendation 1: Ensure all server and telecommunication rooms have locked doors.

Planned Corrective Action:

The agency installed a C-Cure card reader for access control on the Reno server/telecommunications room on August 29, 2018.

The agency will rekey the lock and maintain the key in a locked cabinet for emergency access. We will also install C-Cure card readers for access control to the Carson City telecommunications room. Additionally we will be adding a second locked barrier around the telecommunications equipment.

Estimated Completion Date:
June 29, 2019

Recommendation 2: Review existing access and determine a viable method to monitor personnel entering the Carson City telecommunications room.

Planned Corrective Action:
The agency will install C-Cure card readers for access control to the Carson City telecommunications room. The access records will be reviewed and reported to the internal auditor, ISO, and technical lead on a monthly basis.

Estimated Completion Date:
June 29, 2019

Recommendation 3: Ensure personnel accounts within the card access system are periodically monitored.

Planned Corrective Action:
The department's C-Cure administrator sends a report that includes all entries into the Carson City, Reno, and Henderson server rooms to the Information Security Officer (ISO) and the agency Technical Lead on a monthly basis.

Completion Date:
October 2, 2018

Recommendation 4: Perform an on-site review and develop a plan to ensure the server and telecommunications rooms are maintaining optimum temperatures in accordance with industry and manufacturers' standards.

Planned Corrective Action:

The department is currently working with Leasing Services to address temperature controls for the Henderson server/telecommunications room.

We have installed temperature and humidity monitors in each of our server rooms and the Carson City telecommunications room to record historical temperature and humidity readings. Once we have historical environmental data we will re-address if further action is needed.

Temperature controls for these buildings are outlined in the lease agreements and we are working with the landlord(s) to rectify.

Estimated Completion Date:

June 29, 2019

Recommendation 5: Implement procedures to review building card access within each secured area, delete inactive cards, and disable cards upon termination or transfer.

Planned Corrective Action:

The department's C-Cure administrator maintains an accurate roster of all current employees and their Supervisors. The file is updated bi-weekly using the data from HR Data Warehouse.

When the C-Cure administrator is notified that an employee has left the department the administrator deactivates their profile in C-Cure. To ensure that nothing has been overlooked, a biweekly report called "Compare Active C-Cure Profiles to HRDW Report" is run that compares all of the active profiles in C-Cure to all of the personnel on the roster. Any discrepancies are investigated and resolved.

Completion Date:

October 10, 2018

Recommendation 6: Obtain additional training to utilize full capabilities of systems management application to improve laptop computer administration.

Planned Corrective Action:

Additional training has been taken by department customer support staff. It appears that we will need to develop an alternate means to patch the out of office laptops. We are currently testing system settings that will patch operating system and office applications directly from Microsoft. Then we will only need to patch third-party applications when those users come into the office(s).

Estimated Completion Date:

June 29, 2019

Recommendation 7: Develop procedures to routinely detect and correct failed laptop computer security update installations.

Planned Corrective Action:

The Department has implemented a script-based procedure to check the current patch level of laptop systems prior to and after system patching.

Completion Date:
August 27, 2018

Recommendation 8: Revise the current help desk process to include disabling and removal of VPN accounts.

Planned Corrective Action:
The current list of active VPN accounts was sent to helpdesk staff that plan on updating a notes field in ActiveDirectory to ensure VPN accounts are accounted for when employees leave the agency. VPN accounts will be reviewed by the agency ISO on a quarterly basis.

Estimated Completion Date:
June 29, 2019

Recommendation 9: Maintain a current list of all VPN accounts and verify its accuracy quarterly.

Planned Corrective Action:
The agency ISO now maintains a current list of all VPN accounts. Additionally it is reviewed by EITS, who maintains the accounts, on a quarterly basis.

Completion Date:
October 8, 2018

Recommendation 10: Revise the Department's existing user access review process to include all applications.

Planned Corrective Action:
The agency has implemented a process to include all applications with our quarterly active user report to the agency's internal auditor.

Completion Date:
October 3, 2018

Recommendation 11: Maintain a current list of all user accounts for each application and verify its accuracy at least annually

Planned Corrective Action:
The agency ISO now maintains a master list of all user accounts for each application. Its' accuracy is verified quarterly when the active user report is generated for the internal auditor.

Completion Date:
October 25, 2018

Recommendation 12: Develop a procedure to ensure routine review and removal of obsolete network user accounts.

Planned Corrective Action:
Obsolete network user accounts will be deleted when they exceed 90 days from the last logon date. This will be verified quarterly with the regular AD user report to the internal auditor.

Estimated Completion Date:
June 29, 2019

Recommendation 13: Develop a process to ensure all contractors have required background checks.

Planned Corrective Action:
A master list of agency contractors is maintained by the agency Budget Analyst. A report will be generated by the budget analyst and reviewed by the ISO quarterly.

Completion Date:
November 29, 2018

Recommendation 14: Update the Department's existing backup process documentation.

Planned Corrective Action:
The Department is working to enhance the backup process documentation.

Estimated Completion Date:
June 29, 2019

Recommendation 15: Develop recovery process documentation for each system, application, and associated data.

Planned Corrective Action:
The Department is working to improve the restore process documentation.

Estimated Completion Date:
June 29, 2019

Recommendation 16: Update the existing IT contingency plan to include the recovery priority of the Department's mission-critical systems.

Planned Corrective Action:
The agency is currently updating the Business Impact Analysis (BIA) on each of our IT systems using NIST and State Standards. We will use the information gleaned from the BIA process to update our system prioritization and incorporate that data into the updated IT Contingency Plan.

Estimated Completion Date:
June 29, 2019

Recommendation 17: Revise existing procedures to ensure all employees, consultants, and contractors receive security awareness training and maintain an updated list of completed trainings.

Planned Corrective Action:
The Department's existing procedures have been revised to include a quarterly security awareness training report to the ISO. As of 13 August, 2018, we are 97% compliant with annual security awareness training requirements.

Completion Date:
June 1, 2018

Please contact me if you have any questions or require additional information.

Sincerely,

Melanie Young, Executive Director
Nevada Department of Taxation

MY:jb

cc: Rocky Cooper, CPA, Legislative Auditor, LCB
Michelle White, Chief of Staff, Office of the Governor
Warren Lowman, Administrator, Division of Internal Audits, Office of Finance

Education

Audit Highlights

Highlights of performance audit report on the Department of Education, Use of Class-Size Reduction Funds by School Districts issued on January 18, 2017. Legislative Auditor report # LA18-02.

Background

Responsibility for educating K-12 students is shared among the State, local school districts, and charter schools. The Department is responsible for regulating and supporting the school districts and charter schools.

The Legislature first provided school districts with CSR funds in 1991. The Legislature intended districts to use CSR funds to supplement funding sources, not to supplant existing funding sources. The 2013 Legislature approved "Regular" CSR funding of $161.7 million for grades 1 to 3 in 2014 and $166.5 million in 2015. It also provided Kindergarten CSR funds of $25.5 million in 2014 and $27.9 million in 2015.

During the 2010 Special Session, the Legislature reduced the amount of funds provided to school districts due to the State's fiscal crisis. However, to allow flexibility in addressing budget shortfalls, the Legislature allowed school districts to use a portion of its CSR funds to minimize the impact of budget reductions on class sizes in grades 4 to 12. This portion of CSR funds is referred to as "Plus 2" savings. This flexibility in using some CSR funds was continued by the 2011 and 2013 Legislatures and remained in effect until June 30, 2015.

Purpose of Audit

This audit was required by Chapter 499, Statutes of Nevada, 2015 (A.B. 278). The purpose of this audit was to: (1) evaluate the use of CSR funds by each school district for the 2013-2015 biennium, and (2) analyze the use of CSR funds for school districts that elected the Plus 2 flexibility, including whether Plus 2 savings were used to minimize the impact of budget reductions on class sizes in grades 4 to 12.

Audit Recommendations

This audit report contains two recommendations to the Department of Education for improving accountability over school districts' use of CSR funds. The Department accepted the two recommendations.

Recommendation Status

The Department's 60-day plan for corrective action is due on April 13, 2017. In addition, the six-month report on the status of audit recommendations is due on October 13, 2017.

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Use of Class-Size Reduction Funds by School Districts

Department of Education

Summary

Class-Size Reduction (CSR) funds expended by school districts for fiscal years 2014 and 2015 were appropriately used to pay for the costs of CSR-grade teachers. CSR funds allowed many districts to meet, or come relatively close to meeting, target pupil-to-teacher ratios for each CSR grade on a districtwide basis. Nevertheless, to improve accountability of CSR funds, the Department of Education (Department) needs to better monitor ratios on a districtwide basis to help ensure target class-size ratios are met in the future. In addition, we discovered that the Department did not identify more than $6 million of unused Kindergarten CSR funds, or ensure that those funds were returned to the State when the time for using them had passed.

We found that school districts used the portion of CSR funds permitted to be spent on teachers for grades 4 to 12 ("Plus 2" savings) as intended by the Legislature. Plus 2 savings, generated by increasing class sizes by 2 pupils in grades 1 through 3, were authorized to minimize the impact of budget reductions on class sizes in the upper grades. Although the school districts that chose to utilize Plus 2 funds for such purposes did not submit quarterly reports on class sizes for grades 4 to 12, as required by law, we used other information to obtain assurance that the savings were used as intended. Nevertheless, the Department should have ensured school districts reported class-size information for the upper grades. Without that type of information, the Department could not monitor that the districts used Plus 2 savings to meet the program objectives.

Key Findings

Our tests support that amounts expended by the districts from their CSR funds for fiscal years 2014 and 2015 were used for the salaries and benefits of CSR-grade teachers. Furthermore, most districts met target class-size ratios for many grades, or came relatively close to meeting them, on a districtwide basis. Specifically, districts met target ratios in about 70% of grades in fiscal years 2014 and 2015. Another 20% of grades came relatively close to target ratios, based on our analysis. We analyzed districtwide ratios because that is the basis used by the State to determine the amount of CSR funds provided to districts. (page 9)

The Department needs to improve its monitoring of class-size ratios, by grade, on a districtwide basis. Since reporting requirements changed in 2013 from a districtwide basis to a school-level basis, the Department's focus has been on monitoring school-level ratios. Although monitoring ratios at the school-level is important, districtwide ratios remain important. Monitoring districtwide ratios, by grade, provides assurance to State and local decision-makers that districts are spending enough funds on teachers to achieve target ratios. For districts not meeting target ratios on a districtwide basis, the Department should request a plan of what efforts will be made to meet ratios in the future, and monitor progress toward target ratios. (page 13)

Clark County School District did not return to the State approximately $6.1 million of unused Kindergarten CSR funds received during the 2013-2015 biennium, as required by law. District personnel cited an inability to hire enough teachers and problems setting up enough classrooms as the reasons why funds were not spent. Due to an inadequate review of districts' annual reports of expenditures, the Department did not detect the unused funds. (page 14)

Quarterly reports filed by the districts did not include upper grade pupil-to-teacher ratios (grades 4 to 12) as required under the Plus 2 legislation. The reports were a key part of the accountability the Legislature intended over the use of Plus 2 savings. The Department did not ensure that districts provided this information. (page 20)

Our analyses of various data indicated Plus 2 savings were used by school districts as intended by the Legislature. This included analyses showing: (1) minimal or no increases in upper grade class sizes, and (2) increases in instructional expenses while districts' revenues were flat or declining. These analyses provide assurance that Plus 2 savings were spent to minimize the impact of budget reductions on class sizes in upper grades, as required by education funding legislation. (page 20)

Brian Sandoval
Governor

James R. Wells, CPA
Director

Janet Murphy
Deputy Director

Steve Weinberger, CPA
Administrator

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MEMORANDUM

To: Rocky Cooper, CPA, Legislative Auditor
Nevada Legislative Counsel Bureau

From: James R. Wells, CPA, Director
Governor's Finance Office

Date: October 13, 2017

Subject: Legislative Audit of the Department of Education (LA18-02)

On January 18, 2017 your office released an audit report on the Department of Education (department). The department subsequently filed a corrective action plan on April 11, 2017. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the department to comply with audit findings.

There were two recommendations contained in the report. The extent of the department's compliance with the audit recommendations is as follows:

Recommendation 1

Increase the monitoring of each district's ratios, by CSR grade, on a districtwide basis. Districts not meeting ratios on a districtwide basis should be requested to provide a plan of efforts that will be made to meet target class-size ratios.

Status – Partially Implemented

Agency Actions – The department increased the monitoring of each district's ratios, by CSR grade, on a districtwide basis. The department provided fiscal year 2017 third quarter district class-size ratio results.

Auditor Comments – Currently, the department is developing new standards and criteria regarding class-size ratios. Therefore, they have not requested any plan of efforts for school districts that did not meet target class-size ratios based on fiscal year 2017 third quarter results. The department anticipates full implementation of this recommendation by December 2017.

Recommendation 2

Develop procedures to detect and request unused CSR funds to be returned by school districts to the State General Fund, including enhanced review of districts' annual reporting of revenues and expenditures required under state law.

Status – Partially Implemented

Agency Actions – Currently, the department is developing procedures to detect and request unused CSR funds to be returned by school districts to the State General Fund. The new procedures will require districts to provide quarterly reporting of all expenditures from CSR funds according to the same schedule as other CSR Reporting. These expenditures will be tracked against CSR funds that were provided quarterly to districts. At year-end, any CSR funds issued by the department in excess of CSR funds spent by the districts will be returned. Additionally, annual expenditure totals will be verified against annual reports, which are due November each year. The department anticipates receiving fiscal year 2018, 1st quarter CSR expenditures by November 2017.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

James R. Wells, CPA, Director
Governor's Finance Office

cc: Michael Willden, Chief of Staff, Office of the Governor
Roger M. Rahming, Deputy Superintendent, Department of Education
Steve Weinberger, CPA, Administrator, Division of Internal Audits

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January 8, 2018

Members of the Audit Subcommittee
of the Legislative Commission
Legislative Building
Carson City, Nevada 89701-4747

In January 2017, we issued an audit report on the Department of Education (Department), Use of Class-Size Reduction Funds by School Districts. The Department filed its plan for corrective action in April 2017. NRS 218G.270 requires the Governor's Finance Office to issue a report within 6 months after the plan for corrective action is due, outlining the implementation status of the audit recommendations.

Enclosed is the six-month report prepared by the Governor's Finance Office on the status of the two recommendations in the audit report. As of October 13, 2017, the Finance Office indicated both recommendations were partially implemented. The recommendations not fully implemented and their status are shown below.

Recommendation Number		Status
1	Increase the monitoring of each district's ratios, by CSR grade, on a districtwide basis. Districts not meeting ratios on a districtwide basis should be requested to provide a plan of efforts that will be made to meet target class-size ratios.	Partially Implemented
2	Develop procedures to detect and request unused CSR funds to be returned by school districts to the State General Fund, including enhanced review of districts' annual reporting of revenues and expenditures required under state law.	Partially Implemented

Regarding Recommendation No. 1, the Finance Office's report indicates the Department has increased monitoring of ratios on a districtwide basis and will request plans from districts exceeding ratios when the Department develops new standards and criteria regarding ratios. Full implementation was anticipated by December 2017.

Commerce/Industry

Audit Highlights

Highlights of performance audit report on the Division of Industrial Relations issued on May 2, 2018. Legislative Auditor report # LA18-19.

Background

The Division of Industrial Relations is part of the Nevada Department of Business and Industry. The mission of the Division is to promote the health and safety of Nevada employees and the general public by providing workplace safety consultation and training, conducting inspections of businesses to ensure proper procedures relating to health and safety are being followed, and for confirming that injured employees are properly cared for following an accident on the job.

The Division operates six sections: Mechanical Compliance, Mine Safety and Training, Workers' Compensation, Occupational Safety and Health Administration, Safety Consultation and Training, and Legal / Labor Statistics. The Division is primarily funded with appropriations, fees, and federal grants. The Division oversees four operating accounts and six special purpose budget accounts.

The Division has 215 full-time equivalent positions as of April 2017. Personnel are located in four offices throughout the State, in Carson City, Reno, Elko, and Henderson. The Administrator of the Division is located in Henderson.

Purpose of Audit

The purpose of this audit was to determine the adequacy of the Division's regulatory processes related to elevators, boilers, and mines. The scope of our audit focused on fiscal year 2017; although we reviewed information through October 2017 and from prior years based on data available in the Division's database.

Audit Recommendations

This audit report contains nine recommendations to improve regulatory oversight of elevators, boilers, and mines. These recommendations include developing processes and controls to ensure elevators and boilers have operating certificates and inspection violations are resolved. Additionally, two recommendations address mine safety by requiring better management information and procedures to ensure regulatory functions are performed.

The Division accepted the nine recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on July 27, 2018. In addition, the six-month report on the status of audit recommendations is due on January 27, 2019.

Division of Industrial Relations

Department of Business and Industry

Summary

The Division of Industrial Relations (Division) does not have adequate processes over regulatory activities for elevators and boilers. Specifically, about 5,500 elevators and boilers were operating without required certificates as of June 30, 2017. Operating certificates are issued after a thorough inspection process and verify the elevator or boiler is meeting standards that promote safety. Since operating certificates were not issued, sometimes for multiple inspection cycles, the Division did not collect an estimated $1.4 million in fees over the course of several years. Operating certificates were not issued partly because code violations noted during inspections were not monitored or cleared. In certain instances, serious violations existed for years before follow-up occurred. In an effort to reduce the inspection backlog, the Division transferred certain regulatory duties to outside entities, but did not provide sufficient guidance or oversight over third-party inspections and related activities. Finally, the Division does not have adequate management information over mining regulatory activities to reduce the risk of mining accidents.

Key Findings

The Division does not take reasonable steps to ensure elevators and boilers have certificates to verify operating safety. A review of data from the Division's tracking system indicated as many as 4,360 elevators and 1,188 boilers were operating without a certificate as of June 30, 2017. Some of these objects operated for years without a valid operating certificate. Furthermore, another 90 objects constructed since 2005 never received a final inspection to certify installation was in accordance with established codes. Elevators and boilers operated without certificates because the Division relies entirely upon the owner to identify certificate expiration dates, schedule inspections, and fix code violations. (page 6)

Elevators and boilers were not issued operating certificates for one of three reasons: a routine inspection was not performed, violations were not cleared, or fees were not paid. Our review of 50 objects found nearly half of objects had not been inspected in the cyclical timeframe established by the Division. (page 7)

Our review of information in the Division's database showed at least 90 installations or modified elevators and boilers were not inspected prior to being placed into service, some dating back to 2005. Construction and modification certificates allow 1 year from the date of issuance for the work to be completed before the certificate expires. (page 8)

The Division is not ensuring code violations related to an elevator's and boiler's operating safety are fixed and cleared in a timely manner. Inspection violations are a clear warning these objects are not operating within normally accepted standards and may be unsafe. Yet, our review of 130 inspection violations found the Division is performing limited, if any, procedures to confirm violations are addressed. Unresolved violations also contributed to the Division's loss of certificate fee revenue since some violations must be cleared prior to a certificate being issued. (page 9)

The Division transferred inspection and certain other regulatory responsibilities to third-party agencies, but has not developed sufficient guidance or provided oversight of these activities. Responsibilities were transferred around July 2015 in an effort to reduce the backlog of inspections for elevators and boilers to ensure objects were operating within adopted standards. However, many of the oversight activities outlined in the regulation have not been implemented by the Division. (page 11)

The Division does not have adequate management information to confirm annual mine inspections are performed. Although the Division does have an inspection process, management information to monitor inspections is cumbersome and inefficient. Management reports from its database do not provide sufficient detail to readily identify whether required annual inspections are completed. (page 12)

The Division is not monitoring whether violations from mine inspections are resolved appropriately and timely. Management indicated the Division does not have a uniform process for identifying open violations with past-due deadlines. Three of 20 mine files showed no evidence of any corrective measures being taken by mine operators regarding violations. As a result, the Division cannot be sure violations are resolved and mineworkers are safe. (page 13)

Steve Sisolak
Governor

Susan Brown
Director

Paul Nicks
Deputy Director

Warren Lowman
Administrator

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MEMORANDUM

To: Rocky Cooper, Legislative Auditor
Legislative Counsel Bureau

From: Susan Brown, Director
Governor's Finance Office

Date: January 27, 2019

Subject: Legislative Audit of the Department of Business and Industry – Division of Industrial Relations

On May 2, 2018, your office released an audit report on the Department of Business and Industry – Division of Industrial Relations (division). The division subsequently filed a corrective action plan on July 26, 2018. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the department to comply with audit findings.

There were nine recommendations contained in the report. The extent of the division's compliance with the audit recommendations is as follows:

Recommendation 1

Develop policies, procedures, and controls over tracking, monitoring, and issuing operating certificates for elevators and boilers.

Status – Partially Implemented

Agency Actions – The Mechanical Compliance Section (section) developed policies, procedures, and controls over tracking, monitoring, and issuing operating certificates for elevators and boilers; however, these procedures are not implemented due to limitations in the current database system. The database system is incapable of providing accurate information such as: permit expiration dates, violations, and invoice payments.

The section obtained a new database system that will provide all the required information. The developed policies and procedures will be implemented with the new database system by February 1, 2019.

Recommendation 2

Develop policies, procedures, and controls over tracking, monitoring, and clearing inspection violations. Ensure violations are cleared based on sufficient documentation and by personnel trained in elevator and boiler safety.

Status – Partially Implemented

Agency Actions – The Mechanical Compliance Section (section) developed policies, procedures, and controls over tracking, monitoring, and clearing inspection violations. However, the section is unable to ensure violations are cleared based on sufficient documentation and by personnel trained in elevator and boiler safety because of limitations in the current database system.

The section obtained a new database system that will provide sufficient documentation that shows violations have been cleared by trained personnel. The division anticipates full implementation by February 1, 2019.

Recommendation 3

Establish a graduated and equitable system of sanctions to help ensure elevator and boiler safety compliance.

Status – Fully Implemented

Agency Actions – The Mechanical Compliance Section (section) implemented a graduated and equitable system of sanctions to help ensure elevator and boiler safety compliance by using the rates established in Nevada Administrative Code (NAC) 455C.616. We reviewed documentations for two administrative fines imposed by the section for elevator and boiler safety and determined the sanctions were in compliance with NAC 455C.616.

Recommendation 4

Monitor the construction and modification of elevators and boilers and perform inspections as required.

Status – Partially Implemented

Agency Actions – The Mechanical Compliance Section (section) is limited in monitoring the construction and modification of elevators and boilers and performing inspections as required because the database system does not provide accurate construction permit

data. The section obtained a new database system that will provide functionality for monitoring construction, modifying elevators and boilers, and notifying division personnel of expiring permits. The section anticipates full implementation of this recommendation by February 1, 2019.

Recommendation 5

Notify elevator and boiler owners of violations, deadlines, and related enforcement actions to be applied if violations remain unresolved.

Status – Fully Implemented

Agency Action – The Mechanical Compliance Section (section) notified elevator and boiler owners of violations, deadlines, and related enforcement actions to be applied if violations remain unresolved. The section reports for the period January through December 2018, it sent letters to 446 property owners of non-permitted elevators and boilers. We reviewed a sample of the notification letters sent to owners of non-permitted equipment and verified the section's actions.

Recommendation 6

Develop detailed guidelines regarding third-party inspection regulatory activities.

Status – Partially Implemented

Agency Comments – The Mechanical Compliance Section (section) did not develop a detailed guidelines regarding third-party inspection regulatory activities. The section reports in early 2017 they reviewed and revised compliance forms, established guidelines, and instituted an audit program to assist third-party inspectors with regulatory compliance requirements. Additionally, the section reports it issued documents clarifying permitting, alterations, and violation categories.

Auditor Comments – We reviewed a sample of the revised compliance forms, established guideline, and the audit program and determined the section did not develop a detailed guidelines regarding third-party inspection regulatory activities.

Recommendation 7

Institute a quality assurance program as outlined in regulations regarding third-party inspector activity. Develop policies and procedures over the program to ensure regulatory functions are performed adequately and the public is safeguarded.

Status – Fully Implemented

Agency Actions – The Mechanical Compliance Sections (section) instituted a quality assurance program as outlined in regulations regarding third-party inspector activity. This newly instituted program which includes certification audits, help ensure regulatory functions are performed adequately and the public is safeguarded. We reviewed the section's certification audits of four authorized third-party state inspectors and the applicable Nevada Administrative Code sections and determined compliance with third-party inspection activities. In addition, our consultation with LCB disclosed that performing certification audits and instituting a quality assurance program met the intent of the requirement to develop policies and procedures over the program to ensure regulatory functions are performed adequately and the public is safeguarded

Recommendation 8

Create a database that efficiently organizes and tracks the Division's regulatory activities over mines.

Status – Fully Implemented

Agency Actions – Mine Safety and Training Section (MSATS) created a database that efficiently organizes and tracks the Division's regulatory activities over mines. MSATS implemented the new database on December 1, 2018. We reviewed a sample of mines database records and confirmed they properly contained all information located in the division's spreadsheets.

Recommendation 9

Establish policies, procedures, and controls to ensure mines are inspected when required and inspection violations are cleared timely.

Status – Fully Implemented

Agency Actions – Mine Safety and Training Section (MSATS) established policies, procedures, and controls to ensure mines are inspected when required and inspection violations are cleared timely. MSATS requires inspectors to enter abatement due dates into a common Outlook calendar for monitoring and review. The Safety Manager conducts a weekly review of open inspection orders and notices. We reviewed the policies and procedures and verified that reviews of open orders and notices are conducted weekly by the Safety Manager.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

Susan Brown, Director
Governor's Finance Office

cc: Michelle White, Chief of Staff, Office of the Governor
Michael Brown, Director, Department of Business and Industry
Ray Fierro, Administrator, Division of Industrial Relations
Warren Lowman, Administrator, Division of Internal Audits

Audit Highlights

Highlights of performance audit report on the Housing Division issued on January 17, 2018. Legislative Auditor report # LA18-11.

Background

The Housing Division of the Department of Business and Industry was created by the Nevada Legislature in 1975 to diminish the shortage of safe, decent, and sanitary housing throughout the State for persons and families of low and moderate income. The mission of the Division is to provide affordable housing opportunities, improving the quality of life for Nevada residents.

As of December 2016, the Division had 32 approved, full-time positions, 4 of which were vacant. The Division's expenditures totaled more than $19 million in fiscal year 2016. In fiscal year 2016, the Division received approximately $5 million in federal funding. The Nevada Real Property Transfer Tax and the Universal Energy Charge are other significant sources of income for the Division.

Purpose of Audit

The purpose of this audit was to: (1) determine whether the Housing Division effectively monitored grant and tax credit recipients to ensure compliance with applicable laws and regulations, and (2) evaluate the internal controls, usefulness, and accuracy of the Division's performance measures. This audit included a review of monitoring activities in calendar year 2016 and performance measures for fiscal year 2016.

Audit Recommendations

This audit report contains two recommendations to improve the accuracy and usefulness of the Division's performance measures. The Division accepted the two recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on April 12, 2018. In addition, the six-month report on the status of audit recommendations is due on October 12, 2018.

Housing Division

Department of Business and Industry

Summary

The Housing Division effectively monitored low-income housing properties funded by federal tax credit and grant programs to ensure significant program, project, and financial requirements were met. Compliance monitoring staff annually inspect properties that provide housing for thousands of families. These inspections ensure numerous requirements are met on an ongoing basis, including many related to safe and sanitary conditions. The effective monitoring is the result of controls established by the Division to ensure inspections are done timely and thoroughly.

The Division needs to improve its performance measures used in the state's budget process. Specifically, better controls are needed to ensure the measures reported in the Executive Budget are accurate and reliable. In addition, the Division's measures used in the budget process need to be revised to better reflect the accomplishments of the Division's programs and key activities. Performance measures facilitate accountability and provide an opportunity to evaluate success in achieving goals. Measures must be reliable and applicable to the agency to help the Governor, Legislature, and agency officials make informed budgetary and policy decisions.

Key Findings

We tested 50 of 273 properties the Division currently monitors and found the Division timely and thoroughly monitored them in calendar year 2016. These properties are comprised of approximately 23,000 housing units. The thoroughness and quality of the Division's monitoring provide assurance that families are housed in safe conditions, charged appropriate rent, and are eligible for the programs. Timely and effective monitoring ensures problems are corrected quickly and reported to federal agencies when appropriate. Finally, monitoring properties in accordance with federal requirements helps ensure the State qualifies for future federal funding. (page 4)

The Division has developed various controls to ensure successful monitoring of properties. Its compliance and procedures manuals include expectations above federal requirements. These higher internal standards ensure federal requirements are met even if staff do not meet internal standards. In addition, compliance staff use checklists for the compliance process to help ensure all requirements are verified. Finally, the Division uses compliance auditing management software that is used to schedule upcoming audits, generate reports, document findings, and review tenant qualifications. This software is automatically updated when federal requirements change. (page 6)

The Division's controls for performance measures need improvement to ensure that the numbers reported in future executive budgets are accurate and reliable. The Governor and Legislature use agency measures to help them make budget and policy decisions. Control weaknesses include a lack of documentation, insufficient review, and inadequate written procedures for calculating measures. (page 9)

The usefulness of the Division's performance measures used in the state budget process can be improved. Specifically, five of six measures included in the 2017-2019 Executive Budget did not fully reflect the impact of the Division's efforts. The current performance measures do not provide adequate information on the progress and performance of the Division's programs. Another indication of the limited usefulness of these measures is management utilizes a different set of performance measures to manage its operations throughout the year. Development of useful performance measures can improve internal and external decision-making. (page 10)

Brian Sandoval
Governor

Paul Nicks
Acting Director

Susan Brown
Acting Deputy Director

Steve Weinberger, CPA
Administrator

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MEMORANDUM

To: Rocky Cooper, Legislative Auditor
Legislative Counsel Bureau

From: Paul Nicks, Acting Director
Governor's Finance Office

Date: October 12, 2018

Subject: Legislative Audit of the Department of Business and Industry – Housing Division

On January 17, 2018, your office released an audit report on the Department of Business and Industry – Housing Division (division). The division subsequently filed a corrective action plan on April 16, 2018. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the department to comply with audit findings.

There were two recommendations contained in the report. The extent of the department's compliance with the audit recommendations is as follows:

Recommendation 1

Develop controls to ensure performance measures reported in the budget process are accurate and reliable, including retention of supporting documentation, supervisory review by program and financial staff of calculations and methodology, and detailed written procedures for calculating each measure.

Status – Partially Implemented

Agency Comments – The division reports it developed controls to ensure performance measures reported in the budget process are accurate and reliable, including retention of supporting documentation, supervisory review by program and financial staff of calculations and methodology, and detailed written procedures for calculating each measure. Implementation of the above controls occurred on May 2, 2017 with additional updates made on May 14, 2018.

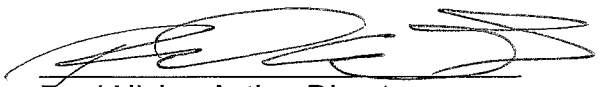
Auditor Comments – We reviewed the division's newly developed controls and noted that detailed procedures for two performance measures were not documented. Additionally, we were unable to recreate two performance measures data reported by the division in the budget process due to a lack of supporting documentation. The division anticipates full implementation of this recommendation by October 31, 2018.

Recommendation 2

Revise performance measures used in the state's budget process to more fully reflect the Division's impact on goals and objectives.

Status –Fully Implemented

Agency Actions – The division revised performance measures used in the state's budget process to more fully reflect the division's impact on goals and objectives. We reviewed the division's mission and goals as documented in the 2018 – 2021 Strategic Plan and verified that the divisions performance measures used in the state's budget process have been revised and appear to more fully reflect the division's impact on its goals and objectives.



Paul Nicks, Acting Director
Governor's Finance Office

cc: Michael Willden, Chief of Staff, Office of the Governor
Carla Manthe, Director, Department of Business and Industry
Stephen Aichroth, Administrator, Housing Division
Steve Weinberger, CPA, Administrator, Division of Internal Audits

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October 19, 2018

Members of the Audit Subcommittee
of the Legislative Commission
Legislative Building
Carson City, Nevada 89701-4747

In January 2018, we issued an audit report on the Housing Division (Division) of the Department of Business and Industry. The Division filed its plan for corrective action in April 2018. NRS 218G.270 requires the Governor's Finance Office to issue a report within 6 months after the plan for corrective action is due, outlining the implementation status of the audit recommendations.

Enclosed is the six-month report prepared by the Governor's Finance Office on the status of the two recommendations contained in the audit report. As of October 12, 2018, the Governor's Finance Office indicated one recommendation was fully implemented and one recommendation was partially implemented. The partially implemented recommendation is shown below.

Recommendation Number		Status
1	Develop controls to ensure performance measures reported in the budget process are accurate and reliable, including retention of supporting documentation, supervisory review by program and financial staff of calculations and methodology, and detailed written procedures for calculating each measure.	Partially Implemented

The Finance Office's report indicates the Division did not detail procedures for calculating two performance measures and Finance Office staff could not recreate two performance measures due to a lack of supporting documentation. Division management anticipates full implementation of the audit recommendation by October 31, 2018.

Question

1. Does the Division still anticipate full implementation of this recommendation by October 31, 2018? If not, when will the recommendation be fully implemented?

Respectfully Submitted,

Rocky Cooper, CPA
Legislative Auditor

RC:sy
cc: Michael J. Willden, Chief of Staff, Office of the Governor
Paul Nicks, Acting Director, Office of Finance, Office of the Governor
Steve Weinberger, CPA, Administrator, Division of Internal Audits, Office of the Governor
CJ Manthe, Director, Department of Business and Industry (DBI)
Stephen Aichroth, Administrator, Housing Division, DBI

Audit Highlights

Highlights of performance audit report on the Division of Financial Institutions issued on May 2, 2018. Legislative Auditor report # LA18-18.

Background

The Division of Financial Institutions (Division), created in 1983, is an agency in the Department of Business and Industry. Its mission is to maintain a financial institutions system for the citizens of Nevada that is safe and sound, protects consumers, and defends the overall public interest. The Division also promotes economic development through the efficient, effective, and equitable licensing, examination, and supervision of depository, fiduciary, and non-depository financial institutions.

The Division's primary responsibilities include reviewing applications for licensing, issuing new and renewal licenses, examining licensees on an annual basis, processing written complaints, and conducting investigations of violations. As of June 1, 2017, the Division had 2,666 licensees.

The Division is self-funded with revenues consisting primarily of assessments on depository and non-depository licensees, and license and examination fees, which amounted to over $3.3 million in fiscal year 2017. As of June 30, 2017, the Division had 30 filled positions in its Carson City, Reno, and Las Vegas offices.

Purpose of Audit

The purpose of this audit was to determine whether the Division's oversight of non-depository financial institutions effectively ensures regulatory compliance. Our audit focused on the Division's regulatory and financial activities for fiscal year 2017. We also included information in certain areas from prior years.

Audit Recommendations

This audit report contains five recommendations to enhance the Division's regulatory processes. The Division accepted the five recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on July 27, 2018. In addition, the six-month report on the status of audit recommendations is due on January 27, 2019.

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Division of Financial Institutions

Department of Business and Industry

Summary

The Division's oversight of non-depository financial institutions effectively ensured regulatory compliance; although, enhancements can be made to strengthen certain processes. The Division adequately administered annual examinations, fees, reports, violations, and complaints. However, inconsistencies in the examination process can be reduced by maintaining better documentation, improving the accuracy of reporting, and enhancing underlying policies and procedures. Additionally, the follow-up process on licensees with less-than-satisfactory examinations needs to be formalized in policies and procedures. The Division can also improve visibility into its ability to accomplish its mission by reporting an outcome-based performance measure detailing the results of examinations. Furthermore, the Division would benefit from a centralized tracking system for payday loans. These enhancements will help protect consumers and promote public interest in non-depository institutions.

Key Findings

The Division has adequately administered state laws and regulations concerning non-depository licensees. The Division completed required annual examinations, ensured licensees submit required fees and reports timely, and took prompt action regarding examination violations and consumer complaints. (page 6)

The Division could improve its documentation of the work performed during an examination. Documentation generally lacked a statement showing the population and sample selection methodology for licensee loans and check cashing transactions reviewed. Additionally, examination periods varied and often did not cover the entire period since the licensee's last examination, as management indicated is a Division practice. (page 9)

Examination reports did not always accurately reflect the scope of work performed. Our testing found instances where the standard language in the Division's report template was not revised to reflect the actual work performed. In addition, 19% of the examination reports reviewed, which stated the loan population and sample size, were inaccurate and did not agree with the reviewed loans documented in the examination workpapers. (page 11)

The Division needs to enhance its written policies and procedures over its examination process. Clearly defined policies and procedures provide a framework for conducting consistent and efficient work, while communicating approved processes and expectations to examination staff. (page 11)

The Division needs to formalize in policies and procedures the follow-up process for licensees receiving a less-than-satisfactory examination. The Division considers licensees' violation response letters and other factors when deciding whether its staff will conduct a follow-up examination to verify corrective actions were properly implemented. Considering approximately 33% of licensed payday lenders received a less-than-satisfactory examination rating annually over the last 5 years, performing adequate follow-up on licensees with noted violations of state laws and regulations is important for ensuring consumers are adequately protected against unfair or unlawful financial practices. Furthermore, documenting this process is important because licensees receiving less-than-satisfactory examinations should receive close regulatory supervision due to their increased risk of non-compliance. (page 13)

The Division can improve its performance measures by reporting an outcome-based measure detailing the results of examinations to the Legislature. Over the last 5 years, on average only 67% of licensees providing loan and check cashing services were in satisfactory compliance with state laws and regulations based on the Division's examinations. Current performance measures provide examination output and workload statistics, but do not show the impact examinations are having on licensees' overall compliance with state laws and regulations. (page 15)

A centralized tracking system for payday loans can be of significant value to the Division, its licensees, and Legislators. A database would assist licensees with managing loans and determining loan eligibility. It would also help licensees comply with state payday lending laws and help consumers avoid becoming overloaded with debt. Additionally, it would help the Division identify irregular lender activity and serve as an information system for staff preparing for an examination. A centralized tracking system would provide regulatory oversight and collect statistical information on licensees providing loan services. (page 17)

Audit Division
Legislative Counsel Bureau

Steve Sisolak
Governor

Susan Brown
Director

Paul Nicks
Deputy Director

Warren Lowman
Administrator

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MEMORANDUM

To: Rocky Cooper, CPA, Legislative Auditor
Legislative Counsel Bureau

From: Susan Brown, Director
Governor's Finance Office

Date: January 27, 2019

Subject: Legislative Audit of the Department of Business and Industry, Financial Institutions Division

On May 2, 2018, your office released an audit report on the Department of Business and Industry, Financial Institutions Division (division). The division subsequently filed a corrective action plan on July 31, 2018. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the division to comply with audit findings.

There were five recommendations contained in the report. The extent of the division's compliance with the audit recommendations is as follows:

Recommendation 1

Establish controls to ensure examinations are performed consistently within established sample selection guidelines, and licensee loan and check cashing reviews are adequately documented, including the population, time period reviewed, and verification of loan listings.

Status – Partially Implemented

Agency Actions – The division established controls to ensure examinations are performed consistently within established sample selection guidelines, and licensee loan and check cashing reviews are adequately documented, including the population, time period reviewed, and verification of loan listings. The division updated its examination policies and procedures to include items such as: sample selection guidelines; examination checklist for loan and check cashing reviews; and loan documentation requirements. We reviewed the updated policies and procedures,

examination checklists, and associated training logs. The division reports the new examination policies and procedures will be implemented after examiners receive formal training, which began on December 10, 2018. The division anticipates full implementation by February 1, 2019.

Recommendation 2

Enhance supervisory oversight to ensure examination workpapers and reports adequately and accurately reflect the work performed.

Status – Partially Implemented

Agency Actions – The division enhanced supervisory oversight to ensure examination workpapers and reports adequately and accurately reflect the work performed. The division established the Non Depository Examination Checklists as part of their new policies and procedures. The new checklists include verifying: the examination review period; the examination scope; the sample methodology; and the examination rating. We reviewed the newly established checklists and determined that implementation of these will help the division enhance supervisory oversight. The division reports that policies and procedures will be implemented after examiners receive formal training which began on December 10, 2018. The division anticipates full implementation by February 1, 2019.

Recommendation 3

Update licensee examination procedures to be inclusive of key aspects of the examination process.

Status – Partially Implemented

Agency Actions – The division updated licensee examination procedures to be inclusive of key aspects of the examination process. The updated procedures include: documenting sample selection methodology; examination period and scope of work performed; and examination ratings review process. We reviewed the updated policies and procedures, examination checklists, and associated training logs and determined the examination procedures include key aspects of the examination process. The division reports that policies and procedures will be implemented after examiners receive formal training which began on December 10, 2018. The division anticipates full implementation by February 1, 2019.

Recommendation 4

Develop policies and procedures to formalize the process and time period for follow-up examinations.

Status – Partially Implemented

Agency Actions – The division developed policies and procedures to formalize the process and time period for follow-up examinations. We reviewed the follow-up examination policies and procedures and determined they include: time period for conducting each type of follow-up examination, and the process for reviewing licensee response letters. The division reports that the new follow-up examination policy will be used for examinations beginning in January 2019, with full implementation expected by February 1, 2019.

Recommendation 5

Report to the Legislature an outcome-based performance measure for monitoring non-depository licensee examination results.

Status – Partially Implemented

Agency Comments – The division will report it developed an outcome based performance measure "Percentage of Satisfactory Examination Non-Depository Licensees." The new performance measure was included in their current biennial budget request. We reviewed the new performance measure and supporting documentation with no exceptions noted.

Auditor Comments – The new outcome based performance measure will be reported to the Legislature as part of the division's Governor Recommends budget.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

Susan Brown, Director
Governor's Finance Office

cc: Michelle White, Chief of Staff, Office of the Governor
Michael Brown, Director, Department of Business and Industry
George Burns, Commissioner, Financial Institutions Division
Warren Lowman, Administrator, Division of Internal Audits

Human Services

Audit Highlights

Highlights of performance audit report on the Department of Health and Human Services, Director's Office issued on May 2, 2018. Legislative Auditor report # LA18-16.

Background

The Department of Health and Human Services promotes the health and well-being of Nevadans through the delivery of essential services to ensure families are strengthened, public health is protected, and individuals achieve their highest level of self-sufficiency. For fiscal year 2017, the Director's Office (Office) was responsible for 11 budget accounts with nearly $73 million in revenues and expenditures. Of this, nearly $26 million is related to grant programs and administration.

The Office of Community Partnerships and Grants, known as the Grants Management Unit is an administrative unit within the Office that administers grants for local, regional, and statewide programs serving Nevadans. Its mission is to help families reach their highest level of self-sufficiency by supporting community agencies that provide service through engagement, advocacy, and resource development.

Purpose of Audit

This audit included a review of grant awards and payments made in fiscal years 2016 and 2017. The purpose of our audit was to determine if the Director's Office had sufficient controls to ensure grant awards and payments were appropriate.

Audit Recommendations

This audit report contains eight recommendations to improve grant administration. These recommendations address coordination between the Office and its various divisions regarding grant awarding and monitoring activities and developing policies, procedures, and controls over grant administration activities.

The Office accepted the eight recommendations.

Recommendation Status

The Department's 60-day plan for corrective action is due on July 27, 2018. In addition, the six-month report on the status of audit recommendations is due on January 27, 2019.

Director's Office

Department of Health and Human Services

Summary

The Director's Office needs to improve controls over grant awards and payments. Grantees received payment for services that exceeded the cost to provide the service. In total, grantees overstated personnel costs by $870,000. Of this, overpayments were made in the amount of $176,000, and $682,000 was improperly categorized as federal cost share to obtain funding. Overpayments occurred partially because grantees were awarded funding for the same position across multiple grants that exceeded 100% of the employee's time and effort. Furthermore, the Office does not coordinate awarding or fiscal monitoring activities with its various divisions and grant award applications were not consistent or properly completed. Finally, additional procedures and controls are needed over year-end adjustments that resulted in overpayments of $12,000.

Provisions in grant agreements authorize the Department of Health and Human Services (DHHS) to recover these overpayments; however, recovery may not be cost effective. As noted in the report, we did not determine overpayments for 6 of 10 grant recipients selected because grant applications had insufficient detail. Nevertheless, based on our testing of the remaining four grant recipients, it is likely overpayments occurred for other grant recipients. Because identifying overpayments requires a detailed comparison of each payment request for multiple grants, a significant commitment of DHHS resources would be necessary to determine all overpayments. In addition, the overpayments we identified were widespread across different funding sources making it difficult to identify which funding source an overpayment might relate to. We believe DHHS's resources would be better spent taking action to correct the issues causing the overpayments than recovering past overpayments. However, the final decision on where to commit DHHS resources rests with management.

Key Findings

Grantees requested payment for certain personnel from multiple grants that exceeded the annual salary and benefit total of the employee. Grants included state and federal funding sources, but were administered and overseen by the Office and its various divisions. Since the Office and its divisions did not coordinate grant activities, $176,000 in personnel costs was overpaid to grantees during fiscal years 2016 and 2017. Grantees, in order to receive funding, overcharged salaries as cost share in the amount of $682,000. Salaries and benefits were overcharged partially because some program activities are interrelated. (page 6)

Four of 10 grantees selected received additional funding because personnel performing program services were dedicated to multiple grant programs, and their time and effort claimed across the grants aggregated to more than 100%. Specifically, 33 of 134 (25%) positions noted on grant applications were for personnel whose time, when aggregated, exceeded a full-time equivalent position. Amounts awarded above the annual salary and benefit cost could have been utilized to fund other programs or awarded to other grantees to provide services to more people in need. (page 6)

Grantees requested funding from a federal program for personnel who were dedicated to providing service to state funded programs. Program activities between the state and federal grants were only marginally related for some personnel and were not related for others. As a result, services provided may have been less than that paid for. (page 8)

Completed grant applications did not provide detail as required, or specific information was not requested to adequately determine if grantees were requesting inappropriate funding. Seventy-eight of 170 (46%) grant applications reviewed did not provide enough information such as the name of the individual or a position number, to determine if grantees were requesting more than necessary to recover costs. Details regarding grant funding are important for determining the adequacy of requests. We noted one grantee received over $2 million in funding for salaries and benefits for one fiscal year, but provided only minimal detail regarding the positions or employees being funded. (page 9)

Grantees also received overpayments when salaries were adjusted at the end of the fiscal and grant year. In total, two of four grantees received overpayments of nearly $12,000 when amounts requested on June 2016 payment requests were also included on July 2016 requests. Additionally, some payment requests near year end included amounts for personnel who had not been charged to the program previously and were not listed on grant budgets. (page 10)

Steve Sisolak
Governor

Susan Brown
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Paul Nicks
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MEMORANDUM

To: Rocky Cooper, Legislative Auditor
Nevada Legislative Counsel Bureau

From: Susan Brown, Director
Governor's Finance Office

Date: January 27, 2019

Subject: Legislative Audit of the Department of Health and Human Services, Director's Office

On May 2, 2018, your office released an audit report on the Department of Health and Human Services (department), Director's Office (office). The office subsequently filed a corrective action plan on July 27, 2018. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the division to comply with audit findings.

There were eight recommendations contained in the report. The extent of the division's compliance with the audit recommendations is as follows:

Recommendation 1

Coordinate, to the extent possible, grant awarding activities to ensure grantees do not receive more than actual cost.

Status – Partially Implemented

Agency Actions – The office is beginning to coordinate, to the extent possible, grant awarding activities to ensure grantees do not receive more than actual cost. The office created a Grants Management Committee (GMC) whose members include grant managers from each division of the department. The GMC developed a grants manual and various templates, and implemented a shared electronic storage drive to facilitate department-wide grants management standardization effective July 1, 2018. All divisions have implemented the standardized Budget Narrative and Request for Reimbursement (RFR) templates that require grantees to provide cost allocations amongst all funding

sources for each expenditure line item included in the budget. The RFR helps ensure grantees do not receive more than actual cost.

Auditor Comments – The department began coordinating grant awarding activities; however, procedures may not ensure grantees do not receive more than actual cost.

We reviewed the department's newly implemented grants management procedures and templates, and selected a sample of grant awards issued following the July 1, 2018 implementation date to ensure that templates are in use and procedures operating effectively. Our review indicates the department's procedures rely on grantees to self-report funding source cost allocations and divisions are not reconciling the information with other records for accuracy and completeness, which could allow grantees to receive funding from multiple funding sources for the same expenditures. Our testing noted deficiencies in seven (82 percent) of 11 awards tested, including three awards with budgets or payments with incorrect funding source allocations and seven awards with inaccurate or incomplete supporting documentation.

Recommendation 2

Collaborate with Department of Health and Human Services divisions who provide grant funding to develop a uniform grant application that requires sufficient information to monitor, review, and approve funding requests.

Status – Partially Implemented

Agency Actions – The office collaborated with Department of Health and Human Services divisions who provide grant funding to develop a uniform grant application that requires sufficient information to monitor, review, and approve funding requests. The Grants Management Committee (GMC) implemented standardized Notice of Subgrant Award and Request for Funding (RFR) templates department-wide effective July 1, 2018. The office reports the GMC continues to meet monthly to further standardize department-wide grant administration activities, discuss high-risk subawards, and improve fiscal monitoring of grantees.

Auditor Comments – Although a uniform grant application has been implemented, supporting documentation provided by grantees is not sufficient to monitor, review, and approve funding requests. Our review indicates department personnel did not ensure that RFR payments and current year award budgets matched actual award funding allocations.

We reviewed the department's newly implemented grants management procedures and templates, and selected a sample of grant awards issued following the July 1, 2018 implementation date to ensure that templates are in use and procedures are operating effectively. Our testing noted deficiencies in seven (82 percent) of 11 awards tested, including three awards with budgets or payments with incorrect funding source allocations and seven awards with inaccurate or incomplete supporting documentation.

Recommendation 3

Develop controls over grant payments to ensure grantees do not receive excess funding.

Status – Partially Implemented

Agency Actions – The office is developing controls over grant payments to ensure grantees do not receive excess funding. The office has drafted a "DHHS Standardized Request for Reimbursement" policy that will be distributed department-wide through the Grants Management Committee (GMC) in January 2019. The policy will establish the minimum requirements for the standardized Request for Reimbursement (RFR) review and approval process. This process includes guidance on allowable and accrued costs, required forms and backup, and the role of department personnel in the process. The GMC additionally implemented a standardized RFR template effective July 1, 2018 that allows staff to monitor total funding and actual expenditures to ensure costs are accurately accounted for on a monthly basis.

Auditor Comments – The office reported that the RFR template is in use by all divisions in the department; however, the department's draft RFR policy will need to be fully implemented department-wide to ensure the RFR process is operating as intended. Our review indicates grant payments are not always processed correctly or supported by accurate or complete information, which could allow grantees to receive excess funding.

We reviewed the department's newly implemented grants management procedures and templates, and selected a sample of grant payments issued following the July 1, 2018 implementation date to ensure that existing RFR procedures are operating effectively. Our testing noted deficiencies in all (100 percent) 11 payments tested, including: nine payments with insufficient or incomplete supporting documentation; one payment with no evidence of review and approval; two payments with errors in the underlying budgets used to review the request; one payment that included costs not yet paid by the grantee; and one payment issued to the wrong grantee that went undiscovered by department personnel until notified by the grantee.

Recommendation 4

Institute a consistent Department-wide approach to the fiscal monitoring of grantees.

Status – Partially Implemented

Agency Actions – The office is instituting a consistent department-wide approach to the fiscal monitoring of grantees. The office hosted site monitoring training for department employees on June 22, 2018. Grant managers from each of the department's divisions attended the training. The office reports that each division adopted the standardized grants management practices included in the grants manual, modified as needed to include division-specific components. The grants manual includes detailed information on fiscal, programmatic, and agency monitoring. Divisions are required to utilize the standardized subrecipient monitoring review templates, which include a "Subrecipient Finance Review Form."

The office also reports that department-wide tracking of ongoing site monitors has been developed and the Grants Management Committee (GMC) continues efforts to coordinate and streamline monitor events. The office has additionally drafted a "DHHS Standardized Request for Reimbursement" policy, which will be distributed department-wide through the GMC in January 2019. Review and approval of Request for Reimbursement (RFR) payments is a component of fiscal monitoring.

Auditor Comments – Although the department has implemented standardized fiscal monitoring procedures, fiscal monitoring activities are not always performed consistent with department policy.

We reviewed the department's newly implemented grants management procedures and templates, and selected a sample of monitoring events that took place following the July 1, 2018 implementation date to ensure that fiscal monitoring templates are in use and related procedures are being followed. Our testing noted deficiencies in nine (82 percent) of 11 monitoring events tested, including: seven that did not utilize the standardized monitoring templates, three with no evidence of a formal report or notice of findings issued to grantees, and three with no evidence of review and approval by someone other than the report preparer.

Recommendation 5

Routinely identify interrelated activities between state and federal programs, calculate the percentage these activities interrelate, and develop controls to ensure grantee requests for reimbursement do not exceed the calculated percentage.

Status – Partially Implemented

Agency Actions – The office is in the process of revising the grants manual to routinely identify interrelated activities between state and federal programs, calculate the percentage these activities interrelate, and develop controls to ensure grantee requests for reimbursement do not exceed the calculated percentage. The office has also drafted a "DHHS Standardized Request for Reimbursement" policy, which will be distributed department-wide through the Grants Management Committee in January 2019. The policy will establish the minimum requirements for the standardized Request for Reimbursement review and approval process. This process includes guidance on allowable and accrued costs, required forms and backup, and the role of department personnel in the process.

Recommendation 6

Require grantees disclose and provide appropriate detail before using state funds to obtain additional funding from other sources for interrelated program activities. Department personnel should review and approve such requests.

Status – Partially Implemented

Agency Actions – The office is beginning to require grantees to disclose and provide appropriate detail before using state funds to obtain additional funding from other sources for interrelated program activities. Department personnel are required to review and approve such requests. The Grants Management Committee implemented a standardized Notice of Subgrant Award template department-wide effective July 1, 2018. Department personnel are required to review the award and supporting documentation prior to issuance of the award. The Notice of Subgrant Award package incorporates a Budget Narrative that requires grantees to provide cost allocations amongst all funding sources for each expenditure line item included in the budget.

Auditor Comments – Although a uniform grant application and budget template have been implemented, supporting documentation provided by grantees does not provide appropriate detail to support funding requests for interrelated program activities.

We reviewed the department's newly implemented grants management procedures and templates, and selected a sample of grant awards issued following the July 1, 2018 implementation date to ensure that templates are in use and procedures are operating effectively. Our testing noted deficiencies in seven of 11 awards tested, including three

awards with budgets or payments with incorrect funding source allocations and seven awards with inaccurate or incomplete supporting documentation.

Recommendation 7

Develop policies, procedures, and controls over grant applications to ensure requested information is obtained prior to approving funding.

Status – Partially Implemented

Agency Actions – The office is developing policies, procedures, and controls over grant applications to ensure requested information is obtained prior to approving funding. The Grants Management Committee developed a grants manual and various templates, and implemented a shared electronic storage drive to facilitate department-wide standardization effective July 1, 2018. The manual includes the department's standardized templates for all pre and post-award documentation and activities, as well as guidance on the grant award approval process. The office reports that each division has adopted the standardized grant management practices documented in the grants manual, modified as needed to include division-specific components.

Auditor Comments – Although a uniform grant application and budget template have been implemented, not all information requested is obtained prior to approving funding.

We reviewed the department's newly implemented grants management procedures and templates, and selected a sample of grant awards issued following the July 1, 2018 implementation date to ensure that templates are in use and procedures are operating effectively. Our testing noted deficiencies in seven of 11 awards tested, including three awards with budgets or payments with incorrect funding source allocations and seven awards with inaccurate or incomplete supporting documentation.

Recommendation 8

Develop policies, procedures, and controls over accrual adjustments and year-end payment requests to ensure amounts are appropriate. Include procedures to ensure accruals are properly accounted for in each grant year and personnel costs are for those noted on original budgets or approved budget modification requests.

Status – Partially Implemented

Agency Actions – The office developed and is in the process of implementing policies, procedures, and controls over accrual adjustments and year-end payment requests to ensure amounts are appropriate, including procedures to ensure accruals are properly accounted for in each grant year and personnel costs are for those noted on original budgets or approved budget modification requests. The office has drafted a "DHHS Standardized Request for Reimbursement" policy, which will be distributed department-wide through the Grants Management Committee in January 2019. The policy will

establish the minimum requirements for the standardized Request for Reimbursement (RFR) review and approval process. The policy has detailed information regarding cost accruals, reimbursement of costs only incurred within the funding period, and ensuring personnel costs are for those noted in budgets.

Auditor Comments – The office reported there were no year-end accrual adjustments. We reviewed the department's newly implemented grants management procedures and templates, and selected a sample of grant payments issued following the July 1, 2018 implementation date to ensure that existing RFR procedures are operating effectively.

We selected grant payments for testing that were processed on or after July 1, 2018 and accounted for in fiscal years 2018 and 2019. Our testing noted deficiencies in all 11 payments tested, including: nine payments with insufficient or incomplete supporting documentation; one payment with no evidence of review and approval; two payments with errors in the underlying budgets used to review the request; one payment that included costs not yet paid by the grantee; and one payment issued to the wrong grantee that went undiscovered by department personnel until notified by the grantee. No year-end accrual adjustments were noted during testing.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

Susan Brown, Director
Governor's Finance Office

cc: Michelle White, Chief of Staff, Office of the Governor
Richard Whitley, Director, Department of Health and Human Services
Stacey Johnson, Deputy Director, Fiscal, Department of Health and Human Services
Vanessa Alpers, Deputy Director, Programs, Department of Health and Human Services
Andrea Rivers, Social Services Chief III, Office of Community Partnerships and Grants
Warren Lowman, Administrator, Division of Internal Audits

Audit Highlights

Highlights of performance audit report on the Aging and Disability Services Division issued January 18, 2017. Legislative Auditor report # LA18-04.

Background

The Division develops, coordinates, and delivers a comprehensive support system of services for Nevada residents aged 60 and over, and children and adults with disabilities or special health care needs. Most of the Division's expenditures relate to services for intellectually disabled persons, which are primarily funded through state appropriations and Medicaid funds. Expenditures for these services totaled about $160 million in fiscal year 2016, mostly for payments to SLA and JDT providers.

SLA providers offer residential support services to individuals who require assistance to live in the least restrictive community setting possible. SLA services were provided to about 1,900 persons per month in fiscal year 2016. JDT providers assist individuals in obtaining meaningful employment and living skills to help them achieve community inclusion, independence, and productivity. JDT services were provided to about 2,400 persons per month in fiscal year 2016.

Purpose of Audit

The purpose of this audit was to determine whether the Division has: (1) adequate controls over payments to providers of Supported Living Arrangement services and Jobs and Day Training services, and (2) effectively monitored these providers to ensure the safety and welfare of individuals with intellectual disabilities. The scope of our audit was calendar year 2015, although we included some activities in 2016.

Audit Recommendations

This audit report contains 10 recommendations to improve the Division's oversight of providers of services to intellectually disabled persons. Six recommendations improve controls to ensure the Division only pays providers for services performed. Four recommendations help ensure the Division effectively monitors providers to ensure the safety and welfare of individuals with intellectual disabilities.

The Division accepted the 10 recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on April 13, 2017. In addition, the six-month report on the status of audit recommendations is due on October 13, 2017.

Aging and Disability Services

Department of Health and Human Services

Summary

The Division needs additional controls to prevent overpayments to providers of services to individuals with intellectual disabilities. Based on our test results, we estimate the Division overpaid providers a combined total between $3.5 million and $4.3 million in 2015. Overpayments to providers included those providing 24-hour care, as well as those providing jobs and day training to the Division's clients. The combined total is based on overpayments identified in three areas: (1) overbilling issues for 24-hour care homes ($2.2 million to $ 3.0 million); (2) billing for more supported living arrangement (SLA) services than were agreed upon ($504,000); and (3) billing for more jobs and day training (JDT) services than were provided ($766,000). Improved controls would help ensure the Division receives the services it pays for and intellectually disabled individuals receive the services they need. Furthermore, by eliminating overpayments to providers, the Division can serve more clients. The Division paid a total of $106 million in calendar year 2015 to providers serving clients of the Desert Regional Center (DRC) and Sierra Regional Center (SRC).

Some of the overbilling problems described in this report may be the result of provider fraud, while others may be unintentional errors. Therefore, as required by NRS 218G.140(2), we reported this information to the Governor, each Legislator, and the Attorney General.

Although the Division has a thorough process for certifying SLA providers, the timeliness of certifying these providers needs to be improved. In addition, the Division has not yet developed a rigorous process for certifying JDT providers, several years after legislation was passed requiring them to do so. A well-developed certification process will include standards for the provision of quality care and training by JDT providers to the Division's intellectually disabled clients. Finally, the Division did not always have documentation showing that deficiencies noted during home inspections were corrected.

Key Findings

We estimate the Division overpaid providers of 24-hour SLA services between $2.2 million and $3.0 million in 2015. Our estimate is based on a detailed review of about $550,000 in payments for about 1,800 days of service, which found overbillings of between 3.1% and 4.3% of the total billed. (page 7)

The level of SLA services provided to the Division's clients often varied from the level agreed upon. In about one-fourth of the days tested, the number of staff hours provided were less than the number established when the contract was developed. On days that clients are underserved, it can affect their health and welfare, as well as the safety of provider staff. Conversely, in about one-fourth of the days tested, the number of hours provided was greater than the number agreed upon. We estimate the Division overpaid providers of SLA services an additional $504,000 in 2015 for days when more hours were provided than were agreed upon. (page 10)

For 27 of 150 (18%) JDT billings tested, the number of days billed was more than the number shown on providers' logs of staff and client daily attendance or other records. We estimate the Division overpaid providers of JDT services about $766,000 in calendar year 2015. Based on the average cost of providing JDT services for a year, eliminating overpayments to JDT providers could have paid for JDT services to about 50 more clients for one year. (page 13)

Our testing of the 29 largest SLA providers found 27 were not certified timely. Certification reviews include inspections and testing to help ensure that clients' living conditions are safe and provider staff are properly trained and have cleared criminal background checks. (page 16)

The Division's certification process for JDT providers is limited to administrative requirements, such as verifying the provider has a Nevada business license. The process excludes criminal background checks, documentation of employee licensure, and proof of staff training. The Division has not yet adopted regulations with more rigorous certification requirements, as required by legislation passed in 2009. In addition, the Division has not documented that additional certification requirements from legislation passed in 2011 have been met. (page 18)

Although the Division inspected homes timely, it did not have an effective process to ensure deficiencies identified during home inspections were corrected. In 14 of the 29 homes we tested that were inspected, corrective action was required to address deficiencies found in the home. However, for 6 of the 14 (43%) homes with deficiencies, the Division did not have documentation showing that corrective action was completed. (page 21)

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

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MEMORANDUM

To: Rocky Cooper, CPA, Legislative Auditor
Nevada Legislative Counsel Bureau

From: James R. Wells, CPA, Director
Governor's Finance Office

Date: October 13, 2017

Subject: Legislative Audit of the Department of Health and Human Services, Aging and Disability Services Division

On January 18, 2017, your office released an audit report on the Department of Health and Human Services, Aging and Disability Services Division (division). The division subsequently filed a corrective action plan on April 12, 2017. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the division to comply with audit findings.

There were 10 recommendations contained in the report. The extent of the division's compliance with the audit recommendations is as follows:

Recommendation 1

Review recent billings of 24-hour care providers and Jobs and Day Training (JDT) providers to determine the amount of significant overpayments, obtain refunds, and refer potential fraud to the Office of the Attorney General.

Status – Fully Implemented

Agency Actions – The division has referred all billings of 24-hour care providers and

JDT providers identified in the performance audit to the Division of Health Care Financing and Policy, Surveillance and Utilization Review (SUR) unit to determine the amount of significant overpayments, obtain refunds, and refer potential fraud to the Office of the Attorney General. The division continues to conduct audits of recent billings and obtain refunds for overpayments from contracted supported living providers and JDT providers.

Recommendation 2

Ensure bills submitted by Supported Living Arrangement (SLA) providers are reviewed by staff with the appropriate training and skills.

Status – Fully Implemented

Agency Actions – The division has developed a policy and procedure to ensure bills submitted by SLA providers are reviewed by staff with the appropriate training and skills. We reviewed the division's policy which requires quality assurance, program, and fiscal staff to audit bills submitted by SLA providers at least every six months. We verified fiscal and program staff, who have the appropriate training and skills, are periodically performing audits of bills submitted by SLA providers.

Recommendation 3

Establish written policies and procedures for reviewing and processing SLA provider billings, including a checklist of items to review and a process to verify hours billed were worked.

Status – Fully Implemented

Agency Actions – The division has established written procedures, including a checklist for fiscal staff to utilize when periodically auditing provider billings to verify hours billed were worked. We reviewed the policy and procedures. We sampled audits of SLA provider billings and verified staff is following the policies and procedures including utilizing checklists.

Recommendation 4

Develop a graduated process for imposing sanctions on providers that overbill the division, including contract termination.

Status – Fully Implemented

Agency Comments – The division has developed a policy which includes sanctions specific to providers who overbill, including but not limited to reimbursement of overpayments, required fiscal training, closure of home, or provider contract termination. We reviewed the policy and verified the sanctions include contract termination.

Recommendation 5

Develop controls to ensure that providers of 24-hour SLA services provide clients with the daily number of hours agreed upon.

Status – Partially Implemented

Agency Actions – The division is developing controls to ensure that providers of 24-hour SLA services provide clients with the daily number of hours agreed upon. The division's policy states the daily hours identified in the SLA staffing grid are a projection and do not reflect the actual daily or weekly staffing ratio's needed. Instead, providers have the authority to be flexible with staffing ratios to ensure individual needs are being met. When staffing ratios are consistently different than the staffing grid, they will be reported to the regional center to determine if the staffing grid should be revised. If the division believes a provider is chronically understaffing homes they will reassign the home to a different provider. The division is working with a consultant to develop a structure for creating daily rates and anticipates full implementation by July 1, 2019.

Recommendation 6

Develop written procedures for reviewing bills submitted by JDT providers, including comparison to provider attendance logs supporting the numbers of days that services were provided.

Status – Fully Implemented

Agency Actions – The division has developed written procedures for auditing JDT provider billings, including a comparison to the provider attendance logs. We reviewed the division's written procedure and verified billings are compared to provider attendance logs during reviews.

Recommendation 7

Develop policies and procedures to ensure deficiencies identified during the SLA certification process are corrected timely, including timeframes to take corrective action and sanctions for not timely correcting items posing a risk to the health and welfare of clients.

Status – Fully Implemented

Agency Actions – The division developed procedures to ensure deficiencies identified during the SLA certification process are corrected timely, including timeframes and sanctions for untimely corrections. We reviewed the division's policy and procedures and sampled SLA certifications. We verified providers with deficiencies identified during the SLA certification process were given timeframes to correct the deficiency and the division followed up to ensure the provider corrected the deficiency.

Recommendation 8

Complete the process to adopt regulations for certifying JDT providers.

Status – Partially Implemented

Agency Actions – The division is in the process of completing the adoption of regulations for certifying JDT providers. The division has tentatively scheduled a public workshop for November 1, 2017. The division expects full completion by January 1, 2018.

Recommendation 9

Develop policies and procedures to document the review of JDT provider financial information.

Status – Fully Implemented

Agency Actions – The division has developed policies and procedures to document the review of JDT provider financial information. We reviewed the division's policy which requires JDT providers to submit their federal income taxes, as well as obtain and submit to the certifying regional center external audits in accordance with generally accepted auditing principles. The division utilizes a checklist to document when the information has been reviewed. We reviewed JDT provider certification checklists and verified the division is documenting when financial information is reviewed or requires follow up with the provider.

Recommendation 10

Develop a process to track and document deficiencies identified in home inspections are corrected.

Status – Fully Implemented

Agency Actions – The division has developed a process to track and document deficiencies identified during home inspections are corrected. We reviewed the policy and documentation of deficiencies identified during home inspections. We reviewed a sample of providers with deficiencies and verified the division is ensuring the deficiencies are corrected by requiring the provider to respond to the deficiencies with a plan of action including estimated completion dates, which the division uses to follow-up with the provider.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

James R. Wells, CPA, Director
Governor's Finance Office

cc: Mike Willden, Chief of Staff, Office of the Governor
Richard Whitley, Director, Department of Health and Human Services
Dena Schmidt, Administrator, Aging and Disability Services Division
Steve Weinberger, CPA, Administrator, Division of Internal Audits

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January 8, 2018

Members of the Audit Subcommittee
of the Legislative Commission
Legislative Building
Carson City, Nevada 89701-4747

In January 2017, we issued an audit report on the Department of Health and Human Services, Aging and Disability Services Division (Division). The Division filed its plan for corrective action in April 2017. NRS 218G.270 requires the Governor's Finance Office to issue a report within 6 months after the plan for corrective action is due, outlining the implementation status of the audit recommendations.

Enclosed is the six-month report prepared by the Governor's Finance Office on the status of the 10 recommendations in the audit report. As of October 13, 2017, the Finance Office indicated eight recommendations were fully implemented and two recommendations were partially implemented. After additional follow-up with Division personnel, we consider one recommendation deemed to partially implemented to now be fully implemented (Recommendation No. 5). However, based on the additional information we received from the Division, we also consider Recommendation No. 1 to not yet be fully implemented. The recommendations not fully implemented are shown below.

Recommendation Number		Status
1	Review recent billings of 24-hour care providers and Jobs and Day Training (JDT) providers to determine the amount of significant overpayments, obtain refunds, and refer potential fraud to the Office of the Attorney General.	Partially Implemented
8	Complete the process to adopt regulations for certifying JDT providers.	Partially Implemented

Regarding Recommendation No. 1, the Division has made considerable efforts to implement this recommendation, but has not completed its efforts yet. We plan to continue to monitor the Division's efforts on this recommendation, but do not have any questions at this time.

Recommendation No. 8 stemmed from delays in adopting regulations required by legislation passed in 2009. The Finance Office's report indicated that the Division expected full completion by January 1, 2018.

Question

1. Has the Division completed the process to adopt regulations for certifying JDT providers?

Respectfully Submitted,

Rocky Cooper, CPA
Legislative Auditor

RC:sy
cc: Michael J. Willden, Chief of Staff, Office of the Governor
James R. Wells, CPA, Director, Office of Finance, Office of the Governor
Steve Weinberger, CPA, Administrator, Division of Internal Audits, Office of the Governor
Richard Whitley, MS, Director, Department of Health and Human Services (DHHS)
Dena Schmidt, Administrator, Aging and Disability Services Division, DHHS

Audit Highlights

Highlights of performance audit report on the Medical Marijuana Program issued on April 14, 2017. Legislative Auditor report # LA18-07.

Background

The Nevada Medical Marijuana Program (Program) administers the provisions of the Medical Use of Marijuana Law adopted in 2001. As of January 2017, Nevada is 1 of 29 states, including the District of Columbia, with a comprehensive medical marijuana program. The Program has two primary functions:

The registry function issues identification cards to Nevada residents and their caregivers. Residents must be recommended by a physician for the use of marijuana for a qualifying medical condition. As of December 31, 2016, the Program reported:

- 25,358 Active cardholders
- 1,759 Active caregivers

The establishment function licenses and regulates medical marijuana dispensaries, cultivators, producers of edibles and infused products, and independent testing laboratories. As of February 9, 2017, the Program reported 381 establishments, with 198 pending final licensure. The remaining 183 establishments are actively licensed, and include:

- 74 Cultivation facilities
- 56 Dispensaries
- 42 Production facilities
- 11 Laboratories

The Program is self-funded and contributed $1.25 million to the Distributive School Account in fiscal year 2016 from excess revenues.

Purpose of Audit

The purpose of this audit was to: 1) determine compliance with statutory and regulatory requirements related to the registry function, and 2) evaluate the adequacy of internal controls over the registry, recordkeeping practices, and billing process for establishments. The scope of our audit included Program activities during calendar years 2015 and 2016.

Audit Recommendations

This audit report contains six recommendations to enhance compliance with statutory and regulatory requirements and three recommendations to improve controls over Program operations.

The Division accepted the nine recommendations.

Recommendation Status

The Program's 60-day plan for corrective action is due on July 11, 2017. In addition, the six-month report on the status of audit recommendations is due on January 11, 2018.

Medical Marijuana Program

Division of Public and Behavioral Health

Summary

The Medical Marijuana Program (Program) needs to make enhancements to ensure requirements for eligible participation in the Program are met. We found some cardholders did not qualify to grow marijuana but were approved by the Program. The Program also needs to scrutinize the authenticity of physician recommendation forms to ensure applicants have qualifying medical needs. Additionally, the Legislature should consider eliminating the requirement for conducting background checks on medical marijuana cardholders. Individuals with disqualifying criminal histories will be able to purchase recreational marijuana and the costs of the existing process outweigh the benefits. The program could have saved about $400,000 in 2016 if background checks were not required.

Key Findings

The Program approves registry applicants' requests to grow marijuana without determining whether they are eligible. As a result, 67% of cardholders we tested, in three counties with operating dispensaries, did not qualify to grow as they lived within 25 miles of a dispensary. Additionally, the Program did not adequately monitor the authorized grower information recorded in its database. Records for 39% of the 2,843 authorized growers did not cite the statutory reason they qualified as a grower. (page 9)

The Program needs to scrutinize the authenticity of physician recommendation forms to ensure applicants have qualifying medical needs. We found physician recommendation forms were not verified and some recommendations were made by medical professionals not meeting the definition of attending physicians in statute. Further, the Program has not coordinated with the Nevada State Boards of Medical Examiners and Osteopathic Medicine to establish a monitoring process as required by statute and regulation. (page 13)

The cost of enforcing the requirement to revoke a registry identification card based on the cardholder's criminal history exceeds the benefit. A background check is required for all initial applications; however, we estimate the number of registry cardholders with a disqualifying criminal history to be minimal. If the background check was not required, the Program could have saved about $400,000 in calendar year 2016. In addition, background checks will not be required to purchase marijuana for recreational use. (page 17)

The Medical Marijuana Program can strengthen controls over its registry function, recordkeeping practices, and billing process. Controls in the registry are ineffective in preventing marijuana sales to cardholders with expired registry identification cards. Records management policies and procedures are lacking, which resulted in poorly organized and misplaced records. Additionally, the Program did not invoice for all billable activities or collect delinquent accounts from medical marijuana establishments. (page 21)

Legalization of Recreational Marijuana Impact

As of January 2017, Nevada became one of nine states to legalize the recreational use of marijuana. Similar to other states' experience, we anticipate the Medical Marijuana Program to continue to be a relevant path for individuals to obtain marijuana. For example, Colorado legalized recreational marijuana in 2012 and sales to the public began in 2014. Since that time, the number of participants in Colorado's medical marijuana program has remained reasonably stable. Additionally, taxes assessed on medical marijuana in Nevada are significantly less than the taxes proposed on recreational marijuana sales. In relation to our report, the Program may be impacted by the legalization of recreational marijuana as follows:

Marijuana Growers – Approval of cardholders authorized to grow marijuana remains relevant because, like the medical program, the recreational program prohibits individuals from growing if their residence is within 25 miles of an operating dispensary. (page 11)

Qualifying Medical Conditions – Verifying the authenticity of physician recommendation forms will continue to be important to ensure medical program applicants have qualifying medical conditions. Further, because recreational use will be illegal for persons under 21 years of age, ensuring those under 21 have qualifying medical conditions for participation in the medical program is crucial. (page 15)

Background Checks – The requirement to verify cardholders' criminal history in the medical marijuana program is no longer pertinent, because purchasing recreational marijuana will not require such verification. (page 18)

Brian Sandoval
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Paul Nicks
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MEMORANDUM

To: Rocky Cooper, CPA, Legislative Auditor
Nevada Legislative Counsel Bureau

From: James R. Wells, CPA, Director
Governor's Finance Office

Date: January 11, 2018

Subject: Legislative Audit of the Department of Health and Human Services, Division of Public and Behavioral Health – Medical Marijuana Program

On April 14, 2017, your office released an audit report on the Department of Health and Human Services, Division of Public and Behavioral Health (division) – Medical Marijuana Program. The division subsequently filed a corrective action plan on May 26, 2017. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the division to comply with audit findings.

There were nine recommendations contained in the report. The extent of the division's compliance with the audit recommendations is as follows:

Recommendation 1

Establish a process to evaluate and verify the applicants' requests to grow marijuana, and ensure the reasons are accurately recorded in the registry and reflected on the log for law enforcement.

Status – Fully Implemented

Agency Actions – The division established a process to evaluate and verify applicants' requests to grow marijuana and ensure the reasons are accurately recorded in the registry and reflected on the log for law enforcement. The division updated the Medical Marijuana Program Cardholder Registry User Manual (manual) to include steps for ensuring the address of an applicant is not within 25 miles of a dispensary. Due to changing dispensary inventory and because an applicants' illness and/or travel

restrictions can change quickly, the division is not requesting additional information from those who qualify to cultivate at home. We sampled application requests for cultivation and verified the division is following the procedures established to verify an applicant is more than 25 miles from a dispensary. We also verified registrants' qualifications to cultivate were recorded on the log used by law enforcement.

Recommendation 2

Develop a process to verify the authenticity of physician recommendations for the use of medical marijuana.

Status – Partially Implemented

Agency Comments – The division reports it has developed a process to verify the authenticity of physician recommendations for the use of medical marijuana. The division receives a list of active health care providers monthly from the appropriate medical boards. This list is uploaded into the division's medical marijuana portal. The processer reviews the doctor recommendation and searches the list in the portal using the license number provided on the doctor recommendation form. If the doctor is not found on the registry, the processor will use the applicable medical board website or forward the application to a manager who contacts the board to determine if the medical professional is authorized to recommend the use of medical marijuana.

Auditor Comments – Although the division has implemented a process to ensure the physician list in the medical marijuana portal is up-to-date with active licensees, it does not have a process for verifying physician recommendations are authentic. The division does not require physicians to send recommendation forms directly to the division or subsequently, verify a sample of recommendation forms with physicians to ensure they are authentic.

Recommendation 3

With the assistance of legal counsel, develop a policy to ensure recommendations for the use of medical marijuana are only accepted from authorized and actively licensed medical professionals.

Status – Fully Implemented

Agency Actions – The division developed a policy to ensure recommendations for the use of medical marijuana are only accepted from authorized and actively licensed medical professionals. The division updated the manual to include the statute which governs who is authorized to recommend medical marijuana and a list of medical professionals that are included within the statute. This policy is used in conjunction with the list of medical professionals received monthly to ensure recommendations for medical marijuana are only accepted from authorized and actively licensed professionals.

Recommendation 4

Coordinate with state medical boards to establish a process to monitor physicians' advising the use of medical marijuana and ensure compliance with state laws and regulations.

Status – Partially Implemented

Agency Comments – The division reports it coordinated with the state medical boards to establish a process to monitor physicians advising the use of medical marijuana. The division developed a list that contains recommending physicians and the number of recommendations they have made. Physician recommendation lists are sent to licensing boards on a monthly basis rather than annually as required by state law. We reviewed the most recent reports sent to the Medical Examiners and Osteopathic boards.

Auditor Comments – Although the division sends physician recommendation lists to the boards monthly, it has not established a process for notifying boards in writing of physicians who are recommending medical marijuana at an unreasonably high rate for potential board action, as required by NAC 453A.716.

Recommendation 5

Establish controls to ensure the completeness of applicant information entered into the registry.

Status – Fully Implemented

Agency Actions – The division established controls to ensure the completeness of applicant information entered into the registry. The division updated the manual to include steps for verifying all documentation is legible and complete. They also utilize a Cardholder Caregiver Checklist that is completed by the processor to ensure all items have been received and are in the applicant's file. We sampled applicant files and verified all information was complete and legible.

Recommendation 6

The Legislature should consider enacting legislation to eliminate the statutory requirement to revoke medical marijuana registry identification cards based on an individual's criminal history identified in background checks.

Status – Fully Implemented

Agency Actions – The Legislature eliminated the statutory requirement to revoke medical marijuana registry identification cards based on an individual's criminal history identified in background checks. Section 21 of Assembly Bill (AB) 422 eliminated the requirement to revoke a medical marijuana registry identification card if the person has been convicted of selling a controlled substance. AB 422 was signed by the Governor on June 12, 2017.

Recommendation 7

Establish controls to prevent the sale of medical marijuana to ineligible cardholders with expired or revoked registry identification cards.

Status – Fully Implemented

Agency Actions – The division established controls to prevent the sale of medical marijuana to ineligible cardholders with expired or revoked registry identification cards. The division updated the coding in the medical marijuana portal to ensure cardholders with expired or revoked cards are marked appropriately. When a registrant goes to the dispensary, it is the dispensary's responsibility to check the portal to ensure the registrant's medical marijuana card is active and not expired or revoked. If the card is revoked or expired, the dispensary informs the registrant they are unable to purchase medical marijuana until they update their information with the division. The coding of the software was tested on March 10, 2017, which verified it was functioning correctly.

Recommendation 8

Develop and document record retention guidelines and a quality control process for scanned records to ensure integrity and safeguarding of sensitive information.

Status – Fully Implemented

Agency Actions – The division developed and documented record retention guidelines and a quality control process for scanned records to ensure integrity and safeguarding of sensitive information. The division updated the manual to indicate how to scan records and destroy records after they have been properly scanned. In addition, the division developed a record retention policy that was approved by Nevada State Library and Archives on November 8, 2017.

Recommendation 9

Provide oversight to ensure adherence to the Program's policies for billing and collecting all billable hours for services provided to medical marijuana establishments.

Status – No Longer Applicable

Agency Actions – The division no longer provides services to medical marijuana establishments. The Governor signed AB 422 on June 12, 2017, which transferred all services relating to medical marijuana establishments to the Department of Taxation (DOT). Consequently, the division transferred all delinquent accounts to DOT. DOT is currently trying to collect the delinquent accounts.

The degree of ongoing compliance with these recommendations is the responsibility of the division.

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Governor's Finance Office

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Richard Whitley, Director, Department of Health and Human Services
Amy Roukie, Administrator, Division of Public and Behavioral Health
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April 20, 2018

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In April 2017, we issued an audit report on the Medical Marijuana Program of the Division of Public and Behavioral Health (Division), Department of Health and Human Services. The Division filed its plan for corrective action in May 2017. NRS 218G.270 requires the Governor's Finance Office to issue a report within 6 months after the plan for corrective action is due, outlining the implementation status of the audit recommendations.

Enclosed is the six-month report prepared by the Governor's Finance Office on the status of the nine recommendations in the audit report. As of January 11, 2018, the Finance Office indicated six recommendations were fully implemented and two recommendations were partially implemented. The remaining recommendation was deemed no longer applicable as the Division no longer provides services to medical marijuana establishments. This function was transferred to the Department of Taxation during the 2017 Legislative Session. The two partially implemented recommendations and their status are shown below.

Recommendation Number		Status
2	Develop a process to verify the authenticity of physician recommendations for the use of medical marijuana.	Partially Implemented
4	Coordinate with state medical boards to establish a process to monitor physicians advising the use of medical marijuana and ensure compliance with state laws and regulations.	Partially Implemented

Regarding Recommendation No. 2, the Finance Office's report indicates the Division has implemented a process to ensure the physician list in the medical marijuana portal is up-to-date; however, it has not developed a process to verify physician recommendations are authentic.

Question

1. Has the Division developed a process to verify the authenticity of physician recommendations by verifying a sample of recommendations or through another means? If so, please provide an explanation of the new process to the Legislative Auditor. If not, when will the process of verifying physician recommendations be implemented?

Regarding Recommendation No. 4, the Finance Office's report indicates the Division is sending lists of recommending physicians to the medical boards monthly, but has not coordinated with the medical boards to establish a monitoring process to comply with the requirements of NAC 453A.716.

Question

2. Has the Division developed a process, in coordination with the medical boards, to establish a process to monitor physicians advising the use of marijuana, consistent with the intent of NAC 453A.716? If so, please provide an explanation of the process to the Legislative Auditor. If not, when will the process be finalized?

Respectfully Submitted,

Rocky Cooper, CPA
Legislative Auditor

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Julie Kotchevar, PhD, Administrator, Division of Public and Behavioral Health, DHHS

Audit Highlights

Highlights of performance audit report on Adult Mental Health Services, Community-Based Living Arrangement Homes issued on January 17, 2018. Legislative Auditor report # LA18-13.

Background

Within the Division of Public and Behavioral Health (Division), the Clinical Services Branch provides adult mental health services, primarily through NNAMHS, SNAMHS, and Rural Counseling and Supportive Services. The primary clients of these agencies are Nevadans with mental illness who are underinsured, uninsured, and those whose conditions have resulted in interaction with law enforcement. Expenditures for adult mental health services totaled about $134 million in fiscal year 2017.

The CBLA living arrangement pays a provider the rent, utilities, and staff service hours up to a predetermined number of hours per month, per client, for supervision and assistance with activities of daily living. According to payment information provided by the Division, the State pays an average of $1,450 per month, per CBLA client. This amount does not include client payments to CBLA providers from social security or other income. For the homes we inspected, the average number of clients in each home was four.

Purpose of Audit

The purpose of this audit was to determine if controls for monitoring providers of CBLA services are adequate to ensure the safety and welfare of adult mental health clients at NNAMHS and SNAMHS.

Audit Recommendations

This audit report contains seven recommendations to improve oversight of providers of CBLA services. Six of these recommendations relate to improving controls to ensure the Division effectively inspects CBLA homes. The other recommendation helps ensure the Division properly certifies CBLA providers.

The Division accepted the seven recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on April 12, 2018. In addition, the six-month report on the status of audit recommendations is due on October 12, 2018.

Adult Mental Health Services Community-Based Living Arrangement Homes

Division of Public and Behavioral Health

Summary

Adults in need of mental health care live in dismal conditions at many community-based living arrangement (CBLA) provider homes. During our inspections of provider homes, we identified serious, deficient conditions prevalent at most of the homes. This includes unsanitary and unsafe conditions, and poor medication management practices. In addition, we identified numerous conditions that could negatively affect the quality of life for mentally ill clients. Furthermore, we observed children living at risk at two homes. We inspected CBLA homes that serve clients of Northern Nevada Adult Mental Health Services (NNAMHS) and Southern Nevada Adult Mental Health Services (SNAMHS). Although the Division developed policies and procedures to inspect provider homes, staff implementation of procedures is inadequate. When home inspections are not performed properly, deficiencies go undocumented, corrective action is not taken, and unsafe and unhealthy conditions may continue and proliferate.

Although the Division is responsible for certifying providers of CBLA homes, certification activities performed by the Division are inadequate. Specifically, reviews and assessments required for certifying providers were not performed for most of the 20 CBLA providers we tested, and were untimely for others. Although NNAMHS and SNAMHS performed some steps, such as obtaining business licenses and proof of insurance coverages, other key activities important for determining whether the providers met the Division's 2014 standards for certification were often omitted. When CBLA providers do not undergo complete or timely certification reviews, there is increased risk that unqualified providers may operate unchecked, needlessly exposing clients to adverse conditions.

Without strong inspection and certification processes, we have serious concerns with the current model for funding CBLA provider homes. Providers operate a business that inherently is driven by a profit motive. In the absence of adequate inspection and certification activities, providers may limit their level of care to maximize profits at the detriment of client services.

Key Findings

During our inspections of CBLA homes, we observed serious, deficient conditions at all 37 homes inspected. Our inspections included 37 of 105 (35%) homes providing services for NNAMHS and SNAMHS clients. Because providers typically operate more than one home, the number of providers included in our inspections exceeded 70% of the total providers. (page 10)

The following are some examples of conditions observed during our inspections of 37 homes:

- Unsanitary conditions (36 homes) – Excessively dirty floors, ceilings, and walls; mold and mildew; rodent and insect infestations; and no hand soap or toilet paper in bathrooms. (page 10)
- Personal health and safety hazards (34 homes) – Expired, spoiled, or improperly stored food; broken bathroom and bedroom doors; and broken and exposed glass. (page 12)
- Fire safety hazards (33 homes) – Expired, non-inspected, or inaccessible fire extinguishers, and missing and disabled smoke detectors. (page 14)
- Inadequate medication management practices (28 homes) – Medication administration records (MAR) left blank, not up-to-date, or completed in advance. Medications were not properly stored, including unsecured, commingled, and expired medications. (page 16)
- Bleak living conditions (36 homes) – Insufficient quantities of food; inadequate lighting; insufficient bedding and linens; and non-functioning or damaged appliances. (page 18)

At two homes, we observed young children of the caregivers living in the homes. In one home, the child's parent was not present and the mentally ill clients provided childcare while the mother reportedly worked another full-time job outside the home. (page 21)

For 11 of 20 (55%) CBLA homes inspected in southern Nevada, the staff member identified as the caregiver spoke little to no English, the language of the clients living in the home. Caregivers are responsible for tasks that necessitate client interaction such as administering medications and supervising client activities. If caregivers are unable to communicate, clients may not receive the services they need, and those for which the State is paying. (page 22)

Most of the 20 CBLA providers we tested had not undergone required review and assessment procedures for certification, and when procedures were performed, they were untimely by up to 5 years. (page 25)

Brian Sandoval
Governor

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MEMORANDUM

To: Rocky Cooper, Legislative Auditor
Nevada Legislative Counsel Bureau

From: Paul Nicks, Acting Director
Governor's Finance Office

Date: October 12, 2018

Subject: Legislative Audit of the Department of Health and Human Services, Division of Public and Behavioral Health – Adult Mental Health Services Community-Based Living Arrangement Homes

On January 17, 2018, your office released an audit report on the Department of Health and Human Services, Division of Public and Behavioral Health (division) Adult Mental Health Services Community-Based Living Arrangement (CBLA) homes. The division subsequently filed a corrective action plan on April 13, 2018. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the division to comply with audit findings.

At the request of the Legislative Commission's Audit Subcommittee, we performed re-inspections of all CBLA homes your office originally inspected that are still operating. Of the original 37 homes inspected, 22 remained in operation at the time of our re-inspection. Two of these are pending certification denial or decertification. The results of these re-inspections support our conclusions as to the implementation status of audit recommendations and are incorporated into the body of the report, as applicable.

Overall, our re-inspections did not find any homes with the substandard environmental conditions documented in your audit. Moreover, we did not find a home where the residents' health or safety appeared at risk during our re-inspection. The division continues to develop policies and procedures to administer new CBLA inspection protocols established since the release of your audit report.

There were seven recommendations contained in the report. The extent of the division's compliance with the audit recommendations is as follows:

Recommendation 1

Develop additional policies and procedures to ensure inspections are regularly and consistently performed, including regular staff training and monitoring by supervisors, and items requiring corrective action are properly documented.

Status – Partially Implemented

Agency Actions – In May 2018, the division transferred the responsibility for certification and regulation of CBLA homes to the Bureau of Health Care Quality and Compliance (HCQC), a regulatory entity that licenses medical and other health facilities in Nevada under the oversight of the division's Regulatory and Planning Services branch. As part of the transfer, the division reclassified eight Psychiatric Caseworker positions to inspection positions that perform home inspection activities. Case manager positions remaining in Adult Mental Health Services continue to address provision of services and care coordination needs of residents.

The division developed a new policy requiring quarterly CBLA home inspections and periodic aggregation and analysis of inspection data. HCQC also relies on its existing policies and inspection staff work performance standards for oversight of corrective action items. The division conducted health facility training of caseworker and inspection staff in May and June 2018.

Auditor Comments – We reviewed the division's newly created and existing policies, inspection staff work performance standards, quality assurance reports, service coordinator visit case notes, and inspection reports issued since the transfer of certification and regulation duties to HCQC to confirm inspections and home visits are regularly and consistently performed and monitored by supervisors. The inspection reports additionally document items requiring corrective action that are noted during inspections.

Our review indicates the division's policies do not address requirements in relation to monitoring of inspection activities. Our re-inspections noted life-safety or health hazard conditions in seven (32 percent) homes that were not noted in previous HCQC inspections. These include a hole in a microwave door covered with a piece of tape and a dishwasher that was badly degraded with insects inside. Five of the 65 residents in the CBLA homes did not have a Service Coordinator home visit within the last six months and visit case notes were missing for eight (12 percent) residents that received a home visit. Residents in 15 (88 percent) of the 17 homes re-inspected in the south did not have a clinical quality assurance review performed in the home within the last six months. Under current division practice, the clinical quality assurance review is not part of the HCQC environmental inspection and will be performed separately by appropriate division clinical staff.

We noted that the division has not developed policies and procedures to ensure regular staff training is ongoing. We obtained division training records and noted that extensive training took place in May and June 2018. However, multiple training logs were missing training dates, locations, trainer information, or even training topics.

Additionally, we noted the existing inspection criteria does not include other potential life-safety or health hazard issues. For example, providers are not required to have carbon monoxide detectors in areas of homes where gas appliances are present, nor keep copies of incident reporting policies, procedures, and reporting forms in homes.

Recommendation 2

Develop a standardized process for documenting and tracking implementation of corrective action items.

Status – Partially Implemented

Agency Actions – The division continues to develop policies and procedures to administer new HCQC inspection protocols. As yet, the division does not have a written, standardized process for documenting and tracking implementation of corrective action items. Rather, HCQC's practice is to issue reports of violations that include corrective action items and conduct re-inspections to ensure compliance. HCQC considers revocation of CBLA certification if compliance is not eventually achieved.

Recommendation 3

Develop procedures for tracking corrective action items by provider and home, including regular analysis to ensure corrective action is sustained.

Status – Partially Implemented

Agency Actions – The division established a written policy that requires the aggregation of inspection data once per calendar year before July 1.

Auditor Comments – The division does not have procedures in place for tracking corrective action items by provider and home. Our re-inspections revealed items requiring corrective action were not documented on reports for inspections performed within the last six weeks, such as a hole in a microwave door covered with a piece of tape and a dishwasher that was badly degraded with insects inside. As a result, high priority violations requiring corrective action are remaining uncorrected.

Recommendation 4

Develop policies and procedures for imposing sanctions when CBLA providers consistently fail to meet standards.

Status – Partially Implemented

Agency Comments – The division developed draft language to amend Nevada Administrative Code (NAC) 433, which governs the administration of CBLA certification and regulation. We reviewed the draft language incorporated into LCB File No. R134-18 and verified it contains sanctions for CBLA providers who consistently fail to meet standards. The amendments are currently in draft status and are not yet enacted. We additionally reviewed documentation for the 15 decertified or denied provider homes, as well as the two homes pending certification denial or decertification, noting these homes were appropriately denied certification or decertified.

Recommendation 5

Develop policies and procedures regarding children living in CBLA homes.

Status – Partially Implemented

Agency Actions – The division developed draft language to amend Nevada Administrative Code (NAC) 433, which governs the administration of CBLA certification and regulation. We reviewed the draft language incorporated into LCB File No. R134-18 and verified it contains language that will regulate the presence of children in CBLA homes. The amended draft language is not yet enacted.

Recommendation 6

Develop policies and procedures regarding language proficiency and essential physical requirements for provider staff that regularly provide one-on-one services to clients.

Status – Partially Implemented

Agency Actions – The division developed draft language to amend Nevada Administrative Code (NAC) 433, which governs the administration of CBLA certification and regulation. We reviewed draft language incorporated into LCB File No. R134-18 and verified it addresses the language proficiency, physical capabilities, and essential functions of CBLA provider staff. The amended draft language is not yet enacted.

Recommendation 7

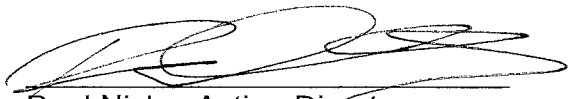
Develop policies and procedures to help ensure provider certifications are performed consistently, timely, and comply with recently enacted laws and regulations.

Status – Partially Implemented

Agency Actions – The division developed policies and procedures to help ensure provider certifications are performed, consistently, timely, and comply with recently enacted laws and regulations. We reviewed the division's policies and procedures and verified that they define the internal certification process. We were unable to test certifications for compliance with the new policy, as it was recently revised in early September 2018.

The division also developed draft language to amend Nevada Administrative Code (NAC) 433, which governs the administration of CBLA certification and regulation. We reviewed draft language incorporated into LCB File No. R134-18 and verified it addresses the provider certification process. The amended draft language is not yet enacted.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.



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October 19, 2018

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In January 2018, we issued an audit report on the Department of Health and Human Services, Division of Public and Behavioral Health (Division), Adult Mental Health Services, Community-Based Living Arrangement (CBLA) Homes. The Division filed its plan for corrective action in April 2018. NRS 218G.270 provides that the Governor's Finance Office shall issue a report within 6 months after the plan of corrective action is due outlining the implementation status of the audit recommendations.

Enclosed is the six-month report prepared by the Governor's Finance Office on the status of the seven recommendations contained in the audit report. As of October 12, 2018, the Finance Office indicated all seven recommendations were partially implemented. The recommendations related to developing policies and procedures to effectively inspect CBLA homes and properly certify providers. Regarding the implementation status of the seven recommendations shown below, we have one question at this time.

Recommendation Number		Status
1	Develop additional policies and procedures to ensure inspections are regularly and consistently performed, including regular staff training and monitoring by supervisors, and items requiring corrective action are properly documented.	Partially Implemented
2	Develop a standardized process for documenting and tracking implementation of corrective action items.	Partially Implemented
3	Develop procedures for tracking corrective action items by provider and home, including regular analysis to ensure corrective action is sustained.	Partially Implemented
4	Develop policies and procedures for imposing sanctions when CBLA providers consistently fail to meet standards.	Partially Implemented
5	Develop policies and procedures regarding children living in CBLA homes.	Partially Implemented
6	Develop policies and procedures regarding language proficiency and essential physical requirements for provider staff that regularly provide one-on-one services to clients.	Partially Implemented
7	Develop policies and procedures to help ensure provider certifications are performed consistently, timely, and comply with recently enacted laws and regulations.	Partially Implemented

Question

1. When does the Division expect full implementation for each of the seven audit recommendations?

We plan to continue monitoring the Division's efforts to implement the recommendations and do not have additional questions at this time. However, the Audit Subcommittee may want to consider asking that representatives from the Division return for additional questions at a future subcommittee meeting.

Respectfully Submitted,

Rocky Cooper, CPA
Legislative Auditor

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Audit Highlights

Highlights of performance audit report on the Adult Mental Health Services, Community-Based Living Arrangement Homes, Residential Services Payments issued on October 29, 2018. Legislative Auditor report # LA18-24.

Background

Within the Division of Public and Behavioral Health (Division), the Clinical Services Branch provides adult mental health services, primarily through Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS), and Rural Counseling and Supportive Services. The primary clients of these agencies are Nevadans with mental illness who are underinsured, uninsured, and those whose conditions have resulted in interaction with law enforcement.

Individuals with mental illness that meet eligibility requirements are screened and assessed for case management needs, which may include residential placement in various home settings throughout the community. CBLA providers are paid rent, utilities, and staff service hours up to a predetermined number of hours per month, per client, for supervision and assistance with activities of daily living. Payments to CBLA providers come from the State General Fund and individuals' Social Security Disability and Supplemental Security Income.

Purpose of Audit

The purpose of the audit was to determine if the Division had adequate controls over payments to providers of community-based living arrangements for adult mental health services, including controls to monitor provider financial sustainability during fiscal year 2017.

Audit Recommendations

This audit report contains 12 recommendations to improve the Division's oversight of CBLA home providers. Eight recommendations improve controls to help ensure the Division's payments to providers are appropriate. Four recommendations help ensure the Division effectively monitors providers for financial sustainability and compliance with labor laws.

The Division accepted the 12 recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on January 29, 2019. In addition, the six-month report on the status of audit recommendations is due on July 29, 2019.

Adult Mental Health Services Community-Based Living Arrangement Homes Residential Services Payments

Division of Public and Behavioral Health

Summary

The Division's oversight of community-based living arrangement (CBLA) provider payments is not adequate to protect against providers overbilling the State, or to help ensure the validity of payments. We estimate the Division was overbilled about $1.5 million in fiscal year 2017. These overbillings resulted from providers billing for more hours than were recorded on staff service logs and payroll documents, and billings for duplicate services. Adequate controls over provider payments are important to help ensure the Division and clients receive the services they pay for and to help ensure the Division's financial resources are used effectively.

In addition, the Division lacked proper oversight of NNAMHS' and SNAMHS' operations to help ensure consistent billing rates for provider services. As a result, the Division paid different rates for similar provider staff service hours, and paid more for client housing costs than it should have. We estimate the State could have realized savings of over $600,000 in fiscal year 2017 with better oversight of CBLA provider pay rates and housing costs.

Some of the overbilling problems described in this report may be the result of provider fraud, while others may be unintentional errors. Therefore, as required by Nevada Revised Statutes (NRS) 218G.140(2), we reported this information to the Governor, each Legislator, and the Attorney General.

The Division needs to provide better management of residential services to help ensure CBLA home providers' sustainability and equality. Our analysis found some homes may find it difficult to make a profit while others may potentially generate annual profits of more than $100,000 per home. The primary factors affecting the financial sustainability of homes' operations include the number of clients placed within each home, the clients' billable service hours, housing costs, and payroll practices.

Key Findings

We estimate providers overbilled the Division about $1.5 million in fiscal year 2017 for staff service hours. Our estimate is based on a statistical sample of 45 monthly billings for provider homes. Because monthly billings include client service hours recorded on staff logs, we reviewed and analyzed tens of thousands of daily entries recorded on 167 staff service logs. Our detailed review of over $475,000 in payments related to the 45 monthly billings identified overbillings totaling more than $52,000 for 35 (78%) of the provider billings tested. Using statistical principles, these overbillings were then extrapolated to a yearly amount to make our estimate. (page 9)

The Division lacked proper oversight of NNAMHS' and SNAMHS' operations to ensure the State did not overpay for CBLA home staff service hours and client housing costs. As a result, the Division paid different rates for similar service hours in northern Nevada compared to southern Nevada. In addition, the Division paid more for client housing costs than it should have, mainly in southern Nevada. We estimate the State could have saved over $600,000 in fiscal year 2017 if there was better oversight of provider pay rates and client housing costs. (page 14)

CBLA providers' supporting documentation used to bill the Division for staff service hours was often inadequate and lacked important information. In addition, this documentation included skills training hours recorded by provider staff that spoke a different language than the client. Because providers are paid for service hours that include teaching or helping a client relearn specific skills, it is important that supporting documentation accurately identifies the hours of service provided. Furthermore, it is imperative that providers' staff have the ability to effectively communicate with a client; thereby, achieving the desired outcome of the services provided. (page 18)

Financial sustainability of CBLA homes' operations varied significantly. The most significant factors affecting providers' cash flows, for the 45 monthly home payments tested, were the number of clients they housed and their monthly billable service hours. The more profitable CBLA providers housed the clients with the greater number of service hours. Conversely, providers housing clients that had fewer service hours, or fewer clients per home, had less favorable cash flows, with some barely breaking even or showing losses. (page 23 and 36)

CBLA home providers used a wide range of payroll practices, some of which may have violated state and federal labor laws and created an unfair advantage over other providers. Although most of the CBLA providers in northern Nevada had adequate documentation that payroll requirements were followed, most of the southern Nevada providers had questionable payroll practices. First, many providers were unable to provide basic employment records of timesheets to support hours worked. Second, nine employees received an hourly rate below the state minimum wage of $8.25 per hour. Third, some providers treated their employees as independent contractors, thus avoiding employment taxes. (page 26)

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January 29, 2019

Susan Brown, Director
Governor's Finance Office
209 East Musser Street, Room 200
Carson City, NV 89701

RE: 60 Day Corrective Action Report - *Adult Mental Health Services, Community-Based Living Arrangement Homes, Residential Services Payments (LA18-24)*

Dear Director Brown:

Pursuant to NRS 218G.250, this letter serves as the written plan of correction within 60 days after receipt of the audit report on *Adult Mental Health Services, Community-Based Living Arrangement Homes, Residential Services Payments (LA18-24)*. On October 19, 2018, the agency accepted all recommendations in the audit report. Below, each recommendation is listed. Discussion regarding how the agency has implemented or progress toward implementing each recommendation is presented herein.

1. Review recent billings by CBLA providers to determine the amount of significant overpayments and obtain refunds, and communicate significant overpayments to the Office of Attorney General, as appropriate.

Administrative Services Officers for Northern Nevada Adult Mental Health Services (NNAMHS) and Southern Nevada Adult Mental Health Services (SNAMHS) determined the level of detail required for this effort would not fit into their current workload. To recoup provider overpayments, SNAMHS and NNAMHS are in the process of contracting with local accounting vendors to perform the review of past CBLA payments.

Contractors will analyze bills and supporting documentation to confirm and determine overpayments and the total amount to attain from overpaid providers. Specific data will be collected to determine breakdowns in processes and procedures will be implemented to prevent this from happening in the future. DPBH will communicate significant overpayments or concerns regarding potential fraud to the Office of Attorney General.

2. Establish written policies and procedures for reviewing and processing CBLA provider billings, including a checklist of items to review and a process to verify hours billed were worked and supporting documentation agrees to hours billed.

DPBH developed a policy on *Internal Control Procedures in Processing Billing of CBLA Provider Billings* so current processes prevent this from happening in the future (see attached).

3. Ensure bills submitted by CBLA providers are reviewed by Division staff with the appropriate training and skills.

NNAMHS and SNAMHS staff who review bills have been provided with the appropriate training and have the skills to implement the Internal Control Procedures attached. Additionally, contractors secured by both agencies will identify practices and procedures that also need to be put into practice.

Myers and Stauffer, LC recently were contracted to assist DPBH in developing a payment model that will eventually replace hourly billing. Until then, the attached Internal Control Procedures will be utilized and staff with skills and training will process billings as indicated in that policy.

4. Develop written policies and procedures to detect and prevent providers from billing the same service hours for multiple clients.

DPBH developed a policy on *Internal Control Procedures in Processing Billing of CBLA Provider Billings* so current processes prevent this from happening in the future. See *section III.B* of attached procedures. That policy explicitly defines how billing should be completed and what will be unacceptable in billing until the time when a new payment model is established. The current process includes entry of invoices into spreadsheets for analysis prior to payment to ensure that no overpayments are issued.

5. Develop written policies and procedures to define those service hours paid to providers and which rates will be paid, including supervision hours that do not require specialized training.

Section II of the attached *Internal Control Procedures in Processing CBLA Provider Billings* defines activities included in service and other activity hours paid to providers. The Division has entered into a contract with Myers and Stauffer, LC to develop a Cost Survey, Acuity Questionnaire, Rate Methodology, including a rent and utilities per diem rate, direct resident care and other expenses (i.e. food, medical supplies, laundry housekeeping, food services and household supplies), and Prepare a Financial Model. This contract was approved by the

Board of Examiners on 1/15/19. Work is scheduled to begin with the contractor on 2/14/19.

6. Establish policies and procedures to help ensure shared costs, such as rent and utilities, are appropriately allocated between clients, private-pay, and live-in caregivers.

The attached document *CBLA Rent and Utility Cost Allocation Procedure* describes how shared costs such as rent and utilities will be appropriately allocated per client. Although it does not directly describe how rent for private pay and live in caregivers will be allocated, it describes how rent will be calculated for CBLA clients. This should prevent overlapping of charges for private pay and live in caregivers.

7. Develop policies and procedures to ensure information on staff service logs contains important, legible information that will help ensure the Division can verify that the appropriate services were provided, staff performing the services were documented, and service times were identified.

The Bureau of Healthcare Quality and Compliance (HCQC) reviews service logs during inspections to ensure legibility and consistency. The attached *Internal Control Procedures in Processing CBLA Provider Billings* identifies billing practices as well as procedures for ensuring hours are not duplicated for clients, specific activities are separately billed for clients, and service log requirements are described. See section III.A of *Internal Control Procedure in Processing CBLA Provider Billings.* SNAMHS and NNAMHS fiscal staff began using this policy when processing provider's billings beginning with November 2018 billings.

8. Develop policies and procedures to help ensure provider staff is proficient in the language of the client, when billing for services that require communication with a client.

Please see adopted regulations (attachment *R134-18P*), which were approved by the Legislative Commission on December 19, 2018. *Page 19, section 18, item 11 (b)* states: "Communicating effectively with each person to whom the employee or independent contractor provides services". Additionally, DPBH is developing a policy and procedure for Service Coordinators to detail which CBLA/client issues require notification to HCQC. Language barrier issues would require notification to HCQC.

9. Perform regular financial assessments of CBLA provider homes' operating costs.

DPBH Internal Auditors have updated the *Annual CBLA Financial Audit Questionnaire* to include financial assessment of the CBLA operating costs (see attached). Policies and procedures for how this will be completed will also be included in development of daily rates. This document is currently only used by SNAMHS since NNAMHS does not employ an

auditor. However, opportunities for NNAMHS to incorporate this assessment are being explored.

10. Develop policies and procedures over client placements to help ensure a fair and equitable balance of billable service hours among CBLA providers when practicable.

Policies and procedures for how this will be completed will be part of development of the new payment model. The Division has entered into a contract with Myers and Stauffer, LC to develop a Cost Survey, Acuity Questionnaire, Rate Methodology, including a rent and utilities per diem rate, direct resident care and other expenses (i.e. food, medical supplies, laundry housekeeping, food services and household supplies), and Prepare a Financial Model. This contract was approved by the Board of Examiners on 1/15/19.

11. Develop policies and procedures to help ensure providers are fairly compensated for housing and utility costs.

See response to Recommendation #10. Until that is completed, a process for fairly compensating housing and utility costs is described in the *CBLA Rent and Utility Cost Allocation Procedure.*

12. Develop policies and procedures to assess provider compliance with state and federal labor laws.

The Division met with Labor Commissioner, Shannon Chambers on November 29, 2019 to discuss CBLA provider compliance with state and federal labor laws. On December 18th and December 19th, 2018 DPBH distributed a letter to all CBLA providers via certified mail regarding labor practices, informing them based on recent audit results, they may receive a visit from the Office of the Labor Commissioner. Attached to that letter was a fact sheet regarding Nevada Labor Laws, emphasizing that room and board will not be calculated into live-in staff pay to determine whether minimum wage laws have been violated. The Nevada Labor Commissioner interprets $7.25 per hour as the minimum wage regardless of whether room and board are included or not.

SNAMHS and NNAMHS will alert the Office of the Labor Commissioner anytime they suspect a provider may be violating a labor law. The Office of the Labor Commissioner offered to provide training for SNAMHS, NNAMHS and HCQC staff regarding labor laws and what to watch out for with providers. The Office of the Labor Commissioner can also provide training for CBLA providers. These will be scheduled for Spring 2019. DPBH is developing a policy and procedure for Service Coordinators to detail which CBLA or client specific issues require notification to HCQC. Labor law compliance issues would be an example of an issue requiring notification to HCQC.

The legislative commission requested additional solutions for ensuring that this model of community support is better able to meet the needs of individuals. Particularly the concern

that caregivers providing supportive services were not licensed professionals with sufficient training to provide the support needed. We have implemented a pilot program that utilizes Occupational Therapists to provide supportive services within their scope of practice. The pilot began in Southern Nevada, but is currently in the process of being implemented in Northern Nevada. The pilot focuses on using licensed professionals to provide the supportive and habilitative services that had historically been provided by the CBLA providers as part of the home-based supports. Instead, licensed therapists will provide those supports and the CBLA providers services and compensation will be focused on more traditional caregiving and residential supports. We believe that the outcomes from the pilot have already had a positive response within the system and will provide a higher level of service for individuals supported in the CBLA model.

Please contact me at jukotchevar@dhhs.nv.gov or 775-684-5959 if you have any questions, concerns or would like additional information.

Sincerely,

Dr. Julie Kotchevar, Administrator
Division of Public and Behavioral Health, Department of Health and Human Services

Attachments: *Internal Control Procedures in Processing CBLA Provider Billings and applicable forms*
Annual CBLA Financial Audit Questionnaire
CBLA Rent and Utility Cost Allocation Procedure and applicable forms attachments
Adopted Regulations: R134-18P

cc: Rocky Cooper, CPA, Legislative Auditor, Legislative Counsel Bureau
Richard Whitley, MS, Director, Department of Health and Human Services
Margot Chappel, MS, DPBH Deputy Administrator, Regulatory and Planning Services
Debi Reynolds, DPBH Deputy Administrator, Administrative Services

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SCOPE: **DIVISION WIDE**

SUBJECT: **Internal Control Procedures in Processing CBLA Provider Billings** **NUMBER: CBLA-29**

EFFECTIVE DATE: 11/2018 **NEXT REVIEW DATE:** 11/2020

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SUPERSEDES: New

I. PURPOSE: The purpose of this procedure is to provide the internal controls and guidelines in processing CBLA provider billings.

II. DEFINITION:

A. COMMUNITY-BASED LIVING ARRANGEMENT (CBLA) – These are flexible, individualized services provided in the home environment to persons with mental illness. CBLA services are designed to promote clients living in the community with support from a Case Manager and a staffing provider to work with clients to develop needed skills to maximize independence.

B. MENTAL ILLNESS – A clinically significant disorder of thought, mood, perception, orientation, memory or behavior which seriously limits the capacity of a person to function in the primary aspects of daily living, including, without limitation, personal relations, living arrangements, employment and recreation. The term does not include other mental disorders that result in diminished capacity, including, without limitation, epilepsy, intellectual disability, dementia, delirium,

brief periods of intoxication caused by alcohol or drugs or dependence upon or addiction to alcohol or drugs.

C. **DPBH CBLA PROVIDER** – A state-contracted certified provider approved by SNAMHS, NNAMHS, and OTHER DPBH AGENCIES to provide CBLA services such as housing lease, supervision hours, direct services, case management and overnight hours as specified in the client's residential support agreement or RSA.

D. **CASE MANAGER OR SERVICE COORDINATOR (SC)** – Any discipline acting on behalf of DPBH to assess the client's clinical or targeted case management needs.

E. **DPBH RESIDENTIAL SUPPORT AGREEMENT (RSA)** – An agreement entered between a DPBH provider and DPBH clients.

F. **DPBH AGENCY** – This may refer to **SNAMHS, NNAMHS,** and other agencies under the Division of Public and Behavioral Health (DPBH).

G. **INDIVIDUALIZED PLAN** – A plan prescribing the services that will be provided to a person with mental illness, the frequency with which the services will be provided and the manner with which those services will be provided.

H. **DIRECT SERVICES (DS)** – These are services that require **ONE-ON-ONE** training with the client and as such **CANNOT OVERLAP** with other client's service hours. These involve the DIRECT TEACHING OR PROVISION OF TRAINING of new skills, behavior, and/or competencies such as:

- Money Management Training
- Medication Management Training
- Housekeeping Training
- Personal Hygiene and Grooming Training
- Personal Fitness Training
- Symptom Management Training
- Leisure Time Training
- Symptom Management Training
- Diet and Nutrition Training
- Independent Living Skills Training
- Community Orientation and any other skill required by the client to function independently in the community

Direct services **do not** include treatment services such as counseling, group therapy or vocational training.

I. **CASE MANAGEMENT (CM)** – This involves planning, coordinating and advocating services for the clients as well as referring them to other needed services under the direction of Service Coordinator including but not limited to:

- Making referrals to other Human Service agencies, under the direction of SC
- Assisting clients in applying for and obtaining community resources
- Assisting clients to locate and make arrangement for finding housing
- Scheduling, transporting and/or attending mental health court mandated/client-related/informational meetings

J. SUPERVISION (SP) – These are services which involve monitoring and supervision of client's daily living and/or community living skills such as:

- Coping and problem-solving
- Money Management
- Medication Management
- Personal Hygiene and Grooming
- Leisure Time
- Socialization
- Communication

K. SUPPORT HOURS (SH) – These are services which involve monitoring, prompting, support and discussion involved with client's needs such as:

- Medication Management
- Daily Living
- Meal Preparation
- Safety and Security
- Social and Communication
- Support System
- Symptom Management
- Transportation

L. OVERNIGHT HOURS (OH) – This involves monitoring and supervision of clients during overnight hours, e.g. 10:00 p.m. to 6:00 a.m.

III. INTERNAL CONTROL PROCEDURES:

A. GENERAL BILLING INSTRUCTIONS – See Attachment A.

1. The DPBH CBLA provider will submit **MONTHLY BILLS OR INVOICES FOR ALL ITS CLIENTS** by the **10th of each month** to the Business Office based on the client's Residential Support Agreement (RSA) specifying the rent amount, food, personal needs and the number of service hours provided.

2. The FRONT OFFICE Accounting staff will stamp and initial the cover sheet of the provider bills or invoices received. Cover sheet will be checked and reviewed based on the Billing Cover sheet instructions provided on Attachment A. This includes checking the signature and the date of services.

3. The designated Business Office/Accounting Assistant will verify **BACKUP DOCUMENTATION** including the total number of service hours submitted by the DPBH CBLA provider for payment.

4. After verification, the designated Business Office/Accounting staff will send the submitted monthly bills or invoices together with the supporting documentation to the client's Service Coordinator for review and approval.

5. The Service Coordinator (SC) will **APPROVE** service hours by the **24th of each month or the following business day** should the 24th fall on a weekend claimed for payment **ONLY IF THE SERVICE HOURS LOG REQUIREMENTS** are met.

B. SERVICE HOURS LOG REQUIREMENTS

1. The type of service hours provided are identified in the logs:

    a. Case Management (CM)
    b. Direct Services (DS)
    c. Support Hours (SH)
    d. Overnight Hours (OH)
    e. Supervision (SP)

        i. **SP (I):** This stands for **INDIVIDUAL Supervision** or instruction intended for **ONLY ONE client.**
        ii. **SP (G):** This stands for instruction given to a **GROUP of clients** in the same location or CBLA address. This may include administering medication or group supervision. If **administering medication to a group, 15-30 minutes per client** will be **ALLOWED** per session.

2. The START and END Time for each service are provided and are in **15-minute increments. In cases where the minutes are not provided in 15-minute increments**, the following guideline will apply:

    a. If **greater** than **7 ½ minutes**, minutes will be **rounded up**
    b. If **less than 7 ½ minutes,** minutes will be **rounded down**

c. No more than **four 15 minute increments** may be submitted **for any one hour time frame**

3. CBLA provider service hours billed DO NOT EXCEED RSA amounts. DPBH Agency may only pay within the MAXIMUM ALLOWABLE amount stipulated in the RSA.

4. The service hours claimed are not for a range of days, e.g. 11/1/18-11/5/18.

5. CBLA provider service hours logs **ARE NOT TEMPLATES/EXACT COPY, PHOTOCOPY OR REPRODUCTION** of client's previous monthly billings. **Original signature** of the provider, the client and the caregiver/staff who provided the service will be **REQUIRED**.

6. If Service Coordinator approves TEMPLATES or PHOTOCOPIES, he/she will provide a **LETTER OF EXPLANATION** on why the service hours are approved for payment.

7. CBLA provider service hours logs **ARE NOT COPY AND PASTE** of other clients' service hours.

8. Supervision service hours for a group SP-G of clients will **ONLY BE ALLOWED** if supervision requires group instruction.

9. CBLA provider service hours logs are **INDIVIDUALIZED PER CLIENT** based on Individual Treatment Plan and must comply with the provisions of the **CBLA Section A** Conditions of Agreement – **See Attachment B, NRS 433.494** (Individualized Plan of Services for Consumer – **See Attachment C, NAC 449.259** (Supervision and Treatment of Residents Generally) and **NAC 449.260** (Activities for Residents) – **See Attachment D**.

10. **Individual Treatment Plan** or programs may include but **ARE NOT LIMITED TO** symptom management, medication management and money management.

11. Original service hours logs are submitted to the Business Office after the SC has **REVIEWED AND APPROVED THE SERVICE HOURS LOGS** based on the log requirements stated above.

12. The designated Business Office/Accounting staff will PROCESS PAYMENT OF SC APPROVED SERVICE HOURS **ONLY IF THE FOLLOWING CONDITIONS ARE MET:**

a. CBLA provider service hours logs **ARE NOT OVERLAPPING WITH THE SERVICE HOURS OF OTHER CLIENTS** if

rendered by the same caregiver EXCEPT when the type of service is **SP(G).**

b. CBLA Direct Services (DS), Case Management (CM), Overnight Hours (OH) and Support Hours (SH) **CANNOT OVERLAP WITH OTHER CLIENTS' SERVICE HOURS** even if the clients live in the same CBLA home/address.

c. CBLA provider service hours logs are **PROPERLY SIGNED** by both provider and client. If client refused to sign or is unable to sign, SC will sign on behalf of the client and provide a **LETTER OF EXPLANATION** on why client cannot sign and for how long.

13. If any of the above conditions are not met, the Business Office Accounts Payable staff reserves the right to **DEDUCT or DENY PAYMENT** of provider service hours that **ARE NOT APPROVED OR ARE BILLED INCORRECTLY.**

14. A copy of the **REJECTED BILL OR INVOICES FOR SERVICE HOURS** will be sent back to the Service Coordinator and the CBLA provider. The designated Business Office/Accounting staff will specify the reason for the deduction or denial of payment.

15. **APPROVED BILLS OR INVOICES** for payment will be processed following the regular **PEND 3 and PEND 4 approvals**.

If there is any suspected fraudulent billing activity, the issue will be reported to the appropriate Outpatient Services Manager or Agency Auditor for investigation. Any audit billing case or allegation if found conclusive will necessitate corrective action including but is not limited to return of payment or overpayment to the DPBH Agency.

IV. REFERENCES:

NAC Chapter 449
NAC and NRS Chapter 433
Provider Contract (RSA) Section A. Conditions of Agreement

V. ATTACHMENTS:

A. Billing Instructions
B. CBLA Contract Section A. Conditions of Agreement

Attachment A

BILLING INSTRUCTIONS

All *Residential Services Agreements* (RSA) must be billed monthly.

Billing cover sheet: *Supported Living Arrangement Billing Form* (copy attached)

Make sure the Billing Cover Sheet is filled in completely. All Billing Information flows into this page.

a. Client name and address should be complete.
b. Provider name, address, and Tax ID must be complete.
c. Form must have original Provider signature.
d. Contract Period is the beginning and ending dates of RSA.
e. Billing for Month/Year is Month for which Services are being billed.
f. Room & Board (Part A) should only be listed if they are in the "State" column of the RSA and should not exceed the amount listed in the State Column.
g. Total from "Room & Board" (Part A) is to be transferred to Lower right side underneath "Part B-Monthly Specialized Services", "Plus Room and Board (Part A)".
h. Service hours are to be listed and detailed according to RSA for actual hours trained. Please note whether AM, or PM, or use military time. These hours will be detailed on the "Provider's daily training and progress data" sheets and turned in with the billing.
i. Please use as many sheets as necessary to report daily training and support adequately. Also be sure client and trainer initial at time service/training is received, except in the case of overnight hours (the next day will suffice).
j. The total from the "Provider daily training" sheets will be transferred to the right side of the "Billing Cover Sheet" under "Part B- Monthly Specialized Services". Hours billed should be either the actual hours provided or the maximum hours on the RSA, whichever is less.
k. "Total Monthly Services (Part B)" should total all services and be recorded above, on the "Billing cover Sheet".
l. "Less Client Share" will only be used if the client has enough income to pay a portion of their own services. This will be indicated on the RSA under "Room & Board" where the Individual and "Total Specialized (SP) Services" columns meet. This will reduce the amount due the Provider, from the State.
m. To arrive at the "Total Due Provider", simply add the "Total Monthly Service (Part B)", to the "Room and Board (Part A)", and subtract "Less Client Share".
n. Fill in the "Total Due Provider (Part A + Part B)".

Client Ledger Sheet: *Supported Living Arrangement Service Client Ledger*

Assists Provider and Service Coordination in tracking the income and expenses of the client for the month. This is a helpful tool but not required. You are also welcome to use your own form to track these items. It shows the actual dates and amounts of disbursements and at times can be used for consumers to initial for personal monies received.

a. Client Name and Billing month must be completed.
b. Client Income (if applicable) and clients' monthly expenses should be posted under "Allowance Per Contract".
c. "Client Share" should be posted to ledger from the RSA if the client has income.
d. "State Share Available" should be entered from "State Column" on RSA.
e. Fill in the amounts that you can "Bill to State". This can never exceed RSA amount in "State" column, or the amounts you posted to "State Share Available". These should transfer to "Part A-Room and Board" of Billing Cover Sheet.
f. Excess client funds not expended may be retained in clients' account for future over/shorts in food, personal, and medical expenditures if applicable. Excess funds should be minimal and should be carried forward to the next month for disbursement or a credit will be taken if not being carried forward.

Direct Service Hours Log(s): *Provider's Daily Training and Progress Data* sheets

All training is to be logged on these sheets. Use as many sheets as necessary to record all dates and times that training is completed. Use a separate sheet for each type of service.

a. Client name, Month/Year and Goal/Type of Training.
b. List type of Service/Training being provided, (amount of time/type of service comes from State RSA).
c. **When training is completed, log should be filled out with date and times initialed by the client and the trainer providing the service. This needs to be done at that time, not at the end of the month. "At time service was provided"** If client refuses to initial, a letter must be included in the monthly billing packet saying this and must be signed off on by the service coordinator agreeing with this. This must be done each month that this happens. **White out cannot be used, if there is an error please cross out with a single line, make changes and initial.**
d. Enter a brief note regarding training/service session next to each occurrence.
e. Total each log and transfer these totals to "Part B-Monthly Specialized Services" on the "Billing Cover Sheet".
f. DPBH Business Office will refuse payment for any duplicate services/hours found in any Direct, Support or Overnight hours, for any clients. This is true for different clients in the same provider home. Resubmission of training, support or overnight hours will not be allowed in this instance.

Support Hours Log(s): *Provider's Daily Training and Progress Data* sheets

All Services paid by State must be logged for backup. Use as many sheets as necessary to record all date and times that training is completed. Use a separate sheet for each type of service

a. Client name, Month/Year and Goal/Type of Training.
b. List type of Service/Training being provided, (amount of time/type of service comes from the "Training Hours per Week" part of the State RSA).
c. **When training is completed, log should be filled out with date and times initialed by the client and the staff/ trainer providing the service. This needs to be done at that time, not at the end of the month. "At time service was provided" Also be sure to note whether AM or PM, or use military time.** If client refuses to initial, a letter must be included in the monthly billing packet saying this and must be signed off on by the service coordinator agreeing with this. This must be done each month that this happens.
d. Enter a brief note regarding training/service session next to each occurrence.
e. Total each log and transfer these totals to "Part B-Monthly Specialized Services" on the "Billing Cover Sheet".
f. DPBH Business Office will refuse payment for any duplicate services/hours found in any Direct, Support or Overnight hours, for any clients. This is true for different clients in the same provider home. Resubmission of training, support or overnight hours will not be allowed in this instance. **White out cannot be used, if there is an error please cross out with a single line, make changes and both client and trainer providing services must initial.**

Overnight Hours Log(s): *Provider's Daily Training and Progress Data* sheets

All Services paid by State must be logged for backup. Use as many sheets as necessary to record all date and times that training is completed. Use a separate sheet for each type of service

a. Client name, Month/Year and Goal/Type of Training.
b. List type of Service/Training being provided, (amount of time/type of service comes from the "Training Hours per Week" part of the State RSA).
c. **When training is completed, log should be filled out with date and times initialed by the client and the staff/trainer providing the service. Also be sure to note whether AM or PM, or use military time.** This can be done the next day as client is sleeping at time of service, not at the end of the month. If client refuses to initial, a letter must be included in the monthly billing packet saying this and must be signed off on by the service coordinator agreeing with this. This must be done each month that this happens.
d. Enter a note regarding any activity during the night. **White out cannot be used, if there is an error please cross out with a single line, make changes and both client and trainer providing services must initial.**

e. Total each log and transfer these totals to "Part B-Monthly Specialized Services" on the "Billing Cover Sheet".
f. DPBH Business Office will refuse payment for any duplicate services/hours found in any Direct, Support or Overnight hours, for any clients. This is true for different clients in the same provider home. Resubmission of training, support or overnight hours will not be allowed in this instance.

ATTACHMENT B

Conditions of Agreement

Board and Care

The Agency Agrees:

1. To make payments to the Provider as a supplement to the client's/resident's revenue sources for payment for services and treatment as defined in NAC 449. Agency will pay up to 14 days board and care prorated on a 30-day month, to hold the placement while the client is an inpatient with the State. The request to hold the placement must be approved, in advance, in writing, by authorized Agency personnel and submitted to the Agency's accounting office with the monthly billing.
2. To provide a current referral regarding the client's/resident's disability and treatment information to the Provider.

The Provider Agrees:

1. To comply with and meet conditions of Chapter 449, Residential Facilities for Groups adopted by the State Board of Health, Nevada State Division of Public and Behavioral Health (DPBH) and the Bureau of Licensing and Certification.
2. To comply with all provisions of NRS, Chapters 433 and 433A.
3. To ensure the receipt of written referral and current treatment information is sufficient to comply with NAC 449.2704 and to cooperate with procedures identified in the treatment plan created by the Case Manager for the client/resident prior to admitting/accepting a client/resident. Each referral shall receive prior approval from the Agency on the **Agency Supplemental Living Agreement (ASLA)** form at a level of pay consistent with the deficit between the full cost for services and treatment and the client's/resident's other fiscal resources. The Provider shall provide written justification, within 72 hours, to the Agency for rejecting/refusing to admit any individual referred by the Agency. The Provider shall provide proof of acceptance within 48 hours of receiving written referral.
4. To implement and/or provide treatment and services as identified by an Agency Case Manager and to document and report the provision of these identified treatments and services. To ensure the receipt of current services and treatment information prior to the renewal date identified in the client's/resident's individualized care plan.
5. To collect from any other revenue resources that the client/resident may have, and to bill the Agency for the approved deficit identified in the ASLA. The Provider shall bill monthly, by the 5th day of the following month, for the preceding month, using a billing format approved by the Agency.
6. To comply with NAC 449.199 and provide 24 hours supervision, transportation for shopping and all medical appointments, attend medication clinic, and notifying the Agency of missed appointments.
7. To orient and to maintain written record of such orientation for the client/resident to the residential facility including, but not limited to fire/safety procedures, facility rules and client/resident rights. This information shall be clearly posted in the residential facility. Content shall be reviewed at least quarterly with each client/resident.
8. To comply with NAC 449.259 and NAC 449.260 by providing a schedule of activities for each client/resident including opportunity for leisure time utilization, activities of daily living, personal room/storage organization/upkeep. Each client resident shall be encouraged to follow through and actively participate. This shall be included in documentation that is readily available to the Case Manager.
9. To notify the Case Manager or, after regular business hours, the Administrator on call within one hour of any incident as defined by NAC 449.0046, or as defined by the Agency and/or the Division of Public and Behavioral Health.
10. To comply with NAC 449.2708 by giving the Case Manager 72 hours verbal and written notice of intent to evict a client from the residence.
11. To participate in a minimum of 8 hours of scheduled training regarding serving individuals with mental illness and shall ensure that all employees of the facility participate in a minimum required training orientation to serve this population. In compliance with NAC 449.231, the Administrator shall submit proof of current CPR and First Aid for self and staff to the Agency as requested. The Administrator shall submit training records, including orientation for all staff working at the facility.

Community Based Living Arrangement (CBLA)

The Client Agrees to:

1. Do my part of the care plan that I develop with my team. This means using the support and teaching. If I am unhappy, I will contact my Case Manager and use the agency grievance process. If I am still unhappy, I can also call the **Nevada Disability Advocacy and Law Center at 1-800-992-5715** and ask them to help me.
2. Let agency staff such as my Case Manager visit my home. Their visits will check on my health and safety, see that I am getting the services I should from my care plan, and see if I am satisfied with the support services.
3. If my income changes, I move or change housemates, I will notify my Service Coordinator.
4. I agree that if I receive any retroactive benefits from Social Security, or increases in any resources, my serving State agency will use these amounts to offset current and previous SLA room and board expenses. I also understand that my income will be exhausted before the state will provide funding assistance.
5. I will abide by all State and Division of Public and Behavior Health policies.

The State Agency Agrees to:

1. Provide a Case Manager for the individual or insure the service is provided in the community.
2. Work with the Provider, person served and natural supports to develop a care plan and give a copy of that care plan to the person and the Provider.
3. Allow the individual to obtain a percentage of work earnings.
4. If new rates are approved by the legislature, Division, or Medicaid, that would affect this agreement, the approved rates will be paid under a new contract.

The Provider Agrees to:

1. Provide trained support staff to provide supports as specified in the individual Care Plan. Support staff will follow the Division of Public and Behavioral Health (DPBH) rules concerning denials of rights and the reporting of abuse and/or neglect. This includes reporting to the Division and the State Agency.
2. Provide notification to the State Agency of any use of restrictive interventions used with individuals and comply with the rules and regulations regarding restrictive interventions as stipulated in state law and DPBH policy.
3. Provide to the State Agency a report of any instance of fraud or abuse within 24 hours.
4. Provide to the State Agency a quarterly written summary of the person's response to supports as specified in the Care Plan. Submit a monthly statement of supports provided for compensation under this Agreement including documentation of expenditures as required by the Agency.
5. Take all steps necessary to maintain eligibility for third party benefits if contracted for Case Management hours. Failure to do this will result in the State Agency deducting the amount of the person's loss of benefits from the State Agency's reimbursement to the Provider.
6. Prepare a monthly accounting of the individual's funds and have it available for the person and/or Agency Service Coordinator's inspection. This monthly accounting shall include beginning balances, receipts, disbursements and ending balances.
7. Provide receipts for any and all one-time expenditures.
8. Provider will maintain the health information of the person served. Provide trained staff that is knowledgeable of state and federal law and Division Policies and Procedures regarding maintaining the privacy of protected health information and that will maintain the individual health information as required.
9. Refrain from unlawful discrimination on the basis of race, color, national origin, creed, political or religious affiliation, sex, age, gender or disability in carrying out the performance of the services named in this Agreement.
10. Provider agrees to meet Division requirements and to participate fully and actively in Division required performance improvement and accreditation activities. This includes reporting fiscal and non-fiscal programs and individual information and data, compliance with corrective action plans issued as part of DPBH authorized performance improvement activities and any related programs.
11. Indemnify and save and hold the Division, its agents and employees, harmless from any and all claims, causes of action or liability arising from the performance of this Agreement by the Provider or Provider's employees or agents.
12. Provider agrees to provide support hours as indicated by clinical need determined and approved by Agency staff.

All Parties Agree to:

1. The supervision of this Agreement is the responsibility of the Agency Director or his/her designee. This Agreement will be reviewed as needed but at least annually.
2. The use and/or disclosure of any part of any information concerning the individual for any purpose not directly connected with the administration of the responsibilities of the Division, State Agency or the Provider with respect to purchased services hereunder is prohibited except on written consent of the individual, his attorney or his legal representative.
3. This Agreement may be terminated for any reason upon prior written notice by any party to the others. In the event of termination for any reason, the Provider agrees any, and all data, information, recommendations, materials and reports collected or prepared by them, pertaining to the services provided pursuant to this Agreement will be turned over to the State Agency. In the event of termination, the Provider will be paid only for actual services rendered from the time of notification until the person is moved.
4. This Agreement may be terminated at any time for cause, which may include abuse, neglect or exploitation by the Provider of any Division or state agency individual. At the discretion of the State Agency, in lieu of termination, payment may be suspended until an investigation of the allegations is conducted. At the completion of the investigation, if no abuse, neglect or exploitation is substantiated, the Provider will be compensated for services rendered up to the time of the report of abuse, neglect or exploitation.
5. Neither the State Agency nor the Division is liable for any debts or Agreement obligations incurred by the Provider in securing or maintaining residences to serve as individualized Community Based Supported Living Arrangements (CBLA) pursuant to the terms of this Agreement.
6. The Provider and its employees and agents are not employees of the agency or the Division and are not in either the classified or the unclassified service of the State of Nevada. They have none of the rights or privileges of officers or employees of the State, and the State deducts no taxes, insurance or other coverage for them from the payments it makes to the Provider. The Provider will carry Worker's Compensation insurance on all persons employed by the Provider who provide services to individuals; on all persons providing special services and will furnish the State Agency with a certificate of compliance as required by State Administrative Manual (SAM) 03209 and NRS 616A to 616D inclusive.
7. This Agreement and its integrated attachment(s) constitute the entire Agreement of the parties and as such are intended as a complete and exclusive statement of the promises, representations, negotiations, discussions, and other Agreements that may have been made in connection with the subject matter hereof. Unless an integrated attachment to this Agreement specifically displays a mutual intent to amend a particular part of this Agreement, general conflicts in language between any such attachment and this Agreement shall be construed consistent with the terms of this Agreement. Unless otherwise expressly authorized by the terms of this Agreement, no modification or amendment to this Agreement shall be binding upon the parties unless the same is in writing and signed by the respective parties hereto.
8. Providers who serve Medicaid recipients agree to comply with all Medicaid requirements.
9. The Agreement has been approved by the Office of the Attorney General and a sample copy is on file with the Research and Fiscal Analysis Division of the Legislative Counsel Bureau and the Clerk of the State Board of Examiners.
10. Providers agree to comply with any Division or Agency Policies and the Mental Health Supported Living Services Standards of Service Provision.
11. Providers agree to comply with any division or agency scheduled or unscheduled visits by the assigned Service Coordinator or quality assurance reviews specific to the Supported Living Standards of Service Provision.
12. Providers agree to adhere to all aspects of NRS 433 and NAC 433.

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SCOPE: **RESIDENTIAL SERVICES AND BUSINESS OFFICE**

SUBJECT: **CBLA Rent and Utility Cost Allocation Procedure** **NUMBER: CBLA- 28**

EFFECTIVE DATE: 1/29/2019 **NEXT REVIEW DATE:** 1/29/2020

PREPARED BY: /s/ Mamdoe Dyamwalle MPH, Clinical Program Planner
Maria Bevers MBA, Auditor II & Brian Sotomayor ASOIII

APPROVED BY:
/s/ Ellen Richardson-Adams, Outpatient Administration & Christina Brooks Director

SUPERSEDES: New

I. PURPOSE: The purpose of this procedure is to provide guidelines for rent and utility cost allocation for Community Based Living Arrangement (CBLA) clients.

II. DEFINITION:

A. **COMMUNITY BASED LIVING ARRANGEMENT (CBLA)** - These are flexible, individualized services provided in the home to persons with mental illness or related conditions. CBLA services are designed to have clients live in the community with support from a Service Coordinator and/or provider to work with clients to develop needed skills to maximize independence.

B. **CBLA PROVIDER** – A state-contracted certified provider approved by SNAMHS, NNAMHS or OTHER DPBH programs to provide CBLA services.

C. **SERVICE COORDINATOR OR CLINICIAN** – Any Employee or Contractor acting on behalf of DPBH to assess the client's clinical or targeted case management needs.

D. **HCQC** – The Bureau of Health Care Quality and Compliance

III. GUIDELINES AND PROCEDURES:

A. The providers will comply with the conditions of agreement as defined in NAC 449 and the provisions of NRS Chapters 433, 433A and 435.3315. These regulations are established for oversight of Community Based Living Arrangement (CBLA) facilities.

B. CBLA services are designed to support long-term recovery of clients from mental illness. Persons may be dual diagnosed or co-occurring.

C. Rent and Utility Cost

1. Method 1. CBLA providers will have flat rent rates based on the number of bedrooms as determined by the County Assessor in the County in which the CBLA Home resides. This is divided by the number of bedrooms or the bed capacity as determined by HCQC, whichever is greater.
2. Method 2. The provider may use the actual mortgage/rental payment for their home split by the number of people residing in the home (family members and / or live-in staff must pay their share of the Mortgage or rent). Documentation of the mortgage/rent payment is required to use this method. Example: The provider's mortgage payment is $1500 per month and four people reside in the home. The provider will receive $375 (1500/4) per person for rent.
3. Method 3. The rental charge for one person as calculated in accordance with the HUD Fair Market Rent.

   Example: Fair Market Rent = 1800 for a 4 bedroom (1800/4) is 450 per person for rent.

Utilities covered include gas, electricity, oil, propane, sewer and trash, if using method 1, the utilities are included in the rent charge, under method 2 and 3 the utilities are charged separately.

Non-utility costs such as phone, cable or internet are not covered.

D. All clients will have leases reflecting the above rent rates. This will apply to all clients living in state-contracted CBLA homes.

E. CBLA BEDROOM REQUIREMENTS

1. The number of bedrooms is determined through the County Assessor's office public website.

2. Occupancy is determined by HCQC and/or local ordinance. In cases where HCQC does not delineate an occupancy, occupancy will default to the County Assessor's number of bedrooms with the assumption of one person per bedroom.

3. HUD funded placements must adhere to the CFRs and grant obligations. The rental charge for one person as calculated in accordance with the HUD Fair Market Rent.
   Example: Fair Market Rent = 1800 for a 4 bedroom (1800/4) is 450 per person for rent.

F. The State of Nevada may subsidize the client's rent; therefore, can impose limits on the amount of rent to be paid to the provider.

G. Occupancy of all available rooms is not guaranteed to any residential provider.

H. Residential providers will be allowed to receive the actual cost of utilities per individual. The contracted amount is largest amount that can be paid.

IV. PRO-RATED RENT AND UTILITIES

A. A pro-rated rent will be granted when rent is less than 30 days. In this case, a One- Time Cost Request may be completed electronically by the Service Coordinator. When the client is transferred from one CBLA facility to another or entered a CBLA facility after the first of the month. As the rent indicated on the Residential Service Agreement form (RSA) is intended as a maximum allowable monthly rent a separate agreement is not needed in the case of Pro-rated rent.

V. CLOSURE AND EVICTION OF CBLA CLIENTS

1. When the CBLA provider intends to cease operation, the provider shall provide at least a 30-day written notice to that effect to each client, all Service Coordinators and Residential Services. The notice must contain the projected closing date.

2. When a CBLA provider does not meet the required standards for HCQC and/or Quality Assurance (QA) environmental reviews, have significant negative audit findings and citation, or the facility posed imminent danger and risk to client's safety and well-being, client will be removed from the home immediately to ensure safety.

3. At the time of the written notice of eviction of the client by the provider, the provider will provide at least a 30-day notice to Service Coordinator, client and Residential Services unless otherwise agreed upon. See Attachment B.

4. If the Service Coordinator intends to terminate services with the CBLA provider, then the Service Coordinator needs to submit a written 30-day notice to the provider.

5. In case of safety or wellness risk, client will be moved immediately or given a 72-hour notice. See Attachment C.

6. If a client leaves the CBLA home due to decompensation and is not able to return to his/her level of care, the rent will be paid for 30 days unless the room is rented before the 30-day period. The personal items of the client must be returned to the Service Coordinator.

7. All 30-day notices given to CBLA clients regardless of reason will be in writing.

VI. REFERENCES:

LCB File No. R134-18
CBLA Internal Procedures in Processing CBLA Provider Billings

VII. ATTACHMENTS:

A. Client Discharge or Transfer Form
B. 30-day Notice Form
C. 72-Hour Notice Form

Community Services Closure Form

Attachment A

The **Program Exit Date** below will be used as the program closure date for episodes marked below.

Client's Name:	
Avatar #	
Social Security #	
Birth Date:	

Program Exit Date:	
Agreement Type:	Choose an item.
Avatar Discharge Type:	Choose an item.
Service Coordinator:	

Avatar Episode Closure (mark all programs that apply)

- ☐ Residential Wait List
- ☐ Group Housing Adult
- ☐ HUD Supported Housing Adult
- ☐ ISLA Adult
- ☐ Long Term Care Housing Adult
- ☒ SLA Adult
- ☐ Special Needs Group Housing Adult
- ☐ Transitional Housing Adult

- ☐ AOT Adult
- ☐ AOT Eligible List
- ☐ AOT Referrals
- ☐ Community Services Adult
- ☐ Detention Center Adult
- ☐ Intensive Service Coordination Adult
- ☐ Intensive Service Coordination Wait List
- ☐ Mental Health Court Adult
- ☐ Mental Health Court Wait List
- ☐ PACT Adult
- ☐ PACT Wait List
- ☒ Service Coordination Adult
- ☐ Service Coordination Wait List

Additional Discharge Notes for Avatar:

Yes	N/A	**Team Lead Closure Checklist**
☐	☐	Discharge progress note posted
☐	☐	HMIS Exit Assessment completed & attached
☐	☐	Client Trust Fund (CTF) closure form completed & attached
☐	☐	SSA Payee Closure Notice
☐	☐	Payee funds returned to SSA

Signature of Service Coordinator Date

Accepted by Residential Services Date

HMIS Exit Assessment Form — Attachment A

Leave no blanks. Put "N/A" or cross out items that don't apply.

Assessment Date:	
Service Coordinator:	
Client's Name:	
Avatar #	
Social Security #	
Birth Date:	
Sex:	☐ Female ☐ Male

Race (mark all that apply):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Ethnicity:
- ☐ And also Hispanic or Latino, in addition to race.

Veteran Discharge Status:
- ☐ Never served in the U.S. Military
- ☐ Honorable
- ☐ General under honorable conditions
- ☐ Under other than honorable conditions (OTH)
- ☐ Bad conduct
- ☐ Uncharacterized

Year Entered Military Service:	
Year Separated from Military Service:	

Branch of the Military:	**Theatre(s) of Operations:**
☐ Air Force	☐ World War II
☐ Army	☐ Korean War
☐ Coast Guard	☐ Vietnam War
☐ Marines	☐ Persian Gulf War
☐ Navy	☐ Afghanistan
	☐ Iraq (Iraqi Freedom)
	☐ Iraq (New Dawn)
	☐ Other

Housing Status at Program Exit:	Choose an item.
Destination Residence Type at Program Exit:	Choose an item.

Client's Address:	
Client's City, ST, ZIP:	

Yes No **Condition/services received prior to program exit:**

- ☐ ☐ **Disabling Condition** (physical, mental, or emotional impairment)
- ☐ ☐ **Physical Disability** (unable to climb stairs, amputation, etc.)
- ☐ ☐ Documentation of the disability and severity on file
- ☐ ☐ Substantial long-term impairment expected
- ☐ ☐ Currently receiving treatment or services for this
- ☐ ☐ **Developmental Disability** (mental retardation, autism, etc.)
- ☐ ☐ Documentation of the disability and severity on file
- ☐ ☐ Substantially impairs ability to live independently
- ☐ ☐ Currently receiving treatment or services for this
- ☐ ☐ **Chronic Health Condition** (diabetes, heart disease, etc.)
- ☐ ☐ Documentation of the condition and severity on file
- ☐ ☐ Substantial long-term impairment expected
- ☐ ☐ Currently receiving treatment or services for this
- ☐ ☐ **HIV-AIDS**
- ☐ ☐ Documentation of the condition and severity on file
- ☐ ☐ Substantially impairs ability to live independently
- ☐ ☐ Currently receiving treatment or services for this
- ☐ ☐ **Mental Health Problem**
- ☐ ☐ Documentation of the condition and severity on file
- ☐ ☐ Substantial long-term impairment expected
- ☐ ☐ Currently receiving treatment or services for this

Substance Use Problem

☐None ☐Alcohol ☐Drugs ☐Both

- ☐ ☐ Documentation of the condition and severity on file
- ☐ ☐ Substantial long-term impairment expected
- ☐ ☐ Currently receiving treatment or services for this
- ☐ ☐ **Domestic Violence Victim/Survivor**

Last Occurrence: ☐Within the last 3 months
☐3 to 6 months ago
☐6 to 12 months ago
☐More than one year ago

- ☐ ☐ **Currently Enrolled in School**

☐Enrolled in Vocational Training or Apprenticeship

Name of School:	
Highest Grade Completed:	Choose an item.

$	Monthly Earned income (i.e. paycheck)
$	RSDI (SSDI): Retirement, Survivors, & Disability Insurance
$	SSI: Supplemental Security Income
$	SNAP (Food Stamps)
$	Other:

- ☐ Medicaid Insurance
- ☐ Medicare Insurance
- ☐ VA Medical Insurance
- ☐ HUD Section 8
- ☐ Temporary Rental Assistance

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
Notification of Termination Form/Client Trust Fund Closure Form

Date:	
From:	Personal Service Coordination
To:	Business Office
Client:	

This form serves as notice to inform that the above client has terminated treatment for the following reasons:

☐ The client has had no contact with treatment coordinators for more than 90 days. SNAMHS policy requires closure of the client's account.

☐ The client has moved to another state.

☐ The client has died.

☐ The client has transferred services to Mojave Mental Health services.

☐ The client has transferred services to another qualified mental health facility (list name, address and phone number):

_____

_____

_____

☐ The client has no clinically assessed needs to use SNAMHS as payee. This signifies that client is legally competent and does not need any representative payee.

☐ Other (explain):

_____

_____

Personal Service Coordinator: _____

Signature of Personal Service Coordinator: _____

The accounting department acknowledges receipt of this notification. In accordance with policy # _____, the department also confirms that required actions have been taken to properly transfer funds to a receiving treatment facility or to close the trust fund account by returning balances to the client. Telephone contact and confirmation of the transfer has been made with the appropriate treatment facility. A copy of this signed form has been sent to the facility where the client has transferred.

Accounting Department Signature: _____

Printed Name and Title: _____

Date: _____

State of Nevada
Division of Public and Behavioral Health
Southern Nevada Adult Mental Health Services Residential Services Department

30 DAY NOTICE TO VACATE FORM

Please complete the form out completely. This form must be sent to the client's service coordinator first, and a copy must be sent to the Residential Services Department.

TO: _____
(Client Name)

_____
(Address)

_____
(City, State, Zip Code)

This letter serves as a 30-day eviction notice to vacate the premises located at _____ Las Vegas, Nevada, _____, a Community Based Living Arrangement (CBLA) home, apartment or Group Home.

The reason for this eviction notice is:

1. _____
2. _____
3. _____

Has there been any prior meeting or discussion regarding any of the reasons listed above? ☐ YES ☐ NO
If yes, please explain:

_____

_____

_____

Provider Name: _____

Contact Person: _____ Phone Number: _____

Address: _____

Service Coordinator Name: _____

Team Lead Name: _____

_____ _____
Signature of Person completing this form Date

_____
Printed Name

State of Nevada
Division of Public and Behavioral Health
Southern Nevada Adult Mental Health Services Residential Services Department

72 HOUR NOTICE TO VACATE FORM

Please complete the form completely. This form must be sent to the client's service coordinator first, and a copy must be sent to the Residential Services Department.

TO: _____
(Client Name)

_____
(Address)

_____
(City, State, Zip Code)

This letter serves as a 72-hour eviction notice to vacate the premises located at _____ Las Vegas, Nevada, _____, a Community Based Living Arrangement (CBLA) home, apartment or Group Home.

The reason for this eviction notice is:

1. _____
2. _____
3. _____

Has there been any prior meeting or discussion regarding any of the reasons listed above? ☐ YES ☐ NO
If yes, please explain:

_____

_____

_____

Provider Name: _____

Contact Person: _____ Phone Number: _____

Address: _____

Service Coordinator Name: _____

Team Lead Name: _____

_____ _____
Signature of Person completing this form Date

_____
Printed Name

PROPOSED REGULATION OF THE

STATE BOARD OF HEALTH

LCB File No. R134-18

July 20, 2018

EXPLANATION – Matter in *italics* is new; matter in brackets [~~omitted material~~] is material to be omitted.

AUTHORITY: §§1-12, 18-22 and 25, NRS 433.324 and 433.609; §13, NRS 433.324, 433.607, 433.609 and 439.150; §§14 and 15, NRS 433.324, 433.607 and 433.609; §16, NRS 433.324, 433.607, 433.609 and 433.613; §17, NRS 433.324, 433.607, 433.609, 433.613 and 439.150; §§23 and 24, NRS 433.324, 433.609 and 433.613.

A REGULATION relating to community-based living arrangement services; establishing standards for the provision of such services in facilities; requiring certain persons to undergo a criminal background check; requiring certain employees or independent contractors of a provider of services to complete training concerning cardiopulmonary resuscitation and first aid; revising provisions governing required training for an applicant for the issuance of a provisional certificate; requiring an application fee for the issuance of a provisional certificate to provide community-based living arrangement services or the renewal of a certificate to provide such services; revising the required contents of an application for the issuance of a provisional certificate; requiring the Division of Public and Behavioral Health of the Department of Health and Human Services to inspect a facility before issuing a provisional certificate to the operator of the facility; requiring a provider to be in substantial compliance with certain provisions; revising provisions governing quality assurance reviews and plans of correction; requiring a provider take certain actions relating to employees and the living environments of recipients of services; clarifying that the Division is not required to be a party to certain contracts; requiring a provider to keep records regarding recipients of services in a secure location on the premises of a facility, if applicable; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the State Board of Health to adopt regulations governing community-based living arrangement services, which are defined as flexible, individualized services that are: (1) provided in the home, for compensation, to a person with a mental illness who is served by the Division of Public and Behavioral Health of the Department of Health and Human Services or any other entity; and (2) designed and coordinated to assist the person in maximizing the person's independence. (NRS 433.605, 433.609)

Section 2 of this regulation defines the term "facility" to mean a home operated by a provider in which services are provided. **Sections 6-11** of this regulation establish standards of operation for facilities. **Section 6**: (1) requires a facility to be owned or leased by its operator; (2) prohibits a facility from having more than 6 residents; and (3) requires the operator of a facility to maintain compliance with all applicable building codes, zoning requirements and business licensing requirements. **Section 7** establishes requirements concerning bedrooms at a facility. **Section 8** requires a provider who operates a facility to furnish common areas and provide a dining area and kitchen for the use of residents. **Section 8** also establishes standards governing food storage. **Section 9** prescribes requirements relating to bathrooms, waste disposal and the maintenance of the premises of a facility. **Section 10** establishes standards governing fire safety at a facility. **Section 11**: (1) prescribes requirements concerning visitors at a facility; and (2) prohibits a provider from allowing a minor child of the provider or an employee thereof to be present at the facility when services are provided.

Existing regulations require each applicant for a provisional certificate to provide community-based living arrangement services or, if the applicant is not a natural person, a member of the governing body of an applicant, to undergo a background check. (NAC 433.330) Existing regulations also provide for the denial of an application or the revocation of a provisional certificate or certificate if a provider or employee or independent contractor of a provider is convicted of certain crimes relevant to the provision of services. (NAC 433.339, 433.384) **Section 4** of this regulation requires an employee or independent contractor of an applicant or any adult who will be present during the provision of services to also undergo a criminal background check. **Sections 15 and 25** of this regulation allow the Division to deny an application or revoke a certificate or provisional certificate if an adult who will be present during the provision of services is convicted of such a crime.

Existing regulations require an applicant for a provisional certificate to provide community-based living arrangement services to submit an application to the Division. Existing regulations require each such applicant who is a natural person to submit as part of that application proof that he or she has received certain training in cardiopulmonary resuscitation and first aid. (NAC 433.330) **Section 5** of this regulation also requires each employee or independent contractor of a provider who provides services to have completed such training. **Section 13** of this regulation requires an application for a provisional certificate to be accompanied by a nonrefundable fee of $100. **Section 17** of this regulation requires an applicant for the renewal of a certificate to submit an application, which must also be accompanied by a nonrefundable fee of $100.

Existing regulations require an application for a provisional certificate to include proof that the applicant has sufficient working capital to provide services for at least 3 months without compensation. (NAC 433.330) **Section 13** revises this requirement to instead require an applicant to attest that he or she has sufficient working capital to effectively provide services and, if the applicant proposes to operate a facility, to operate the facility. **Section 13** additionally clarifies that certain documents may be signed using an electronic signature.

Existing regulations require an applicant for a provisional certificate or each employee of the applicant who will oversee the provision of services to complete 16 hours of training provided by the Division concerning the provision of services. After the completion of that

training, the Division is required to issue a provisional certificate to the applicant. (NAC 433.336) **Section 14** of this regulation: (1) requires that training to be completed between the date on which the application is submitted and 3 months after that date; and (2) authorizes an applicant or employee of the applicant to complete training offered by an entity other than the Division if the training is approved by the Division. **Section 14** also requires the inspection of any facility operated by an applicant and the correction of violations before the issuance of a provisional certificate.

Existing regulations require the holder of a provisional certificate or certificate to comply with provisions of regulations governing community-based living arrangement services (NAC 433.339, 433.342, 433.345, 433.351, 433.384) **Sections 15, 16, 17, 19 and 25** of this regulation instead require substantial compliance with all provisions of chapter 433 of NAC and chapter 433 of NRS.

Existing regulations require the Division to conduct a quality assurance review upon the request of the holder of a provisional certificate within 6 months after the issuance of the provisional certificate. (NAC 433.342) **Section 16** removes the requirement that a holder request a quality assurance review and instead requires the Division to conduct such a review within 12 months of the issuance of a provisional certificate.

Section 18 of this regulation requires a provider of services to: (1) monitor the living environments of persons receiving services; (2) establish policies to immediately assist such persons in repairing unsafe or unhealthy environmental conditions or in finding an alternative residence; (3) develop and implement policies concerning the hiring of persons who will provide services; (4) maintain a personnel file for each such employee; and (5) ensure that each such employee is capable of and qualified to carry out his or her responsibilities and able to communicate effectively with each person to whom he or she provides services.

Existing regulations require a provider to enter into a written contract for the provision of services with each person who will receive services or his or her parent or guardian, if applicable, and the Division. (NAC 433.363) **Section 20** of this regulation clarifies that: (1) the entity providing services is only required to be a party to a contract if the provider is providing services for the Division; and (2) if the provider is providing services for an entity other than the Division, that entity must be a party to such a written contract. **Section 21** of this regulation requires a provider of services to keep records regarding persons for whom services are provided in a secure location which, if the provider operates a facility, must be on the premises of the facility. **Section 22** of this regulation requires a complaint filed with the Division against a provider to be in the form prescribed by the Division.

Existing regulations: (1) require the Division to conduct a quality assurance review before issuing a provisional certificate or renewing a certificate; and (2) authorize the Division to conduct a quality assurance review upon a complaint of abuse, neglect or exploitation of a recipient of services or a concern relating to the health or welfare of a recipient of services. (NAC 433.378) **Section 23** of this regulation instead authorizes the Division to conduct a quality assurance review at any time during the certification of a provider. In addition, **section 23** provides that the Division will conduct a quality assurance review of each provider who operates

a facility at least annually, which must include an inspection of the facility. **Section 23** also clarifies that the Division is authorized to inspect any premises operated by a provider as part of a quality assurance review. Finally, **section 23** requires the Division, after conducting a quality assurance review, to make a report of violations available to a provider.

Existing regulations authorize the Division, after determining pursuant to a quality assurance review that there are deficiencies in the provision of services by a provider relating to the health or welfare of a recipient of services, to require the provider to prepare and submit a written plan of correction. (NAC 433.381) **Section 24** of this regulation requires such a plan to be submitted within 10 days after the report of violations is made available to the provider. **Section 24** also authorizes the Division to require a provider to resubmit a plan of correction or develop a mandatory directed plan of correction for the provider.

Section 1. Chapter 433 of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 11, inclusive, of this regulation.

Sec. 2. ***"Facility" means a home operated by a provider in which services are provided.***

Sec. 3. ***"Resident" means a person who resides at and receives services from a facility.***

Sec. 4. ***1. Except as otherwise provided in subsection 2, within 10 days after hiring a new employee, entering into a contract with an independent contractor or determining that an adult who is not a recipient of services, including, without limitation, an adult child of the applicant or an adult child of an employee or independent contractor thereof, will be present during the provision of services and every 5 years thereafter, a provider shall:***

(a) Obtain from the employee, independent contractor or other adult one set of fingerprints and a written authorization to forward the fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report; and

(b) Submit to the Central Repository for Nevada Records of Criminal History the fingerprints obtained pursuant to paragraph (a) to obtain information on the background and personal history of each employee, independent contractor or other adult to determine whether the person has been convicted of any crime listed in NAC 433.339.

2. Upon receiving information from the Central Repository for Nevada Records of Criminal History pursuant to subsection 1, or evidence from any other source, that an employee, independent contractor or any other adult who is not a recipient of services and who will be present during the provision of services has been convicted of a crime listed in NRS NAC 433.339, the provider shall terminate the employment or contract of that person or prohibit that adult from being present during the provision of services after allowing the person time to correct the information as required pursuant to subsection 3.

3. If an employee, independent contractor or other adult believes that the information provided by the Central Repository for Nevada Records of Criminal History is incorrect, the employee, independent contractor or other adult may immediately inform the provider. The provider that is so informed shall give the employee, independent contractor or other adult a reasonable amount of time of not less than 30 days to correct the information received from the Central Repository before terminating the employment or contract of the person or prohibiting the person from being present during the provision of services pursuant to subsection 2.

Sec. 5. *Each employee or independent contractor of a provider who provides services must:*

1. Be currently certified in standard first aid through a course from the American Red Cross or American Heart Association or their successor organizations or, if the applicant submits proof that the course meets or exceeds the requirements of the American Red Cross or the American Heart Association or their successor organizations, an equivalent course in standard first aid; and

2. Have successfully completed a course in cardiopulmonary resuscitation according to the guidelines of the American Red Cross or American Heart Association or their successor organizations.

Sec. 6. *1. A facility must be owned or leased by the provider who operates the facility.*

2. A provider who operates a facility shall ensure that the facility:

(a) Has no more than 6 residents; and

(b) Remains in compliance with all applicable state and local building codes, zoning requirements and business licensing requirements.

Sec. 7. *1. A provider shall not authorize a resident to share a room in a facility with more than one other resident. A bedroom that is occupied by:*

(a) One resident must have at least 80 square feet of floor space.

(b) Two residents must have at least 120 square feet of floor space.

2. A provider who operates a facility shall provide for each resident a separate bed that is at least 36 inches wide and has a comfortable and clean mattress, at least two sets of clean sheets, at least one blanket, at least one pillow and at least one bedspread.

3. A provider who operates a facility shall not:

(a) Use a bedroom for any other purpose; or

(b) Use any of the following as a bedroom for a resident:

(1) A hallway, stairway, unfinished attic, garage, storage area, shed or similar area; or

(2) A room that can only be reached by passing through a bedroom occupied by another resident.

Sec. 8. *1. A provider who operates a facility shall:*

(a) Furnish each common area with comfortable furniture.

(b) Provide a dining area with a sufficient number of tables and chairs to provide seating for the number of residents for which the facility is certified. The tables and chairs must be sturdy, of proper height for dining and have surfaces that are easily cleaned.

(c) Provide a kitchen that allows for the sanitary preparation of food and is furnished with equipment that is clean and in good working condition.

(d) Ensure that all perishable food is refrigerated at a temperature of 41 degrees Fahrenheit or less, all frozen food is kept at a temperature of 0 degrees Fahrenheit or less and all stored foods have not expired.

(e) Ensure that food is not stored for longer than the length of time recommended by the United States Department of Health and Human Services in "Storage Times for the Refrigerator and Freezer," which is hereby adopted by reference. This chart may be obtained:

(1) From the United States Department of Health and Human Services for free at 200 Independence Avenue, S.W., Washington, D.C. 20201, and at the Internet address https://www.foodsafety.gov/keep/charts/storagetimes.html; or

(2) Under the circumstances described in subsection 4, on an Internet website maintained by the Division.

2. Except as otherwise provided in this section, the most current version of the guidelines adopted by reference pursuant to paragraph (e) of subsection 1 which is published will be deemed to be adopted by reference.

3. If the Division determines that an update of or revision to the guidelines adopted by reference pursuant to paragraph (e) of subsection 1 are not appropriate for use in the State of Nevada, the Division will present this determination to the State Board of Health and the update or revision, as applicable, will not be adopted.

4. If the guidelines adopted by reference pursuant to paragraph (e) of subsection 1 cease to exist, the last version of the guidelines that was published shall be deemed to be the current version.

Sec. 9. *A provider who operates a facility shall ensure that:*

1. The facility has a safe and sufficient supply of water, adequate drainage and an adequate system for the disposal of sewage.

2. Each faucet for a sink, tub, shower or other similar fixture is operable with hot and cold running water.

3. Each toilet is operational.

4. Each container used to store garbage outside of the facility is kept reasonably clean and covered to prevent rodents from entering the container.

5. Each container used to store garbage in the kitchen is covered with a lid or kept in an enclosed cupboard that is clean and prevents infestation by rodents and insects.

6. The premises of the facility are free of:

(a) Offensive odors, insects, rodents and accumulation of dirt, garbage or other refuse; and

(b) Hazards, including, without limitation, obstacles that impede the free movement of residents inside and outside of the facility.

7. Each window in the facility that is capable of being opened and each door that is left open to provide ventilation is screened to prevent insects from entering the facility.

8. The facility has sufficient electrical lighting to ensure the comfort and safety of residents.

9. The temperature of the facility does not exceed 82 degrees Fahrenheit or drop below 68 degrees Fahrenheit.

10. The facility remains in compliance with all applicable federal, state and local laws, regulations and ordinances concerning sanitation, safety and accessibility for persons with disabilities.

Sec. 10. *A provider who operates a facility shall ensure that:*

1. Portable multipurpose class ABC fire extinguishers are installed throughout the facility at the direction of the governmental entity that has jurisdiction over fire safety at the facility.

2. Each portable fire extinguisher available at a facility is inspected, recharged and tagged at least once each year by a person certified by the State Fire Marshal to conduct such inspections.

3. Each exit is maintained free of obstructions.

4. Smoke detectors are installed at the facility at the direction of the governmental entity that has jurisdiction over fire safety at the facility and maintained operational.

5. Smoking does not occur in the facility or within 25 feet of the facility.

6. An extinguishing receptacle approved by the governmental entity that has jurisdiction over fire safety at the facility is placed in each area on the premises of the facility where smoking is allowed.

Sec. 11. *1. A provider who operates a facility:*

(a) Shall maintain a policy concerning visitation by family, friends or acquaintances of residents and employees who enter the facility.

(b) Shall not allow a minor child of the provider or an employee of the provider to be present at the facility when services are provided.

2. A child of a resident may visit the resident in accordance with the policy maintained pursuant to subsection 1 and the individualized plan prepared pursuant to NAC 433.360 for the resident.

Sec. 12. NAC 433.300 is hereby amended to read as follows:

433.300 As used in NAC 433.300 to 433.393, inclusive, ***and sections 2 to 11, inclusive, of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 433.303 to 433.324, inclusive, ***and sections 2 and 3 of this regulation*** have the meanings ascribed to them in those sections.

Sec. 13. NAC 433.330 is hereby amended to read as follows:

433.330 An application for a provisional certificate must be submitted to the Division on a form furnished by the Division ***accompanied by a nonrefundable fee of $100*** and must include:

1. For an applicant who is a natural person:

(a) Three or more letters of professional reference;

(b) A certification, signed by the applicant, that the applicant will maintain the confidentiality of information relating to any person who receives services;

(c) Proof that the applicant has successfully completed a course in cardiopulmonary resuscitation according to the guidelines of the American Red Cross or American Heart Association;

(d) Proof that the applicant is currently certified in standard first aid through a course from the American Red Cross or American Heart Association or, if the applicant submits proof that

the course meets or exceeds the requirements of the American Red Cross or the American Heart Association, an equivalent course in standard first aid;

(e) Written verification, on a form prescribed by the Division, that the fingerprints of the applicant were taken and forwarded electronically or by another means directly to the Central Repository for Nevada Records of Criminal History and that the applicant has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Division deems necessary for reports on the applicant's background to the Division and the applicant;

(f) A copy of the social security card of the applicant;

(g) ~~[Proof]~~ ***A copy of a form of government issued identification, which may include, without limitation, a passport, identification card or driver's license;***

(h) An attestation that the applicant has sufficient working capital to ***effectively*** provide services ~~[for at least 3 months without compensation;~~

~~(h)]~~ ***and, if the applicant proposes to provide services in a facility, operate the facility;***

(i) If applicable, a copy of the applicant's state business license and a copy of the current business license issued for the applicant's business by the county, city or town in which the applicant's business is located or written verification that the applicant is exempt from any requirement to obtain a business license; and

~~[(i)]~~ ***(j)*** Any other information required by the Division.

2. For an applicant other than a natural person:

(a) If applicable, a copy of the state business license of the organization and a copy of the current business license issued for the applicant's business by the county, city or town in which

the applicant's business is located or written verification that the applicant is exempt from any requirement to obtain a business license;

(b) The federal tax identification number of the organization;

(c) A copy of the bylaws, articles of incorporation, articles of association, articles of organization, partnership agreement, constitution and any other substantially equivalent documents of the applicant, and any amendments thereto;

(d) A list of the members of the governing body of the applicant;

(e) If the applicant is an association or a corporation:

(1) The name, title and principal business address of each officer and member of its governing body;

(2) The signature of the chief executive officer or an authorized representative; and

(3) If the applicant is a corporation, the name and address of each person holding more than 10 percent of its stock;

(f) For each member of the governing body:

(1) Three or more letters of professional reference; and

(2) Written verification, on a form prescribed by the Division, that the fingerprints of the member of the governing body were taken and forwarded electronically or by another means directly to the Central Repository for Nevada Records of Criminal History and that the member of the governing body has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Division deems necessary for reports on the member's background to the Division and the applicant;

(g) ~~[Proof]~~ ***An attestation*** that the applicant has sufficient working capital to ***effectively*** provide services ~~[for at least 3 months without compensation;]~~ ***and, if the applicant proposes to provide services in a facility, operate the facility;***

(h) Copies of any policies and procedures of the applicant relating to the provision of services; and

(i) Such other information as may be required by the Division.

3. As used in this section:

(a) "Electronic signature" means a user name attached to or logically associated with a record and executed or adopted by a person with the intent to sign an electronic application or other document.

(b) "Signature" includes, without limitation, an electronic signature.

Sec. 14. NAC 433.336 is hereby amended to read as follows:

433.336 1. ~~[If the Division determines that an application for a provisional certificate is complete, the Division shall establish a screening panel composed of employees of the Division to interview the applicant and determine whether the applicant is qualified to participate in the training required by subsection 2.~~

~~2. Except as otherwise provided in this subsection, if the screening panel determines that an applicant is qualified to obtain a provisional certificate, the]~~ ***An*** applicant ***for a provisional certificate*** must complete 16 hours of training ***approved or*** provided by the Division concerning the provision of services. The training must be completed ***after the application is submitted but*** not later than 3 months after ~~[the]~~ ***that*** date . ~~[on which the screening panel makes its determination.]~~ If the applicant is not a natural person, each officer or employee of the applicant

who will oversee the provision of services by the applicant must complete the training required by this subsection.

3. Upon successful completion of the training required by subsection ~~[2.]~~ ***1,*** the Division shall ~~[issue]~~ ***:***

(a) If the applicant proposes to provide services in a facility, inspect the facility and issue a report describing any violations of the provisions of this chapter or chapter 433 of NRS found during the inspection. If the report describes a violation, the Division may require the applicant to submit a plan of correction. The Division shall issue a provisional certificate:

(1) If the Division requires the applicant to submit a plan of correction, upon approval by the Division of the plan of correction.

(2) If the Division does not require the applicant to submit a plan of correction, upon issuance of the report.

(b) If the applicant does not propose to provide services in a facility, issue a provisional certificate to the applicant.

4. A provisional certificate is valid until the Division completes the initial quality assurance review required by NAC 433.342.

Sec. 15. NAC 433.339 is hereby amended to read as follows:

433.339 1. Each of the following constitutes a ground for denial of an application for a provisional certificate:

(a) Failure by the applicant to submit a complete application for a provisional certificate within the time required by NAC 433.333.

(b) Inability of the applicant to provide proper care for the number and types of intended recipients of services.

(c) Misrepresentation or failure by the applicant to disclose any material fact in the application submitted to the Division or in any financial record or other document requested by the Division.

(d) Conviction of the applicant, an officer or employee of the applicant ~~[or]~~ , an independent contractor of the applicant who oversees the provision of services ***or an adult who will be present during the provision of services*** of a crime relevant to any aspect of the provision of services, including, without limitation:

(1) Murder, voluntary manslaughter or mayhem;

(2) Assault or battery with intent to kill or to commit sexual assault or mayhem;

(3) Sexual assault, statutory sexual seduction, incest or lewdness or indecent exposure that is punished as a felony, or any other sexually related felony;

(4) A felony involving domestic violence;

(5) A misdemeanor involving domestic violence, within the immediately preceding 7 years;

(6) A misdemeanor involving assault or battery, within the immediately preceding 7 years;

(7) Abuse or neglect of a child or contributory delinquency;

(8) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS, within the immediately preceding 7 years;

(9) Abuse, neglect, exploitation, isolation or abandonment of an older person or vulnerable person, including, without limitation, a violation of any provision of NRS 200.5091 to 200.50995, inclusive, or a law of any other jurisdiction that prohibits the same or similar conduct;

(10) A violation of any law relating to the State Plan for Medicaid or a law of any other jurisdiction that prohibits the same or similar conduct, within the immediately preceding 7 years;

(11) A violation of any provision of NRS 422.450 to 422.590, inclusive;

(12) A criminal offense under the laws governing Medicaid or Medicare, within the immediately preceding 7 years;

(13) Any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property, within the immediately preceding 7 years;

(14) Any felony involving the use or threatened use of force or violence against the victim or the use of a firearm or other deadly weapon; or

(15) An attempt or conspiracy to commit any of the offenses listed in this paragraph, within the immediately preceding 7 years.

(e) Exclusion of the applicant, an officer or employee of the applicant or an independent contractor of the applicant who oversees the provision of services from participation in Medicare, Medicaid or any other federal health care program pursuant to federal law.

(f) The existence of any major deficiency in the proposed services to be provided by the applicant which would preclude compliance with ~~[NAC 433.300 to 433.393, inclusive.]~~ ***any provision of this chapter or chapter 433 of NRS.***

2. If an application is denied, the Division shall give the applicant a written notice of the denial in the manner provided by NAC 439.345.

Sec. 16. NAC 433.342 is hereby amended to read as follows:

433.342 1. Within ~~[6]~~ ***12*** months after the issuance of a provisional certificate, ~~[the holder of the provisional certificate shall request]~~ the Division ~~[to]~~ ***shall*** conduct a quality assurance review as provided in NAC 433.378. If ~~[no timely request is made or]~~ the Division determines as

the result of the quality assurance review that the holder of the provisional certificate is not in ~~[full]~~ ***substantial*** compliance with the ~~[standards for the provision of services set forth in NAC 433.300 to 433.393, inclusive,]~~ ***provisions of this chapter and chapter 433 of NRS,*** the Division may revoke or extend the term of the provisional certificate. The Division may extend the term of the provisional certificate for any period not to exceed 6 months.

2. If the Division extends the term of a provisional certificate pursuant to subsection 1, ~~[the holder of the provisional certificate]~~ ***the Division*** shall, before the expiration of the extended term, ~~[request the Division to]~~ conduct another quality assurance review. If ~~[no timely request is made or]~~ the Division determines as the result of the quality assurance review that the holder of the provisional certificate is not in ~~[full]~~ ***substantial*** compliance with the standards described in subsection 1, the Division shall revoke the provisional certificate.

3. If the Division determines as the result of a quality assurance review conducted pursuant to subsection 1 or 2 that the holder of a provisional certificate is in ~~[full]~~ ***substantial*** compliance with the ~~[standards described in subsection 1,]~~ ***provisions of this chapter and chapter 433 of NRS,*** the Division shall issue a certificate to the holder of the provisional certificate. The Division may issue a certificate to a provider for any period not to exceed 2 years.

Sec. 17. NAC 433.345 is hereby amended to read as follows:

433.345 ~~[Upon]~~ ***Not less than 45 days before the*** the expiration of a certificate, the ***holder of the certificate must apply to the Division for renewal in the form prescribed by the Division, accompanied by a nonrefundable fee of $100. The*** Division may renew the certificate ~~[of the provider]~~ for any period not to exceed 2 years if the Division ~~[conducts a quality assurance review as provided in NAC 433.378 and]~~ determines that the ~~[provider]~~ ***holder of the certificate***

is in ***substantial*** compliance with the ~~[standards for the provision of services set forth in NAC 433.300 to 433.393, inclusive.]~~ ***provisions of this chapter and chapter 433 of NRS.***

Sec. 18. NAC 433.348 is hereby amended to read as follows:

433.348 A provider shall:

1. Comply with any state or federal statute or regulation as required for the Division to receive state or federal money for the provision of services, including, without limitation, any standard of care set forth in:

(a) The State Plan for Medicaid; and

(b) The Medicaid Services Manual established by the Division of Health Care Financing and Policy of the Department of Health and Human Services.

2. Comply with all applicable state or federal requirements concerning fiscal management, reporting and employment.

3. Comply with the individualized plan prepared pursuant to NAC 433.360 for each person who receives services.

4. Assure the health and welfare of persons receiving services. Any assessment by the Division of a provider's compliance with the requirements of this subsection must be based upon the self-reporting of persons receiving services from the provider, the observations of members of the staff of the Division and any other information available to the Division.

5. Establish internal procedures for quality assurance.

6. Promptly report to the Division any change in the officers or ownership of the provider.

7. Cooperate with any investigation by the Division.

8. Monitor the living environment of persons receiving services from the provider and establish policies to immediately assist such persons who are living in unsafe or unhealthy environmental conditions to correct those conditions or in find alternative residences.

9. Develop and implement policies concerning the hiring of persons who will provide services.

10. Maintain a personnel file for each employee or independent contractor who provides services. A personnel file must contain, without limitation:

(a) Information concerning the job duties, essential functions, physical capabilities and language proficiency of the employee or contractor; and

(b) Proof that the employee or independent contractor is in compliance with the requirements of section 5 of this regulation, if applicable.

11. Ensure that each employee or independent contractor who provides services is capable of:

(a) Carrying out the responsibilities established in the individualized plan established pursuant to NAC 433.360 for each person to whom the employee or independent contractor provides services and properly qualified by training and experience to do so; and

(b) Communicating effectively with each person to whom the employee or independent contractor provides services.

Sec. 19. NAC 433.351 is hereby amended to read as follows:

433.351 If a provider is a governmental entity or an organization, it shall, in conformance with ~~[NAC 433.300 to 433.393, inclusive,]~~ ***the provisions of this chapter and chapter 433 of NRS,*** establish policies and procedures for the provision of services and the welfare of the persons it serves.

Sec. 20. NAC 433.363 is hereby amended to read as follows:

433.363 A provider shall enter into a written contract for the provision of services with each person who will receive services or his or her parent or guardian, if applicable, and ***, if the person is being served by the Division or another entity for which the provider is providing services,*** the Division ~~[.]~~ ***or other entity.*** The contract must prescribe the services that will be provided to the person and the payment that the provider will receive ~~[from the Division]~~ for those services.

Sec. 21. NAC 433.369 is hereby amended to read as follows:

433.369 A provider shall keep a separate record regarding each person for whom services are provided. Each such record must include the information needed for providing services, to substantiate billing and for the planning and periodic reevaluation of the needs of the person who is receiving services. The record must be ~~[available]~~ ***:***

1. Kept in a secure location, which, if the provider operates a facility, must be on the premises of the facility; and

2. Made available for review by the person who is receiving services or his or her guardian, if applicable, and the Division.

Sec. 22. NAC 433.375 is hereby amended to read as follows:

433.375 1. Any person who receives services has the same rights that are afforded to a consumer by chapter 433 of NRS and any regulations adopted pursuant thereto.

2. A person has the right to file a complaint with the Division against a provider ~~[.]~~ ***in the form prescribed by the Division.***

Sec. 23. NAC 433.378 is hereby amended to read as follows:

433.378 1. The Division:

(a) ~~[Shall conduct a quality assurance review upon a request made pursuant to NAC 433.342 and before renewing a certificate pursuant to NAC 433.345; and~~

~~(b)]~~ May conduct a quality assurance review at any time during the certification of a provider ~~[if there is a complaint of abuse, neglect or exploitation or a concern related to the health or welfare of a person who receives services from the provider.]~~ ***; and***

(b) Shall conduct a quality assurance review of each provider that operates a facility at least once each year during the certification of a provider. A quality assurance review conducted pursuant to this paragraph must include, without limitation, an inspection of the facility.

2. In conducting a quality assurance review, the Division may:

(a) Obtain any information or otherwise review any aspect of the provider's system of delivery of services, including, without limitation, any:

(1) Policies and procedures of the provider;

(2) Personnel or clinical records maintained by the provider;

(3) Documentation regarding any administrative or personnel matter directly related to the health and welfare of any person who is receiving services;

(4) Financial information concerning the provider or any person receiving services; and

(5) Information concerning the quality of care provided to any person receiving services;

(b) Interview or otherwise solicit information from any person receiving services, any employee or independent contractor of any provider or any other agency with knowledge of any person receiving services, and any member of the family or any guardian, friend or advocate of any person receiving services; ~~[and]~~

(c) Observe the services provided to any person receiving services ~~[.]~~ ***; and***

(d) Inspect any facility or other premises operated by the provider to determine compliance with the provisions of this chapter and chapter 433 of NRS.

3. After completing a quality assurance review, the Division shall make available to the provider a report that describes each violation. The provider shall correct any violation described in the report.

Sec. 24. NAC 433.381 is hereby amended to read as follows:

433.381 1. If the Division determines pursuant to a quality assurance review that there are any deficiencies in the provision of services by a provider related to the health or welfare of a person receiving such services, the Division may:

(a) Deny, suspend or revoke the provisional certificate or certificate of the provider;

(b) Require the provider to prepare and submit to the Division a written plan of correction, which must be approved by the Division; or

(c) Require changes concerning the provision of services by the provider before the Division issues, renews or reinstates a provisional certificate or certificate.

2. ***If the Division requires a provider to prepare and submit to the Division a written plan of correction, the provider shall do so not later than 10 days after the report of violations is made available to the provider pursuant to subsection 3 of NAC 433.378. Failure to do so constitutes a separate violation for which the Division may deny, suspend or revoke the provisional certificate or certificate of the provider or impose any sanction listed in subsection 5.***

3. If the Division determines that a written plan of correction is unacceptable, the Division may:

(a) Require the provider to resubmit the written plan of correction; or

(b) Develop a mandatory directed plan of correction for the provider.

4. The Division may impose any sanction described in subsection ~~[3]~~ *5* upon a provider for:

(a) Any aspect of the provision of services by the provider which poses a probable risk of harm to the health or welfare of a person receiving services;

(b) Any refusal by the provider to participate in any aspect of a quality assurance review; or

(c) The failure or refusal of the provider to implement or maintain any action required by the Division to correct a deficiency identified during a quality assurance review ~~[.~~ ~~3.]~~ *, including, without limitation, failure to submit a timely plan of correction, if required.*

5. As a sanction imposed pursuant to subsection ~~[2.]~~ *4,* the Division may, without limitation:

(a) Require the provider to:

(1) Participate in training concerning the provision of services;

(2) Comply with additional measures of accountability concerning the provision of services;

(3) Comply with additional measures of review by the Division; or

(4) Comply with additional performance requirements concerning the provision of services;

(b) Terminate or amend any contract that the Division has with the provider; or

(c) Suspend or reduce any payment otherwise owed by the Division to the provider.

Sec. 25. NAC 433.384 is hereby amended to read as follows:

433.384 Each of the following acts and omissions is a ground for revocation of a provisional certificate or certificate:

1. Any misrepresentation of or failure to disclose any material fact in the application for the provisional certificate or in any financial record or other document requested by the Division.

2. A lack of personnel in sufficient numbers or qualifications to provide proper care and support for the persons receiving services.

3. Conviction of the provider ~~[or]~~ , any employee or independent contractor of the provider ***or any adult present during the provision of services*** of a crime ~~[relevant to any aspect of the provision of services.]~~ ***listed in NAC 433.339.***

4. Any deficiency of the provider relating to the provision of services that poses an imminent or probable risk of harm to the health or welfare of any person receiving services.

5. Any violation of any requirement set forth in ~~[NAC 433.300 to 433.393, inclusive.]~~ ***this chapter or chapter 433 of NRS.***

6. Any accumulation or pattern of minor violations of the provisions of ~~[NAC 433.300 to 433.393, inclusive,]~~ ***this chapter or chapter 433 of NRS,*** if the violations taken as a whole endanger the health or welfare of any person who is receiving services.

7. Any fraudulent activity by the provider or an employee or independent contractor of the provider, including, without limitation, any fraudulent billing, falsification of records or misuse or misappropriation of the property of a person who is receiving services.

8. Failure to comply with any obligation set forth in the contract entered into pursuant to NAC 433.363.

9. Any refusal to participate in any aspect of a quality assurance review or any other review or investigation by the Division.

10. The failure or refusal of the provider to implement or maintain any action required by the Division to correct a deficiency identified during a quality assurance review or any other review or investigation by the Division.

11. Abuse, neglect, exploitation or coercion of a person who is receiving services.

12. Harassing, coercive, intimidating, insulting, abusive or disruptive language or behavior directed at an employee of the Division, an employee or independent contractor of the provider, another provider or a person or entity providing services other than community-based living arrangement services, a person who is receiving services or a family member or guardian of such a person.

13. Exclusion of the provider, an officer or employee of the provider or an independent contractor of the provider who oversees the provision of services from participation in Medicare, Medicaid or any other federal health care program pursuant to federal law.

SNAMHS FY18-19 CBLA RESIDENTIAL AUDIT QUESTIONNAIRE

Provider Name: _____ Provider (Print and Sign): _____

CBLA Address: _____

CBLA License#: _____ Expires: _____ No. of years licensed: ____ Maximum capacity per license: _____

Date of Audit/Visit: _____ Audited by:

A fiscal review is based on the SNAMHS auditor's meeting, conversations and/or interview with the provider, clients and the staff who support them, and a review of the documents. During the audit, selected clients' records and documents shall be reviewed as needed.

Residential audit shall cover all invoices, contracts and other financial records per CBLA provider address for the Fiscal Year (FY) 2018 (Jul'17 to Jun'18). Billings shall be compared to contract to determine conformity with the terms and conditions of the agreement.

AUDIT CRITERIA AND QUESTIONS	YES	NO	N/A if not applicable	COMMENTS
A. Provider Services				
1. What services are available to the clients in the provider's CBLA:				
a. Rent/Lease				
b. Utilities: Are utilities such as electricity, trash & sewer included in the rent? If not, are utilities divided per number of beds in the CBLA home and for how much?				
c. Phone: Does provider bill for landline phone? If yes, does provider divide the phone bill based on the number of clients in the CBLA Home?				
d. Specialized Services Hours: How many hours allowed per contract? (SP, OH, DS, CM)				
e. Food: Does provider get the food allowance or SNAP food stamps from the client and provide the food?				
f. Food Storage and Labelling: Is storage communal or does provider have individual food compartment for each client? If not, are food properly labelled per client?				

	YES	NO	N/A if not applicable	COMMENTS
g. Do clients have access to food anytime of the day or food storage/refrigerator is locked?				
h. Is provider aware of the Department of Welfare regulations on client food storage and labelling?				
2. Number of SNAMHS Clients per CBLA Home/Total Number of SNAMHS Clients with the Provider				
3. Number of Units and Beds per CBLA Home Is this the actual number of beds reported to SNAMHS Residential Services Department?				
4. Number of Beds per CBLA Home reported to the Clark County Assessor Per CBLA location/address:				
B. Fiscal Accountability: ***Documents Needed: Client Contracts, Lease agreement, Invoices paid for clients, Monthly billing to SNAMHS, Bank records and financial statements, Specialized Services Hours documentation, Caregiver or provider staff timesheets and payroll records, other documents as requested by auditor.**				
1. CONTRACT a. Does provider have a State of Nevada contract?				
b. Did the provider comply with the Nevada EPro Request for Qualifications (RFQ) process?				
c. What resources are the client receiving every month?				
d. Does client receive funding or money from other individuals or third party?				

	YES	NO	N/A if not applicable	COMMENTS
e. What is the state payment amount to CBLA provider?				Food: _____ PN: _____ Rent: _____ Phone: _____ Utilities: _____ Other: _____
f. What is the individual payment amount to CBLA provider?				Food: _____ PN: _____ Rent: _____ Phone: _____ Utilities: _____ Other: _____
g. Are Correct Specialized Services hours and rates specified and used?				
h. Are differences or any discrepancy from previous contract explained and supported with document? e.g. Intake change				
i. Are all signatures in place on contract and conditions of agreement?				
j. Does provider have a lease agreement with the client? If yes, is it renewed every year? Is it properly signed by both client and provider?				
k. Does provider provide a copy of the lease agreement to the Service Coordinator?				
2. BILLING a. Is the correct SNAMHS billing form used by the provider? (e.g. billing cover sheet, PN & Food Log, Specialized Services Logs, etc.)				

	YES	NO	N/A if not applicable	COMMENTS
b. Are all logs such as food, PN & services hours submitted by the provider properly signed by the client, caregiver, provider and SC, whenever applicable? If not, please state reason why signature was not in place.				
c. Are provider billings and state payments WITHIN WHAT IS ALLOWABLE in the Residential Services Agreement (RSA)?				
d. Have bills been paid and deposited for clients' use when and where appropriate?				
e. Do rental amounts conform to the lease agreement?				
f. Do Specialized Services hours have proper back up for actual hours provided?				
g. (For Auditor to identify based on Review of Provider Services Hour Logs) Do Specialized Services hours that were billed to SNAMHS "overlap"? What dates or months? Who are the clients the service hours overlap with?				
h. Are Specialized Services hours simply "templates" or "copy and paste" of the client or other clients' Services hours? What dates or months? Who are the clients and caregivers involved?				
i. Is provider aware that his/her caregiver's Services Hours Logs overlap and/or copy and paste of the other clients' services hours logs? (Only answer if "YES" on #2h or #2i) Please state reason for submitting templates or hour overlaps.				
l. Are ONE-TIME COSTS AMOUNTS (used only once) in proper month? Are there receipts or documentation provided to support any or all one-time expenditures?				

3. FUNDS	YES	NO	N/A if not applicable	COMMENTS
a. Are funds paid out on behalf of the clients being used properly to cover all the clients' obligations and are received by the correct creditors/vendors?				
b. Are checks paid for clients for rent, utilities, phone, etc.in the correct amount and paid in a timely manner?				
c. Are checks with client as payee endorsed by the provider or any third party? Is provider aware that third party endorsement is not ALLOWED?				
d. Is provider aware that third party check endorsement is NOT ALLOWED?				
e. Do checks written on behalf of clients MATCH invoice/total?				
f. Have checks written to or for clients cleared providers' account within 6 months? If not, please state reason.				
g. Does provider have any client checks, (with client as payee) or one-time cost checks in his/her possession? If yes, when will these checks be given to the client?				
h. If the provider has client checks in his possession, state the reason why the checks were not given to the client yet.				
i. Are RECEIPTS, PERSONAL NEEDS AND FOOD LOGS, INVOICES and BANK RECORDS or LEDGERS available to review for all payment or purchases made? (Please present receipts, bank records and invoices to auditor for review as requested).				

	YES	NO	N/A if not applicable	COMMENTS
j. Are copies of ALL invoices and receipts kept and filed per client?				
k. Does provider ensure safety of client records?				
l. Does provider ensure safety of client's funds or checks in his/her possession?				
m. Does provider keep electronic and hard copy of clients' files?				
n. If hard copy of files is maintained, where are they kept?				
o. How long do you keep the files? Is it 3 or 5 years?				
p. Are negative balances prohibited by the provider? Does provider allow client to borrow funds from him/her? If so, please state reason for doing so.				
q. Does provider report to SNAMHS discharged or transferred clients promptly or in a timely manner?				
r. Did the Service Coordinator notify the provider of client's discharge in a timely manner? If yes, did SC use the correct discharge form?				
s. Are cancelled funds returned as appropriate or as soon as possible?				
4. PROVIDER PAYROLL, TIMESHEET AND ACCOUNTING RECORDS a. Does provider have staff or his/her caregivers' timesheets and payroll records?				
b. Do timesheets and payroll records support the hours worked and reported by the provider's caregivers in the specialized services hours logs?				

	YES	NO	N/A if not applicable	COMMENTS
c. Does provider have a financial statement/ financial accounting of his or her CBLA home's operating costs or expenses? (Financial assessment based on external audit)				
5. SERVICE COORDINATION AND PROVIDER STAFF a. Is client regularly visited by his/her Service Coordinator? How often?				
b. If you are providing specialized services hours, does your caregiver assist clients in multiple locations or provider facility?				
c. How many clients are assigned to your caregiver? What are their names?				
d. What are the names of your staff in charge of supervising your clients?				
e. Do you have alternate caregiver in case the main caregiver has to leave because of an emergency? What are the names?				
f. Have you or your staff received a copy of the SNAMHS Residential Billing Guidelines? If yes, please sign on the highlighted box.				Printed name and Signature: Date Signed:

Prepared by:

Provider's Name: _____ **Audit Date:** _____

ADDITIONAL NOTES:

CLIENT'S NAME	AVATAR#/SC	NOTES AND FINDINGS

CLIENT'S NAME	AVATAR#/SC	NOTES AND FINDINGS

CLIENT'S NAME	AVATAR#/SC	NOTES AND FINDINGS

CLIENT'S NAME	AVATAR#/SC	NOTES AND FINDINGS

Review Highlights

Highlights of Legislative Auditor report on the Review of Governmental and Private Facilities for Children issued on January 18, 2017. Report # LA18-06.

Background

Nevada Revised Statutes 218G.570 through 218G.585 authorize the Legislative Auditor to conduct reviews, audits, and unannounced site visits of governmental and private facilities for children.

As of June 30, 2016, we had identified 56 governmental and private facilities that met the requirements of NRS 218G: 20 governmental and 36 private facilities. In addition, 124 Nevada children were placed in 20 facilities in nine different states as of June 30, 2016.

NRS 218G requires facilities to forward to the Legislative Auditor copies of any complaint filed by a child under their custody or by any other person on behalf of such a child concerning the health, safety, welfare, and civil and other rights of the child. During the period from July 1, 2015, through June 30, 2016, we received 1,723 complaints from 30 facilities in Nevada. Twenty-six facilities reported that no complaints were filed during this time.

Purpose of Reviews

Reviews were conducted pursuant to the provisions of NRS 218G.570 through 218G.585. This report includes the results of our reviews of 4 children's facilities, unannounced site visits to 4 children's facilities, and a survey of 56 children's facilities. As reviews and not audits, they were not conducted in accordance with generally accepted government auditing standards, as outlined in *Government Auditing Standards* issued by the Comptroller General of the United States, or in accordance with the *Statements on Standards for Accounting and Review Services* issued by the American Institute of Certified Public Accountants.

The purpose of our reviews was to determine if the facilities adequately protect the health, safety, and welfare of the children in the facilities, and whether the facilities respect the civil and other rights of the children in their care. These reviews included an examination of policies, procedures, processes, and complaints filed since July 1, 2014. In addition, we discussed related issues and observed related processes during our visits. Our work was conducted from January 2016 through December 2016.

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Review of Governmental and Private Facilities for Children

January 2017

Summary

Based on the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at three of the four facilities reviewed provide reasonable assurance that they adequately protect the health, safety, and welfare of the youths at the facilities, and they respect the civil and other rights of youths in their care.

The policies, procedures, and processes at one of the four facilities reviewed were not adequate to provide reasonable assurance that they protect the health, safety, and welfare of the youths at the facility. We reported our concerns to this facility's licensing agency in August 2016 after our visits to the facility in June and July 2016.

We also conducted unannounced site visits to four children's facilities and did not note anything that caused us to question the health, safety, welfare, or protection of the rights of the children in those facilities.

Facility Observations

ART Homes' policies, procedures, and processes need substantial improvements related to: medication administration and documentation; ensuring treatment plans are complete and accurate; maintaining comprehensive personnel records related to background investigations and training; and ensuring the safety of the youths in its foster homes. There was no documentation of consent by the person legally responsible for the psychiatric care of the youths for any of the psychotropic medications administered to the three youths whose files we reviewed who were administered psychotropic medications. We also observed a filing cabinet in the ART Homes' office that was filled with expired and unexpired psychotropic medications and expired non-psychotropic prescription medications, including physicians' samples. All nine treatment plans reviewed were missing signature, dates, and the number of approved hours of Medicaid treatment services. Finally, ART Homes did not comply with NRS 424.135, which requires comprehensive personnel records, and was unable to provide 8 of 11 clearance letters upon our request. Clearance letters provide evidence that employees or potential employees have satisfactorily completed the background investigation process. (page 6)

Three of the four facilities reviewed for this report needed to improve their processes and procedures for obtaining consent to administer psychotropic medications to youths from the persons legally responsible for the psychiatric care of each youth. One of the facilities' forms for obtaining consent did not include the information required by statute, and its policy did not address all the required elements of a consent. The other two facilities were missing signed consent forms for one or more youths whose files indicated they received psychotropic medications while at the facilities. (page 8)

Three of the four facilities reviewed did not have evidence that employees who are statutorily required to attend medication administration training had received the training in the timeframe required. At these three facilities, there was no evidence in half (13 of 26) of the employees' files that they had received the training in the timeframes required. NRS 424.0365 and NRS 63.190 require employees who have direct contact with youths to receive certain training, including the administration of medication, within 30 days of employment and annually thereafter. There was no evidence two employees received any medication training even though they had worked at the facility for 3 and 5 years. Another employee had not received training since 2012, and another was missing evidence of training between January 2011 and May 2015. (page 9)All four of the facilities reviewed either did not complete youths' treatment plans timely or the treatment plans were incomplete. In addition, two of the facilities did not review treatment plans periodically or have updated treatment plans in the youths' files. (page 10)

Audit Division
Legislative Counsel Bureau

Review Highlights

Highlights of Legislative Auditor report on the Review of Guidelines for Licensing Children's Facilities issued on January 17, 2018. Report # LA18-15.

Background

Nevada Revised Statutes authorize the Legislative Auditor to conduct reviews, audits, and unannounced site visits of governmental children's facilities. In addition, NRS authorizes the Legislative Auditor to conduct reviews and unannounced site visits of private children's facilities.

Four governmental agencies license children's facilities in Nevada. The Bureau of Health Care Quality and Compliance (HCQC) licenses child care facilities and institutions, psychiatric hospitals, and residential facilities for the treatment of abuse of alcohol or drugs. HCQC is part of the Nevada Department of Health and Human Services, Division of Public and Behavioral Health.

The Washoe County Human Services Agency (HSA) licenses foster homes, including specialized and group foster homes, and foster care agencies located in Washoe County. The Clark County Department of Family Services (DFS) licenses foster homes, including specialized and group foster homes, and foster care agencies located in Clark County. The Division of Child and Family Services (DCFS) licenses foster homes, including specialized and group foster homes, and foster care agencies located in the 15 rural counties. DCFS is part of the Nevada Department of Health and Human Services.

Purpose of the Review

The purpose of this review was to determine if the guidelines used by the agencies that license facilities where children may be placed by a court are reasonably adequate to help ensure the facilities protect the health, safety, welfare, and civil and other rights of the children in the facilities. In addition, we reviewed child welfare agencies' policies and procedures to determine if the agencies have adequate processes to ensure children in their custody have the consents of the persons legally responsible for the psychiatric care of the children before psychotropic medications are administered to the children.

This review included an examination of policies, procedures, checklists, and other documents used by the licensing agencies to inspect and review facilities during calendar year 2017.

Review of Guidelines for Licensing Children's Facilities

January 2018

Summary

The tools and written guidance licensing agencies provide to staff for reviewing facilities that have applied for new or renewed licenses need to be updated and to provide more explanatory detail. Key areas are sometimes missing from the guidance, such as informing youths of their rights, having established grievance processes, or mandatory reporting of known or suspected instances of abuse or neglect of a child. Licensing agencies generally use checklists, which refer to the applicable regulation or statute, rather than written policies and procedures. The checklists generally do not contain sufficient explanatory information for the licensing staff. In addition, most checklists were not dated and did not contain evidence of management approval or review.

Incomplete policies, procedures, and checklists may have resulted in some facilities not obtaining written consent from the person legally responsible for the psychiatric care of a child (PLR) prior to administering psychotropic medications to a child in the custody of a child welfare agency. NRS 432B.4688 forbids a temporary caregiver from administering a psychotropic medication to a child in the custody of a child welfare agency without the prior written consent of the PLR, except in certain situations. Some facilities may not be aware of the requirements of NRS 432B.4688 because the Bureau of Health Care Quality and Compliance (HCQC) does not address the requirements in its licensing information or regulations. In addition, some facilities may be unable to comply with NRS 432B.4688 because they may not have been provided with a copy of a consent or a copy of the withdrawal or denial of consent.

Facility Observations

HCQC does not have policies and procedures to help guide staff when reviewing child care facilities or institutions. Instead, staff use a survey report form, which is a checklist, and a semi-annual checklist for child care facilities and a different survey checklist for child care institutions. Although these checklists are referenced to NAC 432A, they do not provide complete guidance to staff to help ensure the facilities protect the health, safety, welfare, and rights of the children in the facilities. For example, the checklists do not mention that residents of a facility or institution who are over the age of 18 must pass a background investigation unless the resident has been placed at the facility pursuant to the order of a court. (page 7)

HCQC does not have written policies and procedures for licensing psychiatric hospitals, but staff use a checklist for hospitals that has additional steps for psychiatric services. However, the checklist is not specific to youths. For example, the checklist does not contain any requirements for background investigations of staff who care for youths as required by NRS 449.123. (page 10)

HCQC does not have written policies and procedures for licensing facilities for the treatment of abuse of alcohol or drugs, but does use a checklist called a surveyor workbook. However, while the checklist requires medication administration policies and procedures, it does not include documentation of physician's orders or ensuring written consent from the PLR is obtained prior to administering psychotropic medications to a youth in the custody of a child welfare agency. (page 12)

None of the three child welfare agencies included in this review (DCFS, DFS, and HSA) have policies or procedures to assist staff with reviewing foster care agencies' policies and practices. DFS and HSA use checklists or attachments to provider applications to review documents submitted during the licensing process. DCFS reported using the requirements in NRS 424 to review foster care agencies, but this is not formalized into policies, procedures, or checklists. (page 14)

The three child welfare agencies also license specialized foster homes and group foster homes. Generally, the three agencies use checklists and questionnaires to inspect the homes and checklists to ensure the homes submit all required information with or in their applications. However, they do not have policies and procedures to provide direct guidance to the licensing staff. While the home inspection checklists cover multiple aspects of the health, safety, welfare, and rights of the children, they are weak in certain areas. Most notably, the checklists generally do not include a review of the homes' policies and procedures. For example, the checklists ask the licensing staff to conclude on two different pages whether unused prescribed medications are destroyed. It does not ask the licensing staff to review the homes' procedures for destroying medication, such as when it should be destroyed, how it should be destroyed, by whom it should be destroyed, and how the destruction should be documented. (page 17)

Review Highlights

Highlights of Legislative Auditor report on the Review of Governmental and Private Facilities for Children issued on May 2, 2018. Report # LA18-20.

Background

Nevada Revised Statutes 218G.570 through 218G.585 authorize the Legislative Auditor to conduct reviews, audits, and unannounced site visits of governmental and private facilities for children.

As of June 30, 2017, we had identified 55 governmental and private facilities that met the requirements of NRS 218G: 20 governmental and 35 private facilities. In addition, 119 Nevada children were placed in 26 facilities in 11 different states as of June 30, 2017.

NRS 218G requires facilities to forward to the Legislative Auditor copies of any complaint filed by a child under their custody or by any other person on behalf of such a child concerning the health, safety, welfare, and civil and other rights of the child. During the period from July 1, 2016, through June 30, 2017, we received 1,457 complaints from 29 facilities in Nevada. Twenty-six facilities reported that no complaints were filed during this time.

Purpose of Reviews

Reviews were conducted pursuant to the provisions of NRS 218G.570 through 218G.585. This report includes the results of our reviews of 4 children's facilities, unannounced site visits to 4 children's facilities, and a survey of 55 children's facilities. As reviews and not audits, they were not conducted in accordance with generally accepted government auditing standards, as outlined in *Government Auditing Standards* issued by the Comptroller General of the United States, or in accordance with the *Statements on Standards for Accounting and Review Services* issued by the American Institute of Certified Public Accountants.

The purpose of our reviews was to determine if the facilities adequately protect the health, safety, and welfare of the children in the facilities, and whether the facilities respect the civil and other rights of the children in their care.

These reviews included an examination of policies, procedures, processes, and complaints filed since July 1, 2015. In addition, we discussed related issues and observed related processes during our visits. Our work was conducted from December 2016 through March 2018.

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Review of Governmental and Private Facilities for Children

April 2018

Summary

Based on the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at two of the four facilities reviewed provide reasonable assurance that they adequately protect the health, safety, and welfare of youths at the facilities, and they respect the civil and other rights of youths in their care. The policies, procedures, and processes at two of the four facilities reviewed only provided minimal assurance that they protect the health, safety, and welfare of the youths at the facility and they respect the civil and other rights of the youths in their care.

We reported our observations at the two facilities to their licensing agencies pursuant to Section 8.5 of Senate Bill 189 of the 2017 Legislative Session. SB 189 requires the Legislative Auditor to provide a report to the licensing entity of a facility found to have deficiencies in policies, procedures, or processes that could be detrimental to the children in the care of the facility.

We also conducted unannounced site visits to four children's facilities and did not note anything that caused us to question the health, safety, welfare, or protection of the rights of the children in those facilities.

Facility Observations

Many of the facilities had common weaknesses. Improvements to medication administration processes and procedures were needed at all four facilities reviewed. This included three facilities that did not have comprehensive policies and procedures for the administration of medication or the policies and procedures did not have sufficient detail. In addition, three facilities were either missing documentation of some consents from the persons legally responsible for the psychiatric care of the youths for the administration of psychotropic medications, or the consent forms were incomplete. (page 6)

Statutes do not require facilities that provide treatment to children for abuse of alcohol or drugs to have specific policies and procedures for the administration of medication. Other types of children's facilities are required to have specific policies and procedures for the administration of medication. The Legislature may wish to consider enacting legislation to require facilities for the treatment of abuse of alcohol or drugs and that provide residential treatment to children who have been placed in the facility pursuant to an order of a court to adopt policies similar to those adopted for other children's facilities. (page 6)

Summit View Youth Center (reasonable assurance) − Summit View Youth Center provides reasonable assurance that it adequately protects the youths in its care. However, Summit View could improve its medication administration and documentation, ensure timely preparation of mental health documentation, improve suicide prevention documentation, and better ensure safety issues are addressed. (page 11)

Desert Willow Treatment Center (reasonable assurance) − Desert Willow Treatment Center provides reasonable assurance that it adequately protects the youths in its care. However, Desert Willow could improve some policies and procedures, including medication administration. (page 19)

Nevada Homes for Youth (minimal assurance) − The policies and procedures at Nevada Homes for Youth were outdated, incomplete, and did not contain a table of contents, making it difficult for staff to locate key policies and procedures when needed. Medication policies do not establish adequate controls over prescription medication or provide assurance that youths receive their medications. In addition, policies related to treatment plans, safety, and youths' rights are not sufficient to ensure youths receive the services they need. (page 26)

Genesis (minimal assurance) − Genesis's policies, procedures, and processes do not ensure that all youths receive their medication as prescribed or that the administration of the medication is properly recorded. Policies and procedures regarding client rights, including the right to file a grievance, are not complete, are not consistent, and are not being followed. In addition, policies and procedures related to treatment plans, maintaining complete records of required employee training, and safety issues are not complete. Furthermore, the foster care agency's computer does not have a password to protect sensitive information. (page 37)

Audit Division
Legislative Counsel Bureau

Audit Highlights

Highlights of performance audit report on the Investigation Division issued on January 18, 2017. Legislative Auditor report # LA18-01.

Background

The Investigation Division (Division) is a division of the Department of Public Safety. The Division is a law enforcement agency dedicated to public safety statewide. This is accomplished through the professional enforcement of controlled substance laws; by providing comprehensive investigative services to all criminal justice agencies; and, by supporting law enforcement statewide through the collection and dissemination of relevant and timely criminal and threat information.

The Division's headquarters is located in Carson City, with field offices in Elko, Ely, Fallon, and Winnemucca. Funding for the Division is provided primarily from general fund appropriations and grant funding. During fiscal year 2016, the Division's revenues and expenditures amounted to over $6 million. As of June 2016, the Division had 50 authorized, and 48 filled, full-time equivalent positions.

Purpose of Audit

The purpose of the audit was to evaluate the Division's process for administering and tracking fuel procurement, performance measures, and confidential drug buy funds during calendar year 2015.

Audit Recommendations

This audit report contains five recommendations to improve administrative controls over fuel cards, performance measures, and confidential drug buy funds. The Investigation Division accepted the five recommendations.

Recommendation Status

The Investigation Division's 60-day plan for corrective action is due on April 13, 2017. In addition, the six-month report on the status of audit recommendations is due on October 13, 2017.

Investigation Division

Department of Public Safety

Summary

The Investigation Division (Division) can improve administrative controls over certain areas. First, fuel cards and related purchases should be reviewed to verify purchases are made for only Division vehicles. Furthermore, some fuel cards were not canceled when employees left the agency. The Division can also enhance all aspects of determining and reporting adequate and reliable performance measures. Additionally, our review of bank statements revealed control weaknesses existed over certain bank accounts where key duties were not segregated. Finally, although the Division processed confidential drug buy funds accurately, documentation was not consistent among offices.

Key Findings

The Division does not have a process for reviewing fuel purchases. Our review of 45 fuel transactions found 11 (24%) transactions had unexpectedly low miles per gallon (MPG) ratios for assigned vehicles. The Division did not identify or review these purchases. Reviewing fuel card activity will help verify purchases are made for only Division vehicles. (page 3)

The Department of Public Safety does not have an established process to cancel fuel cards for investigators no longer employed by the Division. We reviewed 148 total active fuel cards and found 61 cards were assigned to 26 investigators no longer with the Division. None of the cards had charges after the termination date of the investigator. Division management indicated cards are turned in by investigators upon termination but actual cancellation or deactivation of the card is handled by the Department of Public Safety's fiscal unit who did not notify vendors. (page 4)

The Division can take steps to strengthen the reliability of its performance measures. Underlying records for previously reported measures were not retained, nor did the Division have policies and procedures in place for the calculation and review of performance measures. Performance measures must be reliable because they can affect budget and policy decisions made by oversight bodies, as well as judgments made by stakeholders and the public about the Division's operations. (page 5)

Our review of bank reconciliations revealed control weaknesses over bank accounts in the Carson City office where key duties are not segregated. Our review of outside bank account activity found bank reconciliations were prepared and reviewed by the same employee who is involved in the day-to-day operations of the bank account. Segregation of duties is important in ensuring funds are protected against improper use. The State Administrative Manual requires agencies to have an established system of controls to segregate duties appropriately to safeguard the assets of the agency. (page 6)

The Division processed and tracked confidential drug buy funds accurately, but can make improvements when documenting certain aspects of the process. Criminal cases are developed through the purchase of evidence with drug buy funds issued through an outside bank account. Specifically, documentation used to substantiate cases regarding funds was not always retained. (page 7)

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Audit Division
Legislative Counsel Bureau

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Governor

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MEMORANDUM

To: Rocky Cooper, CPA, Legislative Auditor
Nevada Legislative Counsel Bureau

From: James R. Wells, CPA, Director
Governor's Finance Office

Date: October 13, 2017

Subject: Legislative Audit of the Department of Public Safety, Investigations Division

On January 18, 2017, your office released an audit report on the Department of Public Safety (DPS), Investigations Division (division). The division subsequently filed a corrective action plan on April 4, 2017. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the division to comply with audit findings.

There were five recommendations contained in the report. The extent of the division's compliance with the audit recommendations is as follows:

Recommendations 1

Establish controls to monitor and analyze fuel purchases periodically.

Status – Partially Implemented

Agency Comments – The division reports it has established controls to monitor and analyze fuel purchases. Division Directive 300 sets a priority on the use of fuel cards at filling stations (e.g., purchases must be at Nevada Department of Transportation

(NDOT) pumps unless one is not readily available). In addition, this directive directs the office of the chief or designee to perform quarterly audits of fuel purchases on three randomly selected fuel cards.

Auditor Comments – The first quarterly audit performed by the division included NDOT fuel purchases, but did not include fuel purchases from contracted vendors or oil companies. While NDOT fuel purchases comprise approximately 80 percent, the division should include all fuel purchases in the quarterly audit. The division will include all fuel purchases in the next quarterly audit for the period ending September 30, 2017.

Recommendation 2

Ensure fuel cards are canceled timely when employees leave the agency.

Status – Fully Implemented

Agency Actions – The division established directive 300 "Fuel Card Procedures" to ensure fuel cards are canceled timely. Directive 300 addresses cancellation of fuel cards upon termination or re-assignment of an employee. The division notifies DPS fiscal section to cancel a fuel card. DPS fiscal section cancels the fuel card and notifies the division. We verified there were no fuel cards assigned to terminated or reassigned employees.

Recommendation 3

Develop written policies and procedures for performance measures to ensure reported results are reliable, including data gathering and processing, computations, supervisor review of calculations and methodology, and retention of supporting documentation.

Status – Fully Implemented

Agency Actions – The division developed written policies and procedures for performance measures to ensure reported results are reliable, including data gathering and processing, computations, supervisor review of calculations and methodology, and retention of supporting documentation. Performance measures are calculated based on the division's activities that are entered in one of two computer programs or tracked through a spreadsheet. Monthly, quarterly, and annually the activities' information is reviewed for accuracy. Annually, performance measures are calculated and maintained for the biennial budget information. Information used to calculate performance measures is retained for a minimum of three fiscal years. We reviewed documentation supporting calculation of the performance measures.

Recommendation 4

Ensure duties of bank account daily transactions, bank reconciliations, and bank reconciliation review are segregated.

Status – Fully Implemented

Agency Actions – The division ensures duties of bank account daily transactions, bank reconciliations, and bank reconciliation reviews are segregated. The Administrative Assistants in the outlying offices complete both the bank account daily transactions and the monthly bank reconciliation. Disbursements and deposits require multiple level authorizations including the Division Chief/Deputy Chief. In addition, the division's Administrative Assistant IV (AA IV), who works in the Chief's Office, receives independent bank statements for the outlying office bank accounts and the supporting documentation for disbursements and deposits. The AA IV reviews the bank reconciliations together with the independent bank statements and supporting documentation and follows up on any discrepancies. We reviewed documentation verifying duties are segregated.

Recommendation 5

Update policies and procedures to specify retention of certain documentation of confidential drug buy funds to ensure uniformity across division office locations.

Status – Fully Implemented

Agency Actions – The division has updated policies and procedures to specify the retention of certain documentation of confidential drug buy funds to ensure uniformity across division office locations. Policies and procedures were modified to require all drug buy funds documentation be filed in division case files for both open and closed cases. The case files have specified retention periods defined in the state records management schedule. We verified case files contained required documentation.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

James R. Wells, CPA, Director
Governor's Finance Office

cc: Mike Willden, Chief of Staff, Office of the Governor
James Wright, Director, Department of Public Safety
Patrick Conmay, Chief, Department of Public Safety, Investigations Division
Steve Weinberger, CPA, Administrator, Division of Internal Audits

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January 8, 2018

Members of the Audit Subcommittee
of the Legislative Commission
Legislative Building
Carson City, Nevada 89701-4747

In January 2017, we issued an audit report on the Department of Public Safety, Investigation Division (Division). The Division filed its plan for corrective action in April 2017. NRS 218G.270 requires the Governor's Finance Office to issue a report within 6 months after the plan for corrective action is due, outlining the implementation status of the audit recommendations.

Enclosed is the six-month report prepared by the Governor's Finance Office on the status of the five recommendations contained in the report. As of October 13, 2017, the Finance Office indicated four recommendations were fully implemented and one was partially implemented. The partially implemented recommendation relates to the establishment of controls to monitor and analyze fuel purchases and was expected to be fully implemented by October 2017.

Based on our review of the six-month report and subsequent follow up with staff at the Division, we have determined the partially implemented recommendation is now fully implemented. As a result, we do not have any questions for agency officials.

Respectfully Submitted,

Rocky Cooper, CPA
Legislative Auditor

RC:sy
cc: Michael J. Willden, Chief of Staff, Office of the Governor
James R. Wells, CPA, Director, Office of Finance, Office of the Governor
Steve Weinberger, CPA, Administrator, Division of Internal Audits, Office of the Governor
Patrick J. Conmay, Chief, Investigation Division, Department of Public Safety

(NSPO Rev. 5-17) (O) 1578E

Audit Highlights

Highlights of performance audit report on the Department of Public Safety's Records, Communications and Compliance Division, Information Security issued on January 17, 2018. Legislative Auditor report # LA18-12.

Background

The mission of the Department of Public Safety's (DPS) Records, Communications and Compliance Division (Division) is to support Nevada's criminal justice community and its citizens by providing complete, timely, and accurate information in a manner that balances the need for public safety and individuals' rights to privacy and ensures a positive customer service experience.

The Division has four office locations statewide with two in Carson City and two in Las Vegas. For fiscal year 2017, the Division was authorized 185 full-time equivalent employees statewide.

In the 2013 Legislative Session, the Division's IT staff were removed and consolidated with the Division of Enterprise Technology Services (EITS) within the Department of Administration. The Division relies on EITS for its information technology support.

In fiscal year 2016, the Division had expenditures of $24.9 million. The Division's primary funding source of $15.4 million comes from licenses and fees.

Purpose of Audit

The purpose of our audit was to determine if the Division has adequate information security controls in place to protect the confidentiality, integrity, and availability of its information and information processing systems. Our audit focused on the systems and practices in place during fiscal year 2017.

Audit Recommendations

This audit report contains 10 recommendations to improve the security of the Division's information systems. The Division accepted the 10 recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on April 12, 2018. In addition, the six-month report on the status of audit recommendations is due on October 12, 2018.

Records, Communications and Compliance Division Information Security

Department of Public Safety

Summary

Weaknesses exist in the Division's information security controls. These weaknesses include not disabling and removing former employee network user accounts when they leave Division employment. In addition, some employees did not complete their annual security awareness training. Finally, the Division lacks documentation and review of user access to mission critical applications.

Other security-related controls need improvement. Weaknesses include the Division's lack of a disaster recovery plan, as well as a completed service level agreement with EITS to clarify the scope, quality, responsibilities, and backup requirements of its hosted systems.

Key Findings

Weaknesses exist in managing the Division's network user accounts. Of the Division's 234 network user accounts, we identified 63 accounts of former employees whose network access had not been disabled or removed in a timely manner. Untimely disabling of former employees' network user accounts increases the risk that someone could gain unauthorized access to sensitive criminal justice information. (page 4)

Forty-one of the Division's 179 staff and vendors have not completed their annual security awareness training. State security standards require all state employees to have security awareness refresher training to ensure they stay aware of current security threats, as well as understanding their responsibility to keep state information confidential. (page 5)

The Division does not maintain a master list of authorized users or review system access privileges for several of its mission critical applications. Through these applications, the Division collects and stores sensitive criminal justice information. Without the proper documentation of authorized users and annual review of system access privileges, the Division would not have the ability to determine if current user access was appropriate. State security standards dictate system managers shall reevaluate system access privileges granted to all users annually. (page 5)

The Division does not have a disaster recovery plan. A disaster recovery plan ensures the prioritization of mission critical services for restoration in the event of an emergency. Without a current disaster recovery plan, there is a greater risk that some unforeseeable event or disaster could jeopardize access to sensitive criminal justice information contained in the Division's systems. Timely restoration of such mission critical services could be severely affected when this plan does not exist. For example, public safety could be impacted if DPS was unable to access the criminal history information contained in the Division's systems. (page 7)

A service level agreement is not in place between the Division and EITS. This agreement clearly states what an organization needs, and defines what is expected of a service provider. Without a completed and signed agreement between the Division and EITS, operations continue without a clear commitment in place to clarify the scope, quality, and responsibilities of each party. (page 9)

The Division does not have an agreement in place to communicate backup requirements of its systems hosted with EITS. Without the documentation an agreement provides, the Division is unable to ensure adequate backups are in place for its systems. Adequate backups are essential to ensuring recovery of information and the ability to provide support of critical business functions. We found backups were being performed by EITS, but without the Division's oversight. (page 9)

Brian Sandoval
Governor

Paul Nicks
Acting Director

Susan Brown
Acting Deputy Director

Steve Weinberger, CPA
Administrator

STATE OF NEVADA
GOVERNOR'S FINANCE OFFICE

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MEMORANDUM

To: Rocky Cooper, Legislative Auditor
Legislative Counsel Bureau

From: Paul Nicks, Acting Director
Governor's Finance Office

Date: October 12, 2018

Subject: Legislative Audit of the Department of Public Safety

On January 17, 2018, your office released an audit report on the Department of Public Safety (department), Records, Communications and Compliance Division (division). The division subsequently filed a corrective action plan on April 12, 2018. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the department to comply with audit findings.

There were ten recommendations contained in the report. The extent of the division's compliance with the audit recommendations is as follows:

Recommendation 1

Revise the existing procedure to ensure the network user accounts of former employees are disabled and removed in a timely manner.

Status – Fully Implemented

Agency Actions – The division developed a new "onboarding/off boarding" checklist to document everything a new employee receives including system access and permissions, as well as when an employee transfers or terminates. The checklist also notes when the employee's access to network user accounts is terminated. We reviewed the Employee Checklist/On-board and Off-board instructions, and Employee Checklist/On-board and Off-board checklist effective August 28, 2018 and noted procedures to ensure the network user accounts of former employees are disabled and removed in a timely manner. We also reviewed seven terminated employees since July

1, 2018 and noted employees' access to the network accounts were terminated in a timely manner.

Recommendation 2

Create and maintain a complete list of all network user accounts and verify its accuracy on an annual basis.

Status – Fully Implemented

Agency Actions – The division created an Active Directory spreadsheet from the database its systems feed into to document and maintain a complete list of all network user accounts. The division summarizes user access on a Master User List to verify accuracy of user accounts. This was last performed on June 29, 2018. We reviewed a sample of five user accounts from the Master User List and verified accuracy of user accounts without exception.

Recommendation 3

Revise existing procedures to ensure all employees, vendors, and contractors receive annual security awareness training and maintain an updated list of completed trainings.

Status – Fully Implemented

Agency Actions – The division reports they are refining its use of the FBI's Criminal Justice Information Services Online software to better and more accurately track security awareness training results and expiration dates. In addition, the division created a Security Awareness Training spreadsheet to track and ensure all employees, vendors, and contractors receive annual security awareness training. The division is maintaining an updated list of completed trainings to be reviewed quarterly. We reviewed the list to ensure all division employees were current on security training with no exceptions. We noted 53 vendors in need of training on the listing. The division reports it is contacting, verifying, and advising its vendors and contractors on their compliance or non-compliance for security awareness training.

Recommendation 4

Create a master list of authorized user accounts to critical applications.

Status – Fully Implemented

Agency Actions – The division created a Master User List to document and maintain a complete list of all network user accounts. The division reports critical applications are listed in its service level agreement with Enterprise Information Technology Services (EITS) and was last verified on June 29, 2018. We reviewed a sample of five authorized user accounts and compared it to the Critical Systems listing without exception.

Recommendation 5

Develop procedures to ensure system access privileges to critical applications are reviewed on an annual basis.

Status – Partially Implemented

Agency Actions – The division reports it has held informal meetings with supervisors to discuss roles and responsibilities during the Critical Business Technology Assessment Program project. The division is using its Fingerprint Support Unit as a pilot for setting role-based permissions and mirror the new process within each unit. Individual meetings with supervisors will be held every week until all eight units are converted by November 12, 2018.

Recommendation 6

Review and prioritize current critical information systems and components that support the division's business functions on an annual basis.

Status – Fully Implemented

Agency Comment – The division reviewed and prioritized current critical information systems and components that support the division's business functions on February 14, 2018. We reviewed the division's current critical information systems and components listing and noted items identified as critical systems. The division reports the next annual review is scheduled for February 20, 2019.

Recommendation 7

Develop a disaster recovery plan for the division's systems, applications, and data.

Status – Fully Implemented

Agency Actions – The division developed an initial disaster recovery plan and the division will continue to make adjustments and additions to the document as business practices evolve. We reviewed the disaster recovery plan without exception.

Recommendation 8

Complete a service level agreement between the division and EITS that is reviewed on an annual basis.

Status – Fully Implemented

Agency Actions – The division completed a service level agreement (SLA) with EITS and it will be reviewed on an annual basis. We reviewed the SLA between EITS and the division which covers the EITS service offerings at a high level and the two Computer Facility SLAs specific to services such as internet and servers.

Recommendation 9

Ensure the service level agreement defines backup requirements for the division's systems.

Status – Fully Implemented

Agency Comment – The division completed two specific SLAs with EITS for its two budget accounts to cover backup requirements and schedules. The department's information security officer (ISO) met with the EITS Server Group on August 23, 2018 to review all backup schedules and address recommendations for improved coverage. We reviewed the two SLAs noting backup requirements and schedules.

Recommendation 10

Conduct periodic reviews to ensure schedules and procedures for adequate backups are in place.

Status – Partially Implemented

Agency Actions – The division's ISO met with the EITS Server Group on August 23, 2018 to review the current requirements and schedules to ensure the SLAs match real time. As a result of the review, the division reports it appeared the ISOs may not have been receiving notifications when backups fail to complete successfully. A helpdesk ticket was created to fix the issue so the ISO Team will have visibility on backup status. As of October 4, 2018, the division started receiving notification reports and has a call to meet with the EITS Server Group to better understand the reports.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

Paul Nicks, Acting Director
Governor's Finance Office

cc: Mike Willden, Chief of Staff, Office of the Governor
James M. Wright, Director, Department of Public Safety
Julie Butler, Administrator, Records, Communications, & Compliance Division, Department of Public Safety
Steve Weinberger, CPA, Administrator, Division of Internal Audits

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October 19, 2018

Members of the Audit Subcommittee
of the Legislative Commission
Legislative Building
Carson City, Nevada 89701-4747

In January 2018, we issued an audit report on the Department of Public Safety, Records, Communications and Compliance Division, Information Security (Division). The Division filed its plan for corrective action in April 2018. NRS 218G.270 provides that the Governor's Finance Office shall issue a report within 6 months after the plan of corrective action is due outlining the implementation status of the audit recommendations.

Enclosed is the six-month report prepared by the Governor's Finance Office on the status of the 10 recommendations contained in the audit report. As of October 12, 2018, the Governor's Finance Office indicated eight recommendations were fully implemented and two recommendations were partially implemented. The two partially implemented recommendations are listed below.

Recommendation Number		Status
5	Develop a procedure to ensure system access privileges to critical applications are reviewed on an annual basis.	Partially Implemented
10	Conduct periodic reviews to ensure schedules and procedures for adequate backups are in place.	Partially Implemented

The Division reports it has held informal meetings with supervisors to discuss roles and responsibilities related to system access. The Division is using its Fingerprint Support Unit as a pilot for setting role-based permissions within each unit. Individual meetings with supervisors will be held every week until all eight units are converted by November 12, 2018.

Question

1. Does the Division still anticipate having the eight units converted to the new process by November 12, 2018?

The Division reports it has not been receiving notifications when backups fail to complete successfully. A helpdesk ticket was created to fix the issue. As of October 4, 2018, the

Division started receiving notification reports and plans to meet with the EITS server group to better understand the reports.

Question

2. Has the Division met with the EITS server group to better understand the backup notifications?

Respectfully Submitted,

Rocky Cooper, CPA
Legislative Auditor

RC:sy
cc: Michael J. Willden, Chief of Staff, Office of the Governor
Paul Nicks, Acting Director, Office of Finance, Office of the Governor
Steve Weinberger, CPA, Administrator, Division of Internal Audits, Office of the Governor
James M. Wright, Director, Department of Public Safety (DPS)
Julie Butler, Records, Communications and Compliance Division, DPS

Infrastructure

Audit Highlights

Highlights of performance audit report on the Division of State Parks issued on October 29, 2018. Legislative Auditor report # LA18-22.

Background

The Division of State Parks (Division) was established in 1963, within the State Department of Conservation and Natural Resources. The Division's mission is to provide safe outdoor recreation opportunities for the use, enjoyment, and education of current and future generations, while providing economic benefit to the state and local communities. The Division also preserves and protects scenic, historic, and scientifically significant areas in Nevada.

Nevada state parks are divided into three regions: northern, eastern, and southern. The Division operates 28 state parks that serve over 3.5 million visitors each year.

The Division's main office is located in Carson City with regional offices in Fallon, Las Vegas, and Panaca. In fiscal year 2017 about 43% of the Division's 185 employees were seasonal. Of the 106 permanent positions, 31 were commissioned Nevada peace officers. The Division has seven budget accounts with total expenditures of $14.9 million in fiscal year 2017.

Purpose of Audit

The purpose of this audit was to evaluate the Division's processes relating to the collection of park fees, and the administration of fuel cards and concessions contracts. Our audit focused primarily on the Division's fiscal year 2017 activities; although, we also reviewed fee collection processes in fiscal year 2018, and prior years' concession revenue relating to current concession contracts.

Audit Recommendations

This audit report contains seven recommendations to strengthen administrative processes over fee collections, fuel card oversight, and concessionaire payments.

The Division of State Parks accepted the seven recommendations.

Recommendation Status

The Division of State Parks' 60-day plan for corrective action is due on January 29, 2019. In addition, the six-month report on the status of audit recommendations is due on July 29, 2019.

Division of State Parks

State Department of Conservation and Natural Resources

Summary

The Division can strengthen certain administrative processes over collecting park fees, tracking fuel card use, and reviewing concessionaire payments. Division policies and procedures over the fee collection process are inadequate and leave the Division vulnerable to theft. Additionally, diversifying payment methods and enhancing compliance controls and enforcement could increase revenue to Nevada state parks. We estimate the Division did not collect over $1.2 million in fiscal year 2017 due to visitor noncompliance with required fees. The Division also needs to improve its oversight of fuel card use. The lack of fuel card policies and procedures lead to important administrative controls not occurring, such as accurately tracking fuel card assignments, reconciling mileage with fuel consumption, and monitoring vehicle mileage. Furthermore, the Division can improve its review of concessionaire payments to ensure accuracy in accordance with contract terms.

Key Findings

The Division can improve upon its park fee collection efforts. In fiscal year 2017, the Division collected over $4.3 million in park user fees. We determined the Division has an opportunity to generate additional revenues by strengthening its processes to improve visitor compliance with required fees. We analyzed park visitation and revenue data to estimate the impact of uncollected fees due to visitor noncompliance. We conservatively estimated 30% of park visitors did not pay the required day-use fees in fiscal year 2017, which amounted to over $1.2 million in uncollected revenue. (page 6)

The Division's cash collection from self-pay stations leaves the Division vulnerable to theft from employees and volunteers. Management has identified several methods for detecting theft, but not necessarily preventing theft. Although these methods for theft detection are helpful, stronger controls are needed over the collection of park fees. Division policies and procedures lack specific guidance over park fees collected at the self-pay stations. The procedures require a separation of duties when staffing allows, but do not require two employees present when handling cash, nor do the procedures detail the fee collection process for self-pay stations. (page 9)

By offering visitors different methods for paying park fees, the Division could increase fee revenue. Currently, Nevada state parks collect fees using one or more of three payment methods: self-pay cash stations, staffed fee booths, and self-pay electronic fee stations. Installation of an electronic fee station at Sand Harbor State Park contributed to a 70% increase in entrance fee revenues between October 2017 (when station was installed) and February 2018, compared to fee revenues for corresponding months in the prior year. (page 10)

The Division can strengthen its fee enforcement processes to ensure visitors comply with required park fees. With about 30% of visitors not paying required day-use fees, the Division's enforcement efforts could improve when conveying to park visitors fee expectations and the consequences for not paying. (page 13)

Controls over the administration of fuel cards are weak. We determined the Division's administrative controls over fuel cards do not adequately safeguard against misuse. Fuel card documentation was either incomplete or did not exist. Due to the weaknesses noted in the control system and the lack of policies and procedures over fuel cards, the Division cannot accurately account for all fuel cards and has limited assurance that the cards are being appropriately used for park activities. (page 14)

The Division is unable to effectively monitor fuel card use. Reconciling vehicle mileage to fuel card invoices would help identify improper fuel card use. However, vehicle mileage logs are not consistently tracked throughout the state parks. Additionally, fuel cards are assigned to employees instead of vehicles, making an accurate comparison of vehicle mileage to fuel consumption a challenge. (page 16)

The Division can improve its review of concessionaire payments to ensure the accuracy of fees collected. One of the Division's four concessionaires overpaid the Division about $21,900 between calendar years 2011 and 2017. Although staff indicated payments and supporting documentation are reviewed, no evidence existed documenting this review to identify fee inaccuracies. (page 17)

BRIAN SANDOVAL
Governor

BRADLEY CROWELL
Director

Department of Conservation and Natural Resources

Robert Mergell
Administrator

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STATE OF NEVADA

DEPARTMENT OF CONSERVATION AND NATURAL RESOURCES
DIVISION OF STATE PARKS

1/28/2019

Rocky Cooper, CPA, Legislative Auditor
Legislative Council Bureau
401 S Carson St
Carson City, Nevada 89701

Dear Mr. Cooper,

The following is the Corrective Action Plan related to the findings of the Legislative audit report submitted on September 12, 2018 titled Division of State Parks, Response to Audit Recommendations. Per section 1(c) of NRS 218G.250, the corrective action plan is to be submitted to you within 60 days after receipt of the report, October 30, 2018.

Sincerely,

Robert Mergell
Administrator

RM/ji
Cc: Susan Brown, Director, Governor's Finance Office
Bradley Crowell, Director, Department of Conservation and Natural Resources
Jen Idema, Administrative Services Officer, Division of State Parks

Division of State Parks (NDSP)
Corrective Action response to Audit Recommendations

1. **Develop policies and procedures to strengthen controls over the collection of parks fees, including retrieving money from self-pay fee stations and reconciling monies to fee envelopes. Consider requiring two employees be present for collecting and reconciling fees whenever multiple staff are available.**

As stated in the NDSP's response to the audit recommendations, this is a requirement currently outlined in the Division Fee Manual. This requirement was not followed at parks with only one full time employee and when seasonal staff are not present. See the response to finding #2 for further plans to resolve the issue.

Corrective Action
Update Fee Manual to include 2 staff mandatory for verifying fees from self-pay stations. Revision of Fee Manual to be completed by June 30, 2019.

2. **Perform a cost-benefit analysis to identify parks where installing an electronic fee station would increase fee compliance.**

Parks intent is to put self-pay machines at all the parks where they will function (remote locations may not have adequate cell or satellite service). This will largely eliminate the need for staff to double count deposits as the fees collected from the self-pay stations will be directly deposited to the state's bank account. The agency is also pursuing an on-line reservation system, which would further reduce the amount of cash collected.

Corrective Action
Self-pay machines were requested in the 20-21 biennial budget request. The goal is to put units in as many parks as possible considering connectivity issues with the internet.

3. **Revise policies and procedures over park visitor fee compliance to ensure noncompliance fees are consistently administered among all state parks and to encourage park visitors to pay required fees.**

Parks plans to modify the Fee Manual to make it less discretionary in the enforcement of the noncompliance fees. The Emphasis will be that there is only minimal discretion in imposing noncompliance fees when visitors neglect to use the self-pay stations.

Corrective Action

Revision of Fee Manual by June 30, 2019. A BDR is on this session's agenda to remove the mandatory verbal warning when issuing a citation for not paying an entrance fee to a park. This will assist in staff making fee collection a priority.

4. Establish and implement policies and procedures for monitoring fuel use, including documenting acceptable fuel use, tracking vehicle mileage, and reconciling mileage to fuel consumption.

See response to #5 as it relates to #4 finding. A policy will be developed in the coming months to require the parks and regions to submit monthly reports to the Division office with the mileage of each vehicle. With this, these reports will need to be reviewed and signed off by the park supervisor and/or regional manager. This will then be reconciled to the monthly fuel invoices and backup documentation. Any discrepancies will be reported to the appropriate supervisor for research and investigation if necessary.

Corrective Action

Development of Fuel and Mileage policy by June 30, 2019. This will include reporting by employees of fuel usage and audits to be done by accounting staff and Regional Managers.

5. Improve fuel monitoring controls by assigning fuel cards to vehicles rather than employees.

Parks has already begun the process of assigning cards to vehicles instead of employees. With this process, all cards will be logged at the Division office for tracking. A policy and procedure will then be established for reconciling mileage to fuel consumption as each fuel bill is paid. Completion of this task is estimated to be done at the end of October.

Corrective Action

Fuel cards have now been assigned to each agency vehicle instead of employees. We are currently working with Thomas Petroleum to split the invoices by region for easier reconciliation. This will also be included in the policy as mentioned in #4.

6. Refund calendar year 2011 to 2015 concessionaire overpayments.

The refunds to the concessionaire were processed on 8/2/18 in the amount of $3,482.32 and $4,558.00 on 5/18/18.

Corrective Action

Parks Policy will be updated by March 1st, 2019 to include this additional review by the Administrative Services Officer.

7. Enhance concession policies and procedures to include a detailed process for reviewing concession fee revenue, including supervisory review.

The Administrative Services Officer has started reviewing and initialing the fee calculations quarterly. The policy will also be updated to reflect this review requirement.

Corrective Action
Parks Policy will be updated by March 1st, 2019 to include this additional review by the Administrative Services Officer.

Audit Highlights

Highlights of performance audit report on Nevada's Division of Forestry issued on October 29, 2018. Legislative Auditor report # LA18-21.

Background

Nevada's Division of Forestry (NDF) was established in 1957 within the State Department of Conservation and Natural Resources. NDF's core mission is to protect, conserve, and enhance the state's natural resources and provide protection from wildfire. To support its mission, NDF manages and coordinates all forestry, nursery, endangered plant species, and watershed resource activities on qualified public, state, and private lands.

NDF's programs include Wildland Fire Protection Program, Fire Suppression, Conservation Camps, and Forestry Nurseries.

In fiscal year 2017, NDF was primarily funded with appropriations of $24.2 million, program revenues of $4.7 million, and federal grants totaling $3.1 million. As of April 2018, NDF had 160 filled positions located in its Carson City, Elko, Ely, Carlin, Las Vegas, Minden, Pioche, Tonopah, Washoe Valley, Wells, and Winnemucca offices and conservation camps. During fire season, NDF hires up to 74 additional staff on a seasonal basis. NDF is headquartered in Carson City and operates three regional offices in Elko, Las Vegas, and Washoe Valley.

Purpose of Audit

The purpose of this audit was (1) to evaluate financial and administrative controls related to certain contracts and cooperative agreements and determine whether they comply with state laws, regulations, and other requirements; and (2) to evaluate the effectiveness of operations and administrative controls over the Nursery Program. The scope of our audit included a review of certain financial and administrative processes over the Conservation Camp Program contracts, the Wildland Fire Protection Program, and the Nursery Program operations during fiscal years 2015 through 2017.

Audit Recommendations

This audit report contains 12 recommendations to improve administrative and financial controls over Conservation Camp Program contracts, the Wildland Fire Protection Program, and Nursery Program operations.

NDF accepted the 12 recommendations.

Recommendation Status

NDF's 60-day plan for corrective action is due on January 29, 2019. In addition, the six-month report on the status of audit recommendations is due on July 29, 2019.

Division of Forestry

State Department of Conservation and Natural Resources

Summary

Nevada's Division of Forestry (NDF) can improve controls over contract administration of Conservation Camp Program projects and Wildland Fire Protection Program (WFPP) interlocal agreements. Conservation camp projects were often completed without properly executed contracts in place. Additionally, documentation was frequently not sufficient to justify reduced-rate and non-reimbursable projects. For the WFPP, the Division should also formalize the rate setting process and document assumptions used to establish future participant rate assessments. Current rates cannot be recalculated as supporting documentation and assumptions were not maintained. Finally, administration of non-fire suppression services can be enhanced to include uniform documentation of projects requested by participants and performed by staff, and to improve tracking and communicating the value of services provided to participating jurisdictions.

NDF can improve the effectiveness of its operations and administrative controls over the Nursery Program. Improvements include restructuring its strategic plan and implementing consistent operating practices at both locations to enhance the fiscal sustainability of the program. We found sales discounts were often given without adequate documentation to determine the appropriateness of the discount. NDF's processes are also not sufficient to verify or enforce certain statutory and regulatory requirements limiting sales to conservation purposes. Finally, controls over growing agreements need significant improvement.

Key Findings

Conservation camp projects were often completed without a properly executed agreement in place. Agreements for 17 of 56 (30.4%) projects we requested during fiscal years 2016 and 2017 could not be provided by NDF. Of the 39 conservation camp agreements received, 24 (66.6%) did not have adequate approvals. Additionally, three project agreements (7.7%) were dated and signed after work had commenced. Having a properly executed project contract prior to work commencing is important because without a contract in place, the State could be liable for injury or damages caused by conservation camp crews or could result in lost revenues to the Division. (page 7)

Non-reimbursable and reduced rate conservation camp projects were often not properly approved or did not include supporting documentation for reduced rates. Of 30 nonstandard rate agreements reviewed, 9 (30%) agreements did not include a Project Type and Rate Justification Form. Additionally, 18 of 20 (90%) nonstandard rate agreements that included a justification form did not include sufficient supporting description or details indicating how the appropriateness of the reduced rate was determined. Furthermore, none of the 20 nonstandard rate agreements with justification forms had evidence of area supervisor or Carson City office review or approval on the form. (page 8)

County representatives in participating jurisdictions indicated they are satisfied with the services provided by NDF through the WFPP, although we found oversight and management of the program can be improved. NDF should formalize and document the formula for calculating future county assessment rates. Existing rates cannot be recalculated as supporting documentation and assumptions were not maintained. Non-fire suppression projects requested by participants, and performed under the WFPP should be uniformly documented. Furthermore, when these types of projects are performed, costs associated with non-fire suppression projects should be tracked and communicated to participating jurisdictions. (page 9)

Our review of NDF's Nursery Program's strategic plan and operations identified various opportunities for improvement including maintaining a current and relevant plan with specifically defined objectives and goals. Opportunities include updating the plan to provide product pricing, operational guidance, and consistency between locations to set the direction for the nurseries' operations. Additionally, the plan should identify long-term goals and corresponding actions to solidify the Nursery Program's long-term viability. (page 14)

Nurseries' pricing practices were inconsistent and not adequately documented, even though plant pricing is required to be formalized by the State Forester and approved by the Director of the State Department of Conservation and Natural Resources. Consistent pricing, based on an evaluation of operations and cost, will help ensure prices are adequately covering the costs of operations. (page 16)

Controls over cash receipts at nurseries need to be strengthened due to limited segregation of duties. Our review of bank deposits also identified control weaknesses over revenues recorded for each nursery location, and NDF's fiscal staff do not reconcile received and recorded revenues in the nursery sales system to what is recorded in the state accounting system. Controls to compensate for lack of segregation of duties are important in ensuring funds are safeguarded. (page 18)

BRADLEY CROWELL, *Director*
Department of Conservation and Natural Resources

STEVE SISOLAK
Governor

KACEY KC
State Forester/Firewarden

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January 29, 2019

Mr. Rocky Cooper, CPA
Legislative Auditor
Legislative Council Bureau
401 S. Carson Street
Carson City, NV 89701

Dear Mr. Cooper:

The Legislative Council Bureau audited the Nevada Division of Forestry (NDF) in 2018, submitting a final report with twelve recommendations on December 10, 2018. NDF accepted all of the findings and submitted an initial report showing the status of each recommendation on September 10, 2018. At that time, NDF had already begun implementing actions to correct many of the findings. Today, NDF continues working diligently to fully address all recommendations. Following is a written statement documenting the status of all implemented recommendations, with backup documents attached, and dates of completion for those recommendations not yet fully implemented.

1. Develop controls to ensure compliance with existing policies and procedures requiring a project agreement be executed and properly approved, prior to project commencement, and submitted to the Carson City office.

Status - Partially Implemented

NDF has reviewed, updated, and developed additional controls within the Conservation Camp Program Operating Guidelines and is awaiting administrative review and approval. Project agreement, completion, and execution procedures have been improved, and Conservation Camp Program staff have enhanced monitoring and oversight of all existing and new project agreements prior to project implementation. NDF has revised the project agreement, which now includes enhanced levels of justification, review and approval. NDF anticipates fully implementing the recommendation by May 2019.

2. Enhance current policies and procedures over nonstandard rate projects to include documenting the rationale used to determine and calculate a nonstandard rate, and to require documentation and review of appropriate management approval of all nonstandard rate projects.

Status - Partially Implemented

NDF has been reviewing and developing procedural controls within the Conservation Camp Program Operating Guidelines addressing non-standard rate establishment. The new controls will provide clear guidelines for determining projects that qualify for a non-standard rate. The Operating Guidelines will also establish project prioritization guidelines and policy. This will provide staff with clear direction to accomplish alignment with NDF's goals and mission. NDF will draft the Conservation Camp Program Operating Guidelines by March 2019, and review, approve and implement them by May of 2019.

3. Formalize and document Wildland Fire Protection Program assumptions and processes for calculating future assessment rates charged to counties.

Status - Partially Implemented

NDF will formalize and document the assumptions and process for calculating the assessment rates for Wildland Fire Protection Program (WFPP) partners. NDF has compiled historical fire expense data for all participants that it will use as part of the process. NDF is pursuing software upgrades that should enhance NDF's ability to accurately and timely recover fire cost data and streamline the assessment calculation. NDF has created an executive committee with its WFPP partners to assist in developing rates for the WFPP. The executive committee's first meeting is February 2019. NDF expects to finalize the rate decisions by May 2019, and have all participant contracts in place by July 1, 2019.

4. Develop written policies and procedures over the Wildland Fire Protection Program to standardize documentation of oversight and activity requests for non-fire suppression activities from participants.

Status - Partially Implemented

NDF has statutory responsibility for wildland fire response, fire mitigation, and rehabilitation. NDF will assist the counties in all risk response through a billable process, as requested, or will assist the Department of Emergency Management in all risk response, when elevated to the state level through an interagency agreement. All-hazard assistance is not tied to the WFPP program. Therefore, NDF proposes eliminating the clause in the WFPP agreement that provides NDF assets for all hazard response at no charge. NDF has drafted a new contract that is awaiting discussion and approval by the WFPP executive committee. NDF expects to have the all participant contracts updated and in place by July 1, 2019.

5. Develop a process to communicate with jurisdictions the Wildland Fire Protection Program resources and services provided on their behalf.

Status - Partially Implemented

By agreement, NDF holds an annual meeting to explain these benefits to partners. NDF will further clarify roles and responsibilities through the creation of Annual Operating Plans attached to each participant agreement. NDF will also use verbal and written communication with WFPP partners to document the resources and associated value of the services NDF provides. NDF expects to have these processes completed after the February 2019 executive committee meeting, and implemented with the new contract approvals by July 1, 2019.

6. Update and restructure the Nursery Program's strategic plan it include updated objectives and related strategies, and ways to increase customer base and revenue.

Status - Fully Implemented

In July 2018, NDF completed an updated the strategic plan for the nursery and seed bank program, collectively referred to as the Plant Material Program. The plan contains updated objectives and identifies opportunities for increasing the Plant Material Program's customer base and revenue. See the attached Plan.

7. Evaluate and update the pricing structure of flora, consistent with NRS 528.105, to optimize revenues and to ensure the long-term sustainability of the program.

Status - Partially Implemented

NDF is currently determining and collecting production costs for the most recent operating periods available. NDF will input these costs into a pricing model that will calculate the prices charged per plant. Once all of the costs are collected and input, NDF will run the model to provide a new pricing structure, including provisions for discounts identified below in Item #8. The State Forester and Director of the Department of Conservation and Natural Resources will review and approve the formalized pricing structure (NRS 528.105 compliance) before it is incorporated into the Nursery Program Standard Operating Procedures (SOP) and implemented by the Nursery Program Staff. NDF will complete these actions and implement the new pricing structure for all sales by May 2019.

8. Develop written policies and procedures over recording nursery sales to include documentation of circumstances and timeframes under which discounts or voids are applicable and appropriate.

Status - Partially Implemented

NDF Nursery Staff have been drafting a Nursery Program SOP manual since early 2018. The manual will include procedures and an approval process for price discounting and plant voids. The Nursery Program SOP will be drafted for review by March 1, 2019, and will be approved and implemented by May 2019.

9. Establish a process and develop policies and procedures to compare and reconcile sales recorded in the nursery sales system to deposit amounts recorded in the state accounting system for each nursery location.

Status - Partially Implemented

NDF Nursery and Fiscal staff have been working together to create a process whereby limited segregation of duties is compensated for by additional internal controls for receiving, recording, processing, and reporting sales and revenues to ensure security of deposits. At the core of the procedure will be a reconciliation process for received, recorded, and deposited revenues between the nursery sales program and the state accounting system. The procedures will include meeting deposit timeframes stipulated by NRS 353.250, and will be incorporated into the above state SOP. The Nursery Program SOP will be drafted for review by March 1, 2019, and will be approved and implemented by May 2019.

10. Improve efforts to ensure statutory and regulatory requirements for sales to private parties are adhered to by requiring customers' physical addresses before processing sales, and requiring customers' signatures on the forms to acknowledge proper use of conservations materials.

Status - Fully Implemented

NDF Nursery Program staff verified that some of the order forms used had the standard language (including statutory and codified limitations and qualifications) removed. Additionally, procedures were missing to ensure customer compliance with the law before a sale was finalized. The Nursery Program has now included the standard language on all sales forms as demonstrated in the attached sales forms. The Nursery Program SOP is being updated with the language and direction for the completeness standards (including physical address, confirmation outside of city limits, parcel size, statutory reason for purchase, and customer signature) for all forms, which must be submitted prior to processing a sale. The Nursery Program SOP will be drafted for review by March 1, 2019, and will be approved and implemented by May 2019.

11. Develop written policies and procedures for records maintenance that ensure information related to nursery contracts is historically accurate and contracts are easily retrievable.

Status - Partially Implemented

NDF Nursery Program Staff are currently drafting procedures to be included in the Nursery Program SOP manual that include storage of all growing contracts on the agency server, a defined organizational system, and duration of retention. The procedures will also mandate completeness standards for all contracts and agreements to ensure they are all fully executed before being filed or implemented. According to these new procedures, when discounts are given, the contract must cite the specific reason for the discount in the section of the Nursery Program SOP. The Nursery Program SOP will be drafted for review by March 1, 2019, and will be approved and implemented by May 2019.

12. Develop written policies and procedures over nursery contracts and growing agreements to define circumstances under which deposits are required and associated deposit percentages, to ensure proper approvals are obtained prior to contract and growing agreement commencement, and to ensure equitable pricing practices are followed for volume discounts.

Status - Partially Implemented

The NDF Nursery Program SOP manual is currently being drafted and will include standards for required contract deposits, including percent of the agreed upon sale price and start-up costs incurred to protect the nursery in case of forfeiture. The SOP will include internal controls to ensure established processes are followed. The Nursery Program SOP manual will be fully drafted for review by March 1, 2019, and will be fully approved and implemented by May 2019.

Please contact me if you have any questions regarding the actions NDF is taking in response to the twelve LCB audit recommendations.

Sincerely,

Kacey KC
State Forester Firewarden

cc: Bradley Crowell, Director DCNR
Dominique Etchegoyhen, Deputy Director DCNR
Dave Prather, Deputy Administrator – Fiscal NDF
John Christoperson, Deputy Administrator – Operations NDF
August Isernhagen, Camp Program Manager NDF
Ryan Shane, Resource Program Manager NDF
Ron Bollier, State Fire Program Manager NDF

Audit Highlights

Highlights of performance audit report on the Bureau of Safe Drinking Water issued on May 2, 2018. Legislative Auditor report # LA18-17.

Background

The mission of the Bureau of Safe Drinking Water (Bureau) is to protect the health of the citizens and visitors of Nevada by ensuring that public water systems provide safe and reliable drinking water. The Bureau is a part of the Division of Environmental Protection, tasked with maintaining Nevada's primary implementation and enforcement authority (primacy) for the Federal Safe Drinking Water Act (SDWA) granted in 1978.

The SDWA aims to protect public water supplies from harmful contaminants. The United States Environmental Protection Agency sets national, enforceable standards to protect against particular contaminants shown to cause health problems. Public water systems are responsible for ensuring that contaminants in drinking water do not exceed the standards, by treating their water, and having it frequently tested by water quality testing laboratories.

The Bureau licenses and regulates public water systems and water quality testing laboratories. Through facility inspections, engineering plan reviews, technical assistance, ongoing monitoring efforts, and enforcement activities, the Bureau assists public water systems in safeguarding the safety of drinking water.

The Bureau regulated 598 public water systems and 97 water quality testing laboratories in fiscal year 2017. The majority (82%) of Nevadans are served by five public water systems. The Bureau had expenditures of about $3.4 million in fiscal year 2017. Primary funding sources were federal grants and fees.

Purpose of Audit

The purpose of this audit was to determine whether the Bureau is effectively regulating public water systems and water quality testing laboratories to help ensure safe and reliable drinking water. Our audit focused on Bureau activities in fiscal years 2016 and 2017.

Audit Recommendations

This audit report contains three recommendations to strengthen the Bureau's drinking water efforts.

The Bureau accepted the three recommendations.

Recommendation Status

The Bureau's 60-day plan for corrective action is due on July 27, 2018. In addition, the six-month report on the status of audit recommendations is due on January 27, 2019.

Bureau of Safe Drinking Water

Division of Environmental Protection

Summary

The Bureau of Safe Drinking Water (Bureau) ensures that Nevadans are provided with safe and reliable drinking water. The Bureau effectively supervises public water systems and water quality testing laboratories through regular monitoring of water quality samples, facility inspections, and permitting. However, the Bureau did not always inspect laboratories timely. Additionally, for some small water facilities, the Bureau did not follow up on inspection deficiencies. Implementing these enhancements would strengthen the Bureau's drinking water efforts.

Although the Bureau has provided information to school districts regarding a new voluntary project to test for lead in school drinking water, most school districts have not taken advantage of this project funded by a federal grant. After the project's first year, many schools have not yet been tested for lead, though the Division has received commitments for testing from most districts.

Key Findings

Reviews of water quality testing allow the Bureau to identify and address problems with drinking water standards. Water system operators take samples for numerous contaminants frequently, in some cases hundreds every month. Samples are tested by certified water quality testing laboratories and reported directly to the Bureau. Based on our review of testing data and problem follow up, the Bureau monitored water quality results and ensured any problems were resolved timely. (page 4)

The Bureau's water facility inspections provide assurance that public water systems maintain substantial compliance in many key areas designed to ensure water quality and reliability. For 30 public water system inspections we reviewed, inspections were thorough and any issues noted were usually resolved timely. However, in a few instances, some concerns noted during inspections of small water systems were not followed up on until our inquiries. Lastly, we found inspections were timely for all active public water systems. (page 6)

The Bureau has an effective process for reviewing system plans for water operations, ensuring they are prepared and designed appropriately, in accordance with federal and state laws and regulations. Water systems must submit plans for Bureau review and approval. Additions and modifications for facility operations must also be submitted for Bureau review. In our review of 10 addition and modification requests, we found the Bureau conducted thorough assessments. (page 7)

The Bureau's proficiency testing program allows the Bureau to assess and ensure the accuracy of water quality testing conducted by certified laboratories. Water quality testing laboratories are certified in various methods, which are specific types of tests used to assess contaminants. Laboratories must demonstrate to the Bureau that they are proficient in each certified method by accurately testing a water sample provided by an independent third party every 6 months. The proficiency results for 10 laboratories we reviewed were complete and acceptable for each certified method. (page 9)

The Bureau's onsite laboratory inspections provide assurance that water quality testing laboratories have sufficient expertise and procedures to accurately assess water samples. In our review of 28 laboratories, inspections were comprehensive and any issues noted were resolved quickly. However, when we reviewed inspections for all Nevada laboratories, we found that inspections were not always timely. Nevertheless, all inspections were eventually completed, and most untimely inspections were only a few months late. (page 10)

The Bureau has an extensive process for certifying laboratories to perform water quality tests. Laboratory operations are reviewed to ensure compliance with federal and state laws and regulations, as well as several industry best practices adopted by reference in state regulation. These standards, as assessed by the Bureau promote the consistency and accuracy of water quality testing. (page 11)

Although the Bureau has provided information to school districts regarding a new voluntary project to test for lead in school drinking water, most school districts have not taken advantage of this project funded by a 2-year federal grant. After the project's first year, many schools have not yet been tested for lead, though the Division has received commitments for testing from most districts. For those tested, a very small portion showed unacceptable lead levels at one or more water fixtures. These incidents were resolved by replacing problem water fixtures. The voluntary project pays for schools to test for lead and receive replacement equipment through a federal grant. The Bureau coordinates with public water systems to provide testing personnel to conduct testing, and provides informational and technical assistance. (page 13)

Steve Sisolak
Governor

Susan Brown
Director

Paul Nicks
Deputy Director

Warren Lowman
Administrator

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MEMORANDUM

To: Rocky Cooper, Legislative Auditor
Nevada Legislative Counsel Bureau

From: Susan Brown, Director
Governor's Finance Office

Date: January 27, 2019

Subject: Legislative Audit of the Department of Conservation and Natural Resources, Division of Environmental Protection, Bureau of Safe Drinking Water

On May 2, 2018, your office released an audit report on the Department of Conservation and Natural Resources – Division of Environmental Protection (division), Bureau of Safe Drinking Water (bureau). The division subsequently filed a corrective action plan on July 27, 2018. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the division to comply with audit findings.

There were three recommendations contained in the report. The extent of the division's compliance with the audit recommendations is as follows:

Recommendation 1

Develop additional controls to ensure deficiencies noted on water system inspections are resolved.

Status – Fully Implemented

Agency Actions – The division developed additional controls to ensure inspection deficiencies noted on water system inspections are resolved. First, the division modified its Safe Water Information Field Tool (SWIFT) to document sanitary surveys. Second, the division updated its Standard Operating Procedures (SOPs) and developed standardized letter templates to help guide staff in communicating with Public Water Systems ("systems") and tracking deficiencies. Third, the division committed additional resources to the bureau's compliance staff in January 2018 by adding a Rules Manager whose duties focus on sanitary surveys and required follow-up actions. Additionally, the bureau's compliance branch is now fully staffed. Fourth, the division developed a query

of the Environmental Protection Agency's (EPA's) Safe Drinking Water Information System (SDWIS) database to identify and report systems with deficiencies and also classify deficiencies as approaching or in excess of the federal 120 day correction guideline. The Rules Manager issues the query reports monthly to update supervisors, facility managers, compliance staff, and senior bureau management. Fifth, the division completed staff training in December 2018 on the updated procedures for addressing sanitary survey deficiencies.

We reviewed the January 2, 2019 status, as reported by SDWIS, of all significant deficiencies for the three systems identified in the audit report as having missing or late corrective action plans (CAPs). We noted all past significant deficiencies were resolved and new surveys performed on two of the systems disclosed no new significant deficiencies. Also, we reviewed the updated SOPs noting the procedures provide general guidance on sanitary surveys and regulatory timelines; detail guidance on follow-up for both minor and significant deficiencies; and detailed guidance on resolving sanitary survey deficiencies. Further, we reviewed the query reports for December 2018 noting the bureau achieved a 24 percent reduction in all deficiencies past due in December 2018 as compared to December 2017.

Auditor Comments – Section one of NAC 445A.4665 requires systems to submit a CAP for any significant deficiency to the division within 45 days of receipt of the sanitary survey.[1] The division represented it was not able to provide a status report showing compliance with NAC 445A.4665 for all systems. The division explained that SDWIS, its tracking database, did not have the ability to track state specific requirements as it was developed by the EPA to track federal requirements. The division further explained that its bureau staff documents compliance with NAC 445A.4665 by notations in each system's compliance file. We reviewed the compliance files for the five largest systems in terms of population served from a total of 40 systems listed by SDWIS as having significant deficiencies outstanding for more than 45 days as of January 3, 2019. The five systems represent about 81 percent of a total of about 19,000 people served by all systems listed. We noted all substantial compliance for all five systems with NAC 445.4665 for their most recent sanitary surveys.

The division reports it has implemented an off-SDWIS tracking system to be able to report compliance with NAC 455A.4665 for all systems and has updated its SOPs to provide guidance for generating and distributing monthly deficiency tracking sheets.

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[1] NAC 445A.4665 Sanitary surveys: Significant deficiencies. (NRS 445A.855, 445A.860)

1. Any significant deficiency noted in a sanitary survey must be addressed in writing to the Division or to the appropriate district board of health and must include a proposed implementation plan and schedule for correction of the deficiency within 45 days after the receipt of the sanitary survey report by the public water system.

Recommendation 2

Clarify policies and procedures on the frequency for conducting laboratory inspections.

Status – Fully Implemented

Agency Actions – The division clarified its policies and procedures on the frequency for conducting laboratory inspections. The division implemented a new Excel inspection tracking system to monitor compliance with the two-year inspection frequency requirement of Nevada regulations. As of November 30, 2018, the division reported it was in full compliance with the two-year requirement. We reviewed the "Onsite Assessment Schedule" from the inspection tracking system for November 30, 2018 noting no exceptions.

In addition, the division reports it intends to propose a revision to its regulations in fiscal year 2020 to codify a ± 90 day flexibility timeframe in meeting the two-year inspection frequency requirement.

Recommendation 3

Continue working with school districts and public water systems to advance lead testing efforts.

Status – Partially Implemented.

Agency Actions – The division continues to work with school districts and public water systems to advance lead testing efforts. As of January 3, 2019, the division reports participation by 16 of 18 school districts (including state sponsored charter schools), with testing completed for 358 or about 92 percent of eligible schools, as compared to the 189 or about 48 percent of eligible schools tested as of January 2018 reported by the audit. Only Humboldt and Pershing Counties, with a total of nine eligible schools, have failed to respond to the division's requests to participate. We reviewed the division's tracking spreadsheet for the lead testing in schools project noting no exceptions.

In addition, the division reports that it has successfully negotiated with the EPA for a 12-month federal grant time extension to September 2019 along with an associated workplan revision to maximize the use of unspent grant funds. The workplan revision allows the expansion of the testing project to middle and high schools as district interest and funding allows. Additionally, the EPA requested the division to identify privately owned elementary-aged schools that are not on district rolls. Those schools will also be targeted for project participation. The division reports its continued commitment to achieving 100 percent participation of the eligible schools in the original project scope and maximizing the use of the $72,000, of the original $98,000 in grant funds that currently remains unspent.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

Susan Brown, Director
Governor's Finance Office

cc: Michelle White, Chief of Staff, Office of the Governor
Bradley Crowell, Director, Department of Conservation and Natural Resources
Greg Lovato, Administrator, Division of Environmental Protection
Warren Lowman, Administrator, Division of Internal Audits

Audit Highlights

Highlights of performance audit report on the Nevada Department of Wildlife issued on January 18, 2017. Legislative Auditor report # LA18-05.

Background

The Nevada Department of Wildlife's (NDOW) mission is to protect, preserve, manage, and restore wildlife and its habitat for the aesthetic, scientific, educational, recreational, and economic benefits to citizens of Nevada and the United States, and to promote the safety of persons using vessels on the waters of Nevada.

NDOW consists of a Director's Office and the following seven divisions: Conservation Education, Fisheries, Game, Habitat, Law Enforcement, Operations, and Wildlife Diversity. The Board of Wildlife Commissioners is responsible for establishing policy, setting annual and permanent regulations, reviewing budgets, and receiving input on wildlife and boating matters from entities, such as the 17 county advisory boards.

As of June 30, 2015, NDOW had 283 filled positions located in its Elko, Ely, Fallon, Henderson, Las Vegas, Reno, and Winnemucca offices. In fiscal year 2015, NDOW was primarily funded by licenses and fees of $17.2 million and federal grants of $15.5 million. In addition, NDOW received a General Fund appropriation of about $495,000 in fiscal year 2015.

Purpose of Audit

The purpose of this audit was to evaluate the Department's strategic planning process, including the relevance and reliability of performance measures. Our audit focused on fiscal year 2014 performance data, extending to fiscal year 2015 based on the availability of performance data.

Audit Recommendations

This audit report contains four recommendations to strengthen the agency's strategic planning and performance measurement processes.

The Department accepted the four recommendations.

Recommendation Status

The Department's 60-day plan for corrective action is due on April 13, 2017. In addition, the six-month report on the status of audit recommendations is due on October 13, 2017.

Nevada Department of Wildlife

Summary

NDOW can take steps to strengthen its strategic planning process. Strategic planning is a long-term, future-oriented process of assessment, goal setting, and decision making. It includes a multi-year view of objectives and strategies essential for the accomplishment of agency goals. Our review of NDOW's strategic planning process revealed opportunities for improvement. An up-to-date strategic plan organized by division, with all key strategic planning components identified, will assist the agency in effectively using the plan to achieve and communicate its mission, goals, and objectives.

Improvements are needed regarding the oversight of activities related to the proper administration of performance measures. We found reported results for measures were not always reliable. Improvements are also needed to align measures with the agency's strategic plan and key program activities. Furthermore, additional guidance and oversight can improve the reliability of the agency's measures. Performance measures facilitate accountability and provide an opportunity to evaluate success in achieving goals. Measures must also be reliable to help the Governor, Legislature, and agency officials make informed budgetary and policy decisions.

Key Findings

NDOW's strategic plan is missing certain required components. The agency's plan does not include its mission statement or performance measures, fundamental components necessary to guide the agency in its strategic planning process. (page 9)

The Department's strategic plan is not used in its daily operations. A successful strategic plan enhances decision making by improving internal communication. By not utilizing its strategic plan, the agency is losing out on the many benefits a strategic plan provides. (page 10)

NDOW's strategic plan is outdated and incomplete. Since it was created in 2009, certain outcomes, goals, and objectives are no longer relevant, and revisions are needed to reflect current operations. Our review also revealed incomplete desired outcome and objective statements, as well as unresolved comments and remarks. Management and staff indicated that they are taking steps to improve upon their strategic planning process. The agency plans to revise their strategic plan by July 2017. (page 11)

Performance measures cannot be considered reliable unless they are supported by sufficient underlying records. Our review of NDOW's fiscal year 2014 and 2015 performance measures revealed 16 of 20 measures and 3 of 19 measures were not adequately supported. (page 14)

Performance measures are reliable when the reported results are calculated using a sound and consistent methodology. Our review found 5 of 20 fiscal year 2014 measures and 2 of 19 fiscal year 2015 measures were calculated using an inappropriate methodology. Additionally, three 2015 measures were not calculated in the same manner as in previous years. (page 14)

Certain performance measures were not reliable due to mathematical errors. Our review found one 2014 and three 2015 measures to be inaccurate. The mathematical errors stemmed from manual counts of hardcopy reports and spreadsheet data. Although the mathematical errors were relatively minor, these errors went undetected because of the lack of review over performance data calculations. (page 15)

Some performance measurement descriptions did not match what was reported. Our review found three 2014 and one 2015 measurement title did not reflect reported information. (page 15)

Most performance measures are not aligned with the agency's objectives included in its strategic plan. Our review of fiscal year 2014 and 2015 performance measures revealed 19 of 20 measures and 18 of 19 measures did not relate to a corresponding agency objective. (page 16)

Department policies and procedures do not provide adequate guidance to assist staff with measuring performance. During our testing, division administrators were in the process of developing measurement procedures; however, we found 16 of 20 fiscal year 2014 measures and 14 of 19 fiscal year 2015 measures still lacked adequate procedures. (page 17)

NDOW's current practice for developing, maintaining, and monitoring performance data makes it difficult to assess performance. We found five of the agency's eight divisions do not use their performance measures to manage daily activities. Seven of the eight divisions also did not calculate their fiscal year 2015 measures until July 2016. (page 19)

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

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MEMORANDUM

To: Rocky Cooper, Legislative Auditor
Legislative Counsel Bureau

From: James R. Wells, CPA, Director
Governor's Finance Office

Date: October 13, 2017

Subject: Legislative Audit of the Nevada Department of Wildlife

On January 18, 2017, your office released an audit report on the Nevada Department of Wildlife (department). The department subsequently filed a corrective action plan on April 13, 2017. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the department to comply with audit findings.

There were four recommendations contained in the report. The extent of the department's compliance with the audit recommendations is as follows:

Recommendation 1

Update the strategic plan to ensure compliance with state law and policy, including planning components and activity level reporting, and establish a process to ensure the plan is periodically updated.

Status – Partially Implemented

Agency Actions – The department is currently updating the strategic plan to ensure compliance with state law and policy, including planning components and activity level reporting, and establishing a process to ensure the plan is updated every three to five years. Additionally, the department is requiring each division, including the Director's Office, to develop their own strategic plan. The department anticipates full implementation of this recommendation by December 31, 2017.

Recommendation 2

Complete written policies and procedures for compiling performance measures to help ensure reported results are reliable, including appropriate measurement descriptions and computations, supervisory review of calculations and methodology, and retention of supporting documentation.

Status – Partially Implemented

Agency Actions – The department is currently refining draft policies and procedures for compiling performance measures to help ensure reported results are reliable, including appropriate measurement descriptions and computations, supervisory review of calculations and methodology, and retention of supporting documentation. The department anticipates full implementation of this recommendation by December 31, 2017.

Recommendation 3

Evaluate and revise performance measures to help ensure proper alignment of measures with the strategic plan and that key program activities are measured.

Status – Partially Implemented

Agency Actions – The department is currently evaluating and revising performance measures to help ensure proper alignment of measures with the strategic plan and that key program activities are measured. The department anticipates full implementation of this recommendation by December 31, 2017.

Recommendation 4

Ensure applicable staff receives adequate training for compiling performance data in a timely manner and using the data to manage the agency's operations.

Status – Fully Implemented

Agency Actions – The department ensured applicable staff received adequate training for compiling performance data in a timely manner and using the data to manage the department's operations. We reviewed the department's vendor provided training materials and the training class roster, verifying attendance of the appropriate staff.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

James R. Wells, CPA, Director
Governor's Finance Office

cc: Michael Willden, Chief of Staff, Office of the Governor
Tony Wasley, Director, Department of Wildlife
Elizabeth O'Brien, Deputy Director, Department of Wildlife
Steve Weinberger, CPA, Administrator, Division of Internal Audits

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SUSAN E. SCHOLLEY, *Research Director* (775) 684-6825

January 8, 2018

Members of the Audit Subcommittee
of the Legislative Commission
Legislative Building
Carson City, Nevada 89701-4747

In January 2017, we issued an audit report on the Nevada Department of Wildlife (Department). The Department filed its plan for corrective action in April 2017. NRS 218G.270 requires the Governor's Finance Office to issue a report within 6 months after the plan for corrective action is due, outlining the implementation status of the audit recommendations.

Enclosed is the six-month report prepared by the Governor's Finance Office on the status of the four recommendations contained in the audit report. As of October 13, 2017, the Governor's Finance Office indicated that one recommendation was fully implemented and three recommendations were partially implemented. The three partially implemented recommendations concern updating the strategic plan, refining draft policies and procedures for performance measures, and evaluating and revising performance measures. The three partially implemented recommendations are shown below.

Recommendation Number		Status
1	Update the strategic plan to ensure compliance with state law and policy, including planning components and activity level reporting, and establish a process to ensure the plan is periodically updated.	Partially Implemented
2	Complete written policies and procedures for compiling performance measures to help ensure reported results are reliable, including appropriate measurement descriptions and computations, supervisory review of calculations and methodology, and retention of supporting documentation.	Partially Implemented
3	Evaluate and revise performance measures to help ensure proper alignment of measures with the strategic plan and that key program activities are measured.	Partially Implemented

The Department indicated that the three partially implemented recommendations would be implemented by December 31, 2017.

Question

1. Did the Department implement the three partially implemented recommendations by December 31, 2017? If so, please provide documentation supporting full implementation to the Legislative Auditor. If not, when does the Department anticipate full implementation?

Respectfully Submitted,

Rocky Cooper, CPA
Legislative Auditor

RC:sy
cc: Michael J. Willden, Chief of Staff, Office of the Governor
James R. Wells, CPA, Director, Office of Finance, Office of the Governor
Steve Weinberger, CPA, Administrator, Division of Internal Audits, Office of the Governor
Tony Wasley, Director, Nevada Department of Wildlife (NDOW)
Liz O'Brien, Deputy Director, NDOW

Other

Audit Highlights

Highlights of performance audit report on Horse Power issued on April 14, 2017. Legislative Auditor report # LA18-08.

Background

Horse Power incorporated with the Secretary of State in 2005 as a non-profit organization. The Horse Power license plate was approved by the Commission on Special License Plates on October 19, 2006. In its presentation, Horse Power indicated license plate proceeds would be used as a philanthropic program to aid groups, organizations, and individuals that care for wild equine throughout the State of Nevada.

Horse Power receives almost all of its funding from its special license plate issued by the Department of Motor Vehicles. Plate holders pay $62 in the initial year and $25 each year thereafter, of which Horse Power receives $30 and $20, respectively. Horse Power has received nearly $1 million in special license plate revenues since 2007.

Horse Power expended $140,000 on program operations in fiscal year 2016. Slightly over half of the expenditures were for direct animal care since the program has evolved from providing financial aid to others to supporting an equine rescue facility.

Purpose of Audit

The purpose of this audit was to review the appropriateness of expenditures and evaluate whether Horse Power had adequate methods and procedures in place to ensure grants and expenditures benefit the intended recipient. The scope of our audit was fiscal years 2015 and 2016. As necessary, we included information from prior years to provide perspective on Horse Power's operations.

Audit Recommendations

This audit report contains 15 recommendations to reduce animal care expenditures and improve oversight of program and financial transactions. Horse Power accepted 12 recommendations and rejected 3.

Additionally, we have a recommendation for the Commission on Special License Plates to consider whether Horse Power is utilizing funding in a manner that meets its approved use.

Horse Power

Special License Plate

Summary

Horse Power spends almost all of its special license plate funds to operate an equine rescue facility in Northern Nevada, leaving little funding left over to aid others who care for equine. The organization can take steps to reduce costs for this facility by purchasing feed at lower costs and by actively seeking to adopt out animals. Since Horse Power currently supports over 40 animals, reductions in feed costs and herd size can generate significant savings to serve more equine in the State through grant activities. Furthermore, the Horse Power Board has not provided effective oversight to ensure proper practices of financial administration. For example, the business purpose for fuel purchases was not documented, the Board did not follow its methods and procedures for monitoring debit card transactions, budgets did not contain sufficient details to oversee activities, and receipts were not provided for many expenditures.

Grant funding to organizations and individuals who care for equine has sharply declined in recent years as Horse Power has increasingly spent funding on the support of a rescue facility operated by the Executive Director. Because funding has been redirected to support more equine at the facility, it is questionable if Horse Power is meeting the original intent of establishing a philanthropic program to financially aid others who care for equine, as was approved by the Commission on Special License Plates in 2006. Furthermore, grant application and award processes are not sufficient to ensure opportunities are reaching potential grantees and applicants are treated fairly and consistently.

Key Findings

Horse Power could have reduced feed costs by an estimate $5,000 for fiscal year 2016 simply by purchasing from other businesses who offered similar products at lower prices. Moreover, Horse Power can save significantly more if it considered purchasing feed in bulk quantities. Buying in bulk would reduce the frequency of delivery and could have saved between $14,000 and $24,000 in 2016 depending on the type of hay purchased. (page 6)

Horse Power did not have an effective adoption program to provide for an ongoing reduction in the size of the herd. Based on discussions with the Executive Director and a review of ownership documentation, the organization did not adopt out any horses to individuals during fiscal years 2015 and 2016. (page 7)

Horse Power did not provide any ownership records of equine at its facility even though we requested this information on multiple occasions. Therefore, we obtained available records from the Nevada Department of Agriculture. We found Horse Power has more equine at its facility than Nevada Department of Agriculture records reflect. (page 7)

The Executive Director did not document the business necessity of travel expenses when using a personal vehicle; therefore, the appropriateness of vehicle expenses could not be determined. For fiscal years 2015 and 2016, over $5,400 in fuel and vehicle expenses was paid for by the Executive Director with a Horse Power debit card. Of this amount, $4,400 was paid for fuel and $1,000 was vehicle repairs. Documentation to support the business use of a personal vehicle is required by the Internal Revenue Service. (page 8)

Transactions made with a debit card were not monitored or approved by the Board as required in its methods and procedures. Debit card purchases are linked to Horse Power's bank account designated for operating expenses, and more than $130,000 was paid by this method during fiscal years 2015 and 2016. Therefore, monitoring and approving these transactions is essential to ensuring expenditures are appropriate. (page 9)

Budgetary data submitted to the Board for review and approval is not sufficiently detailed to monitor and oversee the activities of the organization. The budget included a few percentages and no amounts. Additionally, the Board does not routinely receive and review periodic financial comparisons of budget to actual information. (page 10)

As Horse Power's revenues from the sale and renewal of special license plates has increased, the amount of money awarded to others has declined significantly. Specifically, grant expenditures have declined over 90% from a high of $56,303 in calendar year 2009 to only $4,825 in 2015. (page 14)

Horse Power's grant awarding process needs improvement to ensure fair and consistent treatment of applicants. For instance, the application process limits the number of applicants because: 1) publication of funding opportunities is limited, 2) application requirements are burdensome, and 3) timeframes to submit applications are short. Furthermore, the Board does not have adequate policies and procedures detailing the process, including types of funding awarded, review of applications, exceptions, and emergency grant qualifications. (page 17)