FLORIDA NETWORK
of youth and family services

Florida Network for Youth and Family Services
Compliance Monitoring Report for

Lutheran Services Florida Northwest – Currie House
4610 West Fairfield Drive West
Pensacola, FL 32505

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Lutheran Services Florida – Northwest (LSF-NW) for the FY 2021-2022 at its program office located at 4610 West Fairfield Drive West Pensacola, Florida 32505. Forefront LLC (Forefront) is an independent compliance monitoring firm contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. The LSF-NW Pensacola region program is contracted with the FNYFS to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 1, 2021 through June 30, 2022.

The review was conducted by Keith Carr, Lead Reviewer/Consultant for Forefront LLC, and Tara Frazier, Regional Monitor, Florida Department of Juvenile Justice. Agency representatives in attendance at the entrance interview included Sherri Kirkpatrick, Regional Director, Cindy Freshour, Quality Services Manager, Jaime LaPointe, Outreach Coordinator, and Howard Jordan, Sr. Administrative Assistant. The last onsite QI visit was conducted November 18-19, 2020.

The Reviewer found LSF-NW – Currie House has met all compliance monitoring contract requirements FY 2021-2022. LSF-NW – Currie House **received an overall compliance rating of 100% for achieving full compliance** with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. There were no corrective actions as a result of the monitoring visit and no recommendation was made.

The following report represents the results of the in-depth evaluation of the provider's General Administrative performance, with all findings clearly documented. Copies of all completed tools utilized during the visit to determine these ratings will be maintained on file with the Reviewer. If any information or clarification is required, please contact Keith Carr by E-mail: keithcarr@forefrontllc.com.

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 03-30-31-2022

Agency Name: Lutheran Services Florida-NW Currie House	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 4610 W Fairfield Drive West, Pensacola, FL 32505**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 30-31, 2022**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **D**	☐	☐	☐	☒	☐	Documentation: Commercial General Liability through Markel Global Reinsurance Company for limits of coverage $1,000,000 each occurrence, $1,000,000 damage to rented premises, $10,000 medical expenses, $3,000,000 personal injury & advertising injury, $3,000,000 general aggregate, $3,000,000 products, effective 06/01/22-06/01/22. Workers Comp insurance through United WI Insurance Company for limits of coverage $1,000,00,000 each accident; $1,000,000 disease employee; $1,000,000 disease each policy limit. The policy is effective 06/01/21-06/01/23. Automobile liability insurance is provided through Century Surety Company for combined limits of	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						liability/property damage for $1,000,000 combined single limit. The policy is effective 06/10/21-06/10/22. Umbrella Liability is provided by Century Surety Company for $4,000,000 for each occurrence and $4,000,000 aggregate. The policy is effective 06/01/21-06/01/22. Professional Liability Insurance is provided by Markel Global Reinsurance Company for $1,000,000/$3,000,000. Abuse Molestation limits are set for $1,000,000/$3,000,000. At the time of this compliance monitoring review, the Florida Network is listed on the Worker's Compensation certificate as certificate holder.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with Generally Accepted Accounting Principles and provide	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in the agency's Financial Services Policy and Procedures Manual. The manual is divided into	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
sound internal controls. Agency maintains fiscal files that are audit ready. **D**						thirty-four topic sections. Fiscal policies are in place signed by the VP of Finance and the CFO with a revision date of 6/30/2020. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for general ledger, cost accounting, payroll, petty cash, computer backup, and other relevant financial processes and internal controls for all financial transactions.	
b. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: The agency has not incorporated and change in the method or practice related to petty cash counts and reconciliation since the last site program review in November 2020. Petty cash is reconciled on a consistent basis (monthly/quarterly) by designated Residential Supervisor and reviewed by the Regional Director. The reviewer observed the Residential Supervisor conduct a petty cash reconciliation on day 2 March 31, 2022, of all cash on hand in the shelter. The Petty Cash fund with	**No recommendation or Corrective Action.**

Agency Name: Lutheran Services Florida-NW Currie House						Monitor Name: Keith Carr, Lead Reviewer	
Contract Type: CINS/FINS						Region/Office: 4610 W Fairfield Drive West, Pensacola, FL 32505	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): March 30-31, 2022	
	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						cash on hand, total petty cash slips and outstanding petty cash does not exceed the established amount of $600. Petty cash is stored in a secure locked location known by the Residential Supervisor and the Regional Director.	
c. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – At the time of this onsite compliance monitoring site visit, the agency reported that they have not purchased any property inventory items with Florida Network funds.	**No recommendation or Corrective Action.**
d. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit was conducted for the fiscal year beginning June 30, 2021 – 2020 by RSM US LLP. A letter dated February 10, 2022, stated no corrective action was needed. A copy was submitted directly to the Florida Network of Youth and Family Services.	**No recommendation or Corrective Action.**

CONCLUSION

Lutheran Services Northwest – Currie House has met all requirements for the CINS/FINS contract as a result of full compliance with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. One of the five indicators was not applicable because the provider does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing Satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

If required, the provider must submit a corrective action plan to address corrective actions cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Lutheran Services Florida Northwest (Currie House)
CINS/FINS Program

March 30-31, 2022

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	**Satisfactory**
1.04 Training Requirements	**Failed**
1.06 Client Transportation	**Limited**

Percent of indicators rated Satisfactory: 33.33 %
Percent of indicators rated Limited: 33.33 %
Percent of indicators rated Failed: 33.33 %

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	**Satisfactory**

Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	**Satisfactory**
3.06 Staffing and Youth Supervision	**Limited**

Percent of indicators rated Satisfactory: 50 %
Percent of indicators rated Limited: 50 %
Percent of indicators rated Failed: 0 %

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	**Satisfactory**
4.03 Medications	**Limited**

Percent of indicators rated Satisfactory: 50 %
Percent of indicators rated Limited: 50 %
Percent of indicators rated Failed: 0 %

Overall Rating Summary

Percent of indicators rated Satisfactory: 44.44 %
Percent of indicators rated Limited: 33.33 %
Percent of indicators rated Failed: 11.11 %

Rating Definitions

Ratings were assigned to each indicator by the review team using the following definitions:

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Reviewers

Members

Keith Carr - Lead Reviewer Consultant, Forefront LLC/Florida Network of Youth and Family Services
Tara Frazier – Regional Monitor, Department of Juvenile Justice

Methodology

This modified review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused in particular areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (effective January 2022).

Persons Interviewed

X	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
	Program Director	X	Direct – Part time	1	# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern	1	# Maintenance Personnel
X	Clinical Director		Volunteer		# Other (listed by title): ___
X	Counselor Licensed		Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records		# Health Records
X	Logbooks	X	Key Control Log	4	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	15	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	3	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	2	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	2	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

	Intake	X	Posting of Abuse Hotline		Staff Supervision of Youth
	Program Activities	X	Tool Inventory and Storage		Facility and Grounds
	Recreation	X	Toxic Item Inventory & Storage	X	First Aid Kit(s)
	Searches		Discharge		Group
X	Security Video Tapes		Treatment Team Meetings		Meals
	Social Skill Modeling by Staff		Youth Movement and Counts	X	Signage that all youth welcome
	Medication Administration		Staff Interactions with Youth	X	Census Board

Surveys

3	# Youth Surveys	13	# of Staff Surveys		# of Other

Comments

Due to COVID-19, this review was conducted **on-site using the modified QI review plan.**

Monitoring Purpose:

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and non-residential services.

Strengths and Innovative Approaches

Lutheran Services Florida Northwest – (LSF-NW) operates four emergency youth/crisis shelters in the State of Florida that are contracted with Florida Network of Youth & Family Services, Inc. (FNYFS). LSF-NW Currie House is located in Pensacola, LSF-NW Hope House is located in Crestview, LSF-Southeast is located in Fort Lauderdale and LSF-Southwest is located in Ft. Myers, Florida. LSF-NW Currie House is contracted to provide Children In Need of Services and Families In Need of Services (CINS/FINS) in Circuit 1: which encompasses Escambia, Santa Rosa, Okaloosa and Walton Counties. The LSF-NW Currie House's shelter is licensed for twelve beds and offers 24-hour availability, youth supervision, food and clothing, life skills education, crisis counseling, individual and family counseling, recreation and leisure activities, and case management services. Youth are provided educational services at their home schools and transportation is arranged and provided by local school bus and by LSF-NW as needed. LSF-NW Currie House provides Community Counseling/non-residential counseling services in the aforementioned service regions. The services provided under the non-residential CINS/FINS contract with the FNYFS allow the agency to serve all eligible youth between the ages of ten to seventeen-years-old in its residential program and six to seventeen-years-old who are runaway, ungovernable and/or truant, locked out, homeless, abused, neglected, or possess other presenting problems. The agency also provides specialized services to eligible youth with other profiles such as Staff Secure shelter, Domestic Minor Sex Trafficking, Domestic Violence, and Probation Respite and the SNAP program.

The agency reported that they have been heavily impacted by the COVID-19 Pandemic. The agency stated the largest challenge they face as an organization is dealing with staff shortages. The agency reported that staff turnover was originally caused by fears surrounding COVID and then the agency observed a "Big Resignation" in Escambia County and the regional area. The agency further states with businesses being so desperate to hire workers, salaries have skyrocketed to levels that have made it exceedingly difficult to compete to fill vacant staff positions.

The agency reported that they are fortunate to have a core group of loyal staff who have stayed with the organization during this current period of workplace uncertainty. However, the agency reports that many staff have moved on. At the time of this onsite review, the agency reported that they have lost 2 non-residential counselors, but have replaced one. The agency also reported that one of their residential counselors resigned. The agency's SNAP case manager left for a higher wage-earning opportunity. The agency has experienced a total of 5 different facilitators that have been hired in this role. Despite the SNAP changes, the program took on an extra SNAP In Schools group and developed a relationship with a new school, for the next school year. In addition, the agency reported that they also lost the Life Skills Coach, which left a gap in the "extra" activities for our youth.

Since the last QI visit (November 18-19, 2020), the program has appointed a new Regional Director. This long time Regional Director of LSF-NW Region for 30 years recently retired in January 2022. The agency made a smooth transition and promoted Sheri Kirkpatrick, the previous Clinical Director to the role of LSF-NW Regional Director. Instead of replacing the Clinical Director, the agency has chosen to hire a Shelter Manager to support both Currie and HOPE House. The Counseling Supervisor has accepted additional responsibilities and has stabilized the agency's Community Counseling Services by utilizing interns.

Due to the staff shortages, Currie House has reduced capacity to four clients, instead of twelve. This has resulted in the agency not being able to offer this service at its normal capacity, which is a loss for the community, but also for staff having to turn youth away. At the time of this onsite Quality Improvement program review, the agency had a youth census of three CINS/FINS youth during the two-day program review.

According to the organizational chart and staff roster provided by LSF-NW, the residential and non-residential staff members include a Regional Director, a Manager I, Outreach Coordinator, Vacant Clinical Director (Licensed), a Counselor III, 4 Counselor II positions, a Counselor I full time, a Counselor I part time, 1 Youth Care Supervisor, 4 Youth Care Specialist II, 3 Youth Care Specialist I, 5 PRN staff, 1 - .63 staff member and 4 .50 (half-time) staff members, Sr. Administrative Assistant, Administrative Assistant III, Administrative Assistant I, Maintenance Technician, and 3 Interns. The non-residential team consists of one director, two full-time counselors/case managers, 2 vacant positions, 1 SNAP Site Coordinator, supervisor, 5 SNAP facilitators, 3 part time SNAP facilitators, and one SNAP Case Manager. The agency reported the following vacant positions include Shelter Manager FT, Youth Care Specialist III FT, Youth Care Specialist PT, Youth Care Specialist FT, 4 Youth Care Specialists Temporary, SNAP Case Manager, 4 SNAP Facilitators, Life Skills Coach Community Counselor II, and Residential Counselor II.

The agency reported they have made improvements to the property. The agency replaced the subfloor and stabilized the floor joist in one of the counseling offices. In addition, the agency replaced the shelter clothes dryer, refrigerator, and stove. The agency also had to repair the fuse box in the new bus and replaced the tires, breaks and rotors on the second transportation van.

The agency's Outreach Coordinator is a member of the Suicide Prevention Committee, which is a group of community partners focused on suicide prevention. The youth subcommittee came to Currie House to speak with a panel of youth about suicide prevention and what the community could do to help with this serious issue. The outcome of the youth panel resulted in an incredible discussion with youth from both Currie and HOPE House sharing their views on suicide. The participants expressed appreciation for being asked to participate and said they just wanted to be listened to.

Throughout the year the agency has promoted a "Dress for Success" day. This program activity involves youth to utilize the shelter closet to dress and learn to groom and prepare themselves for a job interview. In this staff and youth engagement exercise, the staff participate heavily and pose as the employer and review appropriate questions to ask and remind them to thank the person for the interview.
The program also has other staff and youth engagement activities. As part of the Behavior Management System, to reach "Achievement Level" clients are required to pick a topic and facilitate a group discussion with the other clients. They grow from the process and build confidence along the way.
The agency also reported they receive donations for the shelter closet throughout the year. For the last two years, volunteers that include a mother and her two daughters have adopted Currie House for Christmas. They shop for each youth, according to their wish list.

Narrative Summary

The overall findings for this Modified QI Review for LSF-NW – Currie House are summarized as follows:

Standard 1: This standard has a total of three indicators regarding management accountability. One of the three indicators were rated Satisfactory. Indicator 1.01 Background Screening was rated Satisfactory with no exceptions. Indicator 1.04 Training Requirements was rated Failed. The reasons the agency received a Failed rating for this indicator are listed below. Indicator 1.06 Transportation was rated Limited. The reasons the agency received a Limited rating for these indicators are listed below.

Standard 2: This standard has a total of one indicator reviewed for the agency's adherence to intervention and case management. The indicator 2.03 Case/Service Planning was rated Satisfactory with exceptions.

Standard 3: This standard has a total of two indicators regarding shelter care. Indicator 3.01 Shelter Care was rated Satisfactory with exceptions. Indicator 3.06 Staffing and Supervision was rated a Limited. The reasons the agency received a Limited rating for this indicator are listed below.

Standard 4: This standard has a total of two indicators regarding mental health and health services. One indicator 4.02 Suicide Prevention was rated Satisfactory with no exceptions noted. Indicator 4.03 Medication was rated a Limited. The reasons the agency received a Limited rating for this indicator are listed below.

Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable):

Standard 1:

Indicator 1.04 Training Requirements was rated Failed due to new hire staff did not complete pre-service required trainings within the first 90 days of employment and staff did not complete in-service annual training requirements within the required timeframes.

Standard 3

Indicator 3.06 Staffing and Supervision was rated a Limited due to three falsifications on 3/17/22 on night shift. Staff stated in logbook that bed check was completed and while reviewing video surveillance, the check was not completed. The DJJ Central Communication Center was notified during the onsite program review and a report was accepted (#202201956). An additional finding included the program not being sufficiently staffed to be able to operate seven days a week. All shifts are required to maintain 2 staff. Only 1 staff was on duty for 3rd shift on March 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20, 2022. However, the agency has reported that staffing full time on the overnight shift has been challenging to ensure that the program is able to cover this work shift. The agency supervisory and management has also had to have staff work overtime, additional shifts, and has had to use staff holdover over from the previous shifts to address these staffing issues.

Standard 4

Indicator 4.03 Medications was rated a Limited due to the following findings. Medication distribution log for a controlled substance does not maintain a shift-to-shift count. A total of four counts were not documented on the third to first shift and sixteen counts from the first to second shift. Review of the second to third shift indicated that twenty-six shift-to-shift counts were not conducted for this one controlled medication. The weekly over-the-counter medications and other prescribed medications had inconsistencies and did not appear to be maintaining an accurate perpetual inventory. Further, a review of the receipts from the Pyxis Med-Station 4000 identified discrepancies by youth care staff in related to inventory ranging from1-5 days on varying weeks. These discrepancies are not being resolved until the registered nurse is back on-site to resolve them upon her return.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators: Add an "X" in the applicable column *Satisfactory* *Non- Compliant (E.g. Exceptions)* *No Eligible Items for Review* *No Practice* *Not Applicable*	Satisfactory (S)	Non-compliant (E)	No Eligible Items for Review (N)	No Practice (NP)	Not Applicable (N/A)	Review Based Upon Document Source *For example: Interview/Surveys, Observation, and/or Type of Documentation*	Notes Explain any items that have any deficiencies, exceptions or are not applicable.
Standard One – Management Accountability							
1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						**YES** If NO, explain here: The agency has a policy in place, 1.01, Background Screening of Employees and Volunteers. This policy was reviewed and approved by Regional Director, Beth Deck on December 4, 2021.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.	X					Currie House utilizes the Predictive Index Assessment Tool for all direct care staff upon hire. Eleven staff were reviewed for prescreening assessments. Three of the eleven staff reviewed were not hired for a direct care position, therefore were not required to take the prescreening assessment. The eight eligible staff all completed the Predictive Index Assessment prior to employment. All eight staff received a passing score on this assessment.	
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	X					Eleven direct care staff and three interns were reviewed for background screening. All fourteen files reviewed had an initial background screening completed prior to working with youth.	
Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.			X			None of the fourteen staff reviewed met the criteria for employees who had a break in service.	

Five-year re-screening completed every 5 years from initial date of hire	X					One staff was eligible for a five-year re-screening. This staff's original hire date is August 19, 2018. The background screening was completed and received an eligibility rating on March 1, 2022.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					An Annual Affidavit of Compliance with Level 2 screening Standards was completed by the former Regional Director on January 12, 2022 and sent to the background screening unit as evidence through emails provided.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					All eleven eligible staff had a proof of E-Verify obtained from the Department of Homeland Security.	
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						**YES** If NO, explain here: The agency has a policy in place, 1.04, Training Requirements. This policy was reviewed and approved by Regional Director, Beth Deck on December 4, 2021.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*	X					Three new hire staff were reviewed for training. All three staff completed the Civil Rights and Federal Funds training within thirty days from date of hire.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				Two of the three staff reached their first ninety days of employment. One staff is still within the ninety-day requirement and appears to be on target to complete the remaining trainings. The first staff had 99 hours total, but failed to complete Managing Aggressive Behavior/Crisis Intervention and Cultural Humility. The second staff had 53 hours and failed to complete Managing Aggressive Behavior/Crisis Intervention. The third staff is still within the initial ninety days of his hire date and has time to complete the remaining trainings within the timeframe as required.	Exceptions: Two of three staff reviewed had 1 or more trainings missing completion within the required timeframe. E.g. Managing Aggressive Behavior/Crisis Intervention, and Cultural Humility.
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training			X			There were no non-licensed mental health clinical staff hired during this past year.	

Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).			X			There were no non-licensed mental health clinical staff hired during this past year.	
In-Service Direct Care Staff							
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*		X				Per policy, direct care staff, in residential programs licensed by DCF, are required to have forty hours of training per year after the first year. Three staff were reviewed for in-service training. One staff completed sixteen hours, the second completed twenty-two, while the third staff completed thirty-six hours of annual training. One staff, who is also a supervisor, failed to complete the DJJ Suicide Awareness and Prevention, Florida Network Youth Suicide Prevention, Fire Safety Equipment, Human Trafficking, and Child Abuse: Recognition, Reporting, and Prevention. The second staff did not complete DJJ Suicide Awareness and Prevention, CPR, First Aid, Fire Safety Equipment, and Child Abuse: Recognition, Reporting, and Prevention. The third staff failed to complete DJJ Suicide Awareness and Prevention, Florida Network Youth Suicide Prevention, CPR, First Aid, and Child Abuse: Recognition, Reporting, and Prevention.	Exceptions: Three (3) of three staff did not meet the required 40 hours of required annual training. All 3 staff files reviewed were missing evidence of all required trainings as follows; DJJ Suicide Awareness and Prevention, Florida Network Youth Suicide Prevention, Fire Safety Equipment, Human Trafficking, Child Abuse: Recognition, Reporting, and Prevention, CPR, First Aid, and Child Abuse: Recognition, Reporting, and Prevention.
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					The program provided a training file for all six staff, which included all staff's training hours tracking form and related documentation.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: The agency has a policy in place, 1.06, Client Transportation - FNYFS YFS-PPM2020 - 5.07. This policy was reviewed and approved by the Regional Director, Beth Deck on December 4, 2021.	**Add any exceptions below:**

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The agency policy explains in detail that prior to assigning staff members driving duties, the agency conducts a process that includes reviewing the employee's record to determine if the staff member has a valid Florida driver's license and are covered under the company insurance policy.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					The agency's policy requires that the staff member be in possession of a valid Florida's Driver's license. The agency has a requirement in place that all staff members are covered under the LSF organization's insurance policy. A review of staff member personnel files indicates that staff members hired by the agency have valid Florida Driver's licenses. A sample of staff personnel files reviewed indicate that the staff have valid Florida driver's licenses.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting		X				The agency's current policy includes provisions that permit the transport of clients with a third person present in the vehicle. The policy does not permit a single client transportation event unless there is no one available as a third party. The policy then requires that a Shelter Supervisor or Manager be notified prior to the transportation event of transporting a single client. All single transport events documented in the last six months were reviewed to assess the agency's adherence to the requirements of this standard. The agency submitted documentation of a total of 62 single client transportation events over the last six months. The review of all single transport events over the last six months revealed that of the last 62 transport events, 47 documented events in the logbook show proof of approval from a supervisor in real-time prior to the transportation taken place.	Exception: A total of 15 documented single client transportation events in the logbook platform do not show proof of approval from a supervisor being aware or notified prior to the occurrence of the event of an individual staff transporting a single client as demonstrated in the other 47 other documented transportation events.
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	X					The agency's policy requires a multi-step process that includes 5 criteria that the program must adhere to in the event a third party cannot be obtained for transport. The agency requires the Shelter Manager and Supervisor follow screening procedures that include client history, behavior, and evaluations. The policy also includes provisions to review and know the status of the transporting employee's work performance and history and conduct with no inappropriate behavior.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The policy does include provisions that explain that the third party in a transportation event can be another staff person, an approved volunteer, an intern, or another youth.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	X					The agency policy requires all transportation events be logged in the official Transportation Log. The policy also requires the mileage log is completed every time the transportation vehicles are used. A review of the agency's vehicle logs for 2 vehicles were reviewed onsite during the program review. All transportation vehicles use a log sheet that captures the date, time, beginning and ending odometer readings, number of passengers, purpose and location.	
Standard Two – Intervention and Case Management							
						YES	

Provider has a written policy and procedure that meets the requirement for Indicator 2.03						If NO, explain here: The agency has a policy in place, 1.06, Case / Service Plan - FNYFS YFS-PPM2020 - 4.04. This policy was reviewed and approved by the Regional Director, Beth Deck on December 4, 2021.	Add any exceptions below:
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case/Service plan is developed within 7 working days of NIRVANA		X				The agency has a detailed policy called Case/Service Plan. The policy requires the service plan to be initiated by the assigned counselor at the first intake session. The policy requires that the agency develop these plans for each client within 7 days following the completion of the assessment. Three (3) out of four client files have evidence of service plans developed within 7 working days of the assessment.	Exception: One (1) of four client files did not have evidence of the service plan being developed in within 7 working days.
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated		X				The organization utilizes a standardized form to develop and execute a service plan for each client. The agency's process for service plans must include identification of needs; develop relative goals; indicate the type, frequency and location of services; identify the person's responsible; identify target dates for completion and actual completion dates; include signatures; and identify the plan initiation dates. A total of four client files were randomly selected to determine the agency's adherence to requirements. Three out of four client cases opened after January 1, 2022. These three cases contained completed NIRVANA Assessments. One of the four cases was a closed case that was opened prior to January 1, 2022. Two non-residential client files have date that plan was initiated; evidence of individualized goals; services type, frequency, location; persons responsible; target date; signature or parent, counselor and supervisor. One of these non-residential case had evidence of significant challenges with obtaining signatures, completion and target dates from the youth and family due to non-participation within days of opening this client's case. The agency has documented evidence of attempts to meet client and obtain proper youth parent engagement in order to provide necessary services to the family. The parent is documented as only making one appointment. Case was properly closed. The second non-residential client's case was closed and the youth was court-ordered to the youth shelter in less than 30 days. Two residential client files have date that plan was initiated; evidence of individualized goals; services type, frequency, location; persons responsible; target date; signature or parent (1 of the 2 only), counselor and supervisor.	Exceptions: Two (2) non-residential client files did not have evidence of completion dates and client signatures on the initial plan. There is no evidence of parent/guardian signatures for one non-residential and one residential case. One non-residential case was discharged early due to lack of parent participation is missing a parent/guardian signature on the service plan.

Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	X					A total of four client files were reviewed for adherence to the requirements of this indicator. Of these four files, two were open cases and two were closed. There was one open residential and open non-residential client files and one closed residential and closed non-residential client file reviewed. Of these files, two were residential client cases discharged for completion of services in less than 30 days. The two non-residential client cases provided services more than 2 weeks. Of these files, both had evidence of initiated service plans. However, one non-residential client did not have evidence of service plan after the first 30 day plan review session. One non-residential client was discharged early due to lack of parent participation and is missing a parent/guardian signature on the service plan. The second non-residential case was closed and the youth was court ordered to the shelter. This client was discharged prior to the plan review. This non-residential client's case does have all signatures for the initial plan review.	
Standard Three – Shelter Care							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: The agency has a policy in place, 3.01, Shelter Environment - FNYFS YFS-PPM2020 - 4.01. This policy was reviewed and approved by the Regional Director, Beth Deck on December 4, 2021.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Facility Inspection		X				A tour of the shelter environment was conducted. The youth shelter was found to be safe, clean and maintained. The furnishings in the shelter are in good repair. There was no observation of insect investigation. The bathroom and shower areas are functioning properly and are clean. There are no orders, mildew at the time of this review. There was an observation of moisture accumulating which resulted in exhaust vents appearing to show some early signs of rusting. Lighting in the shelter is adequate. All doors are locked and secure. Facility key controls are in place from shift to shift. There is a detailed map and egress plans of the facility that is located in the day room and in the hallway leading to the sleeping areas. There is a bulletin board that lists most all major event, activities and information about contacting abuse hotline. There is also information about reporting grievances. There were no hazardous chemicals accessible to residents nor other metal or foreign objects. All chemicals are listed and have material safety data sheets. The chemical inventory is being maintained on a weekly count. The washer and dryer are operational and the lint collector is clean. The DCF license is displayed in the shelter. Each resident has clean bedding and access to clean sheets and other bedding items as required. Each resident also has a metal locker to secure their personal belongings. The exterior of the facility was maintained and all grass, shrubs and edges were trimmed. The vehicles on the property were secured and locked. The agency vehicles were clean and contained safety equipment. The facility does have a digital camera system with backup. The trash dumpster cover was closed on top of the waste disposal bin. An inspection of the wash room was found and revealed one clothing item and used dryer sheets behind the washing machines. Lighting ballast in the washer and dryer room was not working properly. Lighting in hall way between sleeping rooms 3 and 4 is not working properly. The light fixtures in sleeping room and laundry room were replaced immediately. During the onsite tour, the refrigerator was observed at a temperature of 37 degrees and the freezer at 4 degrees.	Exceptions: Cold food items are stored in the refrigerator in a zip lock storage bags are not marked. One of the 2 zip lock bags contained food with early signs of spoiling. This item was brought to the agency's attention during the tour and was immediately discarded. The exhaust fans in the bathrooms are metal and the moisture is accumulating and causing rusting to initially appear on the exhaust vents. An inspection of the wash room was revealed one clothing item and used dryer sheets behind the washing machines.
Additional Facility Inspection Narrative (if applicable)							

Fire and Safety Health Hazards		**X**				At the time of this program review, a total of 9 extinguishers on the property in the shelter and transportation vehicles we inspected, tested and maintained on July 7, 2021. The fire safety equipment was inspected by Hiller Fire Protection and Security Solutions. An annual fire safety inspection on the residential facility was conducted by he Escambia County Fire - Rescue Office of Fire Prevention. The inspection of the facility was conducted on October 26, 2021. At the time of the inspection, there were no violations documented by the Fire Inspector. The most recent Florida Department of Health Group Care Inspection report was conducted on 4/27/2021. The agency's report indicates 3 violations that include Preparation/Protection; Storage; and Maintenance. The agency provided evidence of completing a minimum of 1 fire drill per month within 2 minutes or less from September 2021 - March 2022. Fire drills conducted in December 2022 were not completed as required. The agency provided evidence of completing one mock emergency drill per shift per quarter between September 2021-March 2022. □	Exception: The agency completed 1 out of 3 fire drills in December 2021.
Additional Fire and Safety Health Hazards Narrative (if applicable)	At the time of this program review, the program has a total of 9 fire extinguishers on the property. The extinguishers are located in the shelter and transportation vehicles. These items were inspected, tested and maintained on July 7, 2021. The fire safety equipment was inspected by Hiller Fire Protection and Security Solutions. An annual fire safety inspection on the residential facility was conducted by the Escambia County Fire - Rescue Office of Fire Prevention. The inspection of the facility was conducted on October 26, 2021. At the time of the inspection, there were no violations documented by the Fire Inspector. The most recent Florida Department of Health Group Care Inspection report was conducted on 4/27/2021. The agency's report indicates 3 violations that include Preparation/Protection; Storage; and Maintenance.						
Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal.						The agency has a detailed daily activity schedule posted in the youth shelter. Specifically, the schedule is posted on the bulletin board in the day room area. The program conducts a daily activities schedule that includes caring for all of the youth's basis needs and a broad range of structure events each day. These events include chores, education, physical activity, groups, free time, quiet time, homework, counseling and numerous life skills. The schedule specifically provides for daily physical activity and weekly faith-based activities. The environment is abuse free and does offer non-punitive activities to those youth	

b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	X					who do not participate in faith-based activities. The agency has a behavior management system (BMS) that each direct care staff member is trained to use when engaging with residents during their shelter stay.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: The agency has a policy in place, 3.06, Staffing and Youth Supervision. This policy was reviewed and approved by Regional Director, Beth Deck on December 4, 2021.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	X					A video surveillance review was conducted of random nights, evenings, and days. During all the observations, the program maintained staffing ratio of at least 1:6 during awake hours and 1:12 during sleeping periods.	
All shifts must always provide a minimum of two staff present		X				During the video surveillance review, March 17 and 20, 2022 third shift was observed with only one staff present at the program. The ratio was 1:3 and 1:4 on those nights. A video surveillance was also conducted on March 4, 7, and 8, 2022 of the third shift. Only one staff was observed on video for the shift. Per schedule for the month of March 2022, the following days only had one staff scheduled for third shift, March 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20, 2022.	Exception: A review of the staff schedule found evidence that on one staff member was on 3rd shift for following dates in March 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20, 2022.

Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	X					During the video surveillance review, all staff observed have completed a background screening and are properly trained youth care workers, supervision staff, and/or treatment staff.	
The staff schedule is provided to staff or posted in a place visible to staff	X					The staff schedule is posted in a placed visible to all staff.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed		X				Due to the shortage of staff, the program does not have, nor could they utilize a holdover or overtime rotation roster. The program has had to lower the youth census due to the staffing shortages. On-call and part-time staff shortages has limited their ability to consistently staff on the overnight shifts and maintain overtime rotation roster.	Exception: The program does not utilize a holdover or overtime rotation roster.
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction		X				During the video surveillance review, all bed checks were completed at least every fifteen minutes while the youth were in their sleeping room. The program had an exception on March 17, 2022. Staff falsified the logbook stating a bed check was completed at 1:15AM, 2:10AM, and 2:29AM. These checks were never completed. Therefore, no bed checks were completed between 1:40AM - 2:00AM, 2:00AM - 2:19AM and 2:19AM - 2:39AM. The CCC was notified by the program. (CCC#202201956)	Exceptions: Three missing bed checks were observed on 1 night, resulting in falsifications.
Standard Four – Mental Health/Health Services							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES** If NO, explain here: The agency has a policy in place, 4.02, Suicide Prevention. This policy was reviewed and approved by Regional Director, Beth Deck on December 4, 2021.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Suicide Risk Screening and Approval							

Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	X					A random sample of four client cases were reviewed to determine the agency's adherence to the requirements of this indicator. All cases have evidence that each client was screened for suicide risk during the screening process. All four youth client cases have screening information that has been reviewed and signed by the supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					All four of the client files reviewed had risk assessment content that meets the Florida Network policy requirements.	
Supervision of Youth with Suicide Risk							
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	X					All four youth client cases have evidence that the youth has been immediately placed on the correct level of supervision that is based on the risk screening results.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					All four youth client cases have evidence that each of the youth have client observation sheets which are required to be used to document the status of the youth every 30 minutes or less.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	X					All four youth client cases have evidence of each youth's suicide risk supervision level was not changed without consultation of the licensed clinician. The agency has two licensed clinicians on the current staff roster. The credentials of the licensed clinicians are valid and current.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES** If NO, explain here: The agency has a policy in place, 4.03, Medications. This policy was reviewed and approved by Regional Director, Beth Deck on December 4, 2021.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Medication Storage							

a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med-Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	X					The program utilizes the Pyxis Med-Station 4000 Medication Cabinet. This cabinet is inaccessible to youth and stored in accordance with guidelines in F.S. 499.0121 and policy section in medication management. As observed during the review, oral medications are stored separately from injectable epi-pens and topical medications. Currently the program does not have any youth who require an epi-pen. The refrigerator used for storing medication was observed at the required temperature, but no youth currently has any medication requiring refrigeration. The nurse showed where all narcotics and controlled substances are stored in the Med-Station 4000, but none of the youth have a current prescription for these medicines. The Pyxis keys are stored in the desk accessible to staff in the event they need to access medication if there is a Pyxis malfunction.	
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)						The program maintains a minimum of two super users for the Pyxis Med-Station 4000. The program has only designated certain staff permissions to have access to secured medications, with limited access to controlled substances. The program utilizes a medication distribution log for distribution of medication by a non-licensed and licensed staff member. The agency verifies medication using one of the four methods listed in the FNYFS policy and procedure document. The delivery process is consistent with the FNYFS medication management and distribution policy. The program does not accept youth who are prescribed injectable medications, excluding epi-pens. When on duty, the registered nurse is the only person distributing and facilitating medication duties	

c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	X					registered nurse is the only person distributing and facilitating medication duties and tasks when on duty. The registered nurse also provided orientation training for all user permitted to distribute medication utilizing the Pyxis Med-Station 4000. According to training records, non-licensed staff have received training in the use of epi-pens from the registered nurse.	
Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory						A review of a past youth's medication distribution log from March 8-28, 2022 was conducted. Several shift-to-shift counts were not conducted on the medication distribution log. As for the over-the-counter medications and other prescribed medications, eleven receipts were obtained during the review dating from February 22-March 21, 2022, which identified discrepancies by the youth care specialists in comparison to the inventory. Some of those discrepancies were cleared by the nurse the same day or could take up to five days, when the nurse was back on-site.	Exceptions: Medication distribution log for a controlled substance does not maintain a shift-to-shift count. A total of four counts were not documented on the third to first work shift and sixteen counts from the first to second shift. Review of the second to third work shift

c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly		X				site. Syringes and sharps are secured, counted, and documented weekly.	second to third work shift indicated that twenty-six shift-to-shift counts were not conducted for this one controlled medication. The weekly over-the-counter medications and other prescribed medications had inconsistencies and did not appear to maintain an accurate perpetual inventory.
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					The program is conducting monthly reviews of medication management practice via Knowledge portal or Pyxis Med-Station reports.	
Medication discrepancies are cleared after each shift.		X				During a review of the over-the-counter medications and other prescribed medications, eleven receipts were obtained during the review dating from February 22-March 21, 2022, identifying discrepancies by the youth care specialists in the inventory. Some of those discrepancies were cleared by the nurse the same day or could take up to five days, when the nurse was back on-site.	Exception: A review of the receipts from the Pyxis Med-Station 4000 identified discrepancies by the YCS in the inventory ranging from 1-5 days on varying weeks. These discrepancies are not being resolved until the nurse is back on-site to resolve them upon her return.