Florida Network for Youth and Family Services
Compliance Monitoring Report for

Family Resources - Manatee
1001 9th Avenue West
Bradenton, FL 34205

December 14-15, 2022

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC (Forefront) conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) compliance monitoring visit at the Family Resources-Manatee SafePlace2B program for the FY 2022-2023. This review was conducted at its youth shelter located at 1001 Ninth Avenue West, Bradenton, FL 34205. Forefront is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. Family Resources agency is contracted with the Florida Network of Youth and Family Services (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, 2022 through June 30, 2023.

The onsite review was conducted by Keith Carr, Consultant for Forefront, and Marvin Bliss, Florida Department of Juvenile Justice (DJJ) Central Region Monitor. Agency representatives from Family Resources present for the entrance interview were Andy Coble, Chief Operating Officer and Nicole Leslie, Vice President of Impact. The last QI visit was conducted November 17-18, 2021.

In general, the Reviewer found that Family Resources-Manatee is in compliance with specific contract requirements. Family Resources-Manatee SafePlace2B 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

2022-2023 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 12-14-15-2022-2023

Agency Name: Family Resources Manatee	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 1001 9th Street, Bradenton, FL 34205**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): December 14-15, 2022**

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**		
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. **PTV**	☐	☐	☒	☐	☐	Documentation: General Liability through Alliance of Nonprofits for Ins. RRG, for limits of coverage $1,000,000 each $3,000,000 aggregate and medical expenses of $20,000 for any one person, effective 6/1/2022-6/1/2023. Workers Compensation through Florida Insurance Trust with limits of $2,000,000 each and aggregate, effective 6/1/2022-6/1/2023. Automobile insurance through Alliance of Nonprofits for Ins. RRG with combined single limits of $1,000,000, effective 6/1/2022-6/1/2023. An umbrella policy through Alliance of Nonprofits for Ins. RRG, with limits of $4,000,000 each/aggregate, effective	**No recommendation or Corrective Action.**

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	Explain Rating						
Major Programmatic Requirements	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)
						6/1/2022-6/1/2023. Directors and Officers Liability insurance through Alliance of Nonprofits for Ins. RRG with limits of $1 million each/ $2 million aggregate, effective 6/1/2022-6/1/2023. Florida Network is listed on the Certificate of Insurance as Certificate Holder.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency has an employee fiscal manual. The agency's fiscal manual appears to be consistent with Generally Accepted Accounting Principles (GAAP). Specifically, the manual addresses procedures for the agency's budget process, authorization levels, credit cards, donations, capital assets, petty cash, sales tax exemption, required vendor information, journal entries, investment policy, general ledger, cost allocation, internal controls, travel, and purchasing process.	**No recommendation or Corrective Action.**

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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: No change in practice was reported for the agency since the last site program review in November 2021. A review of petty cash Policy and Procedure was conducted. The agency utilizes a credit card for making routine shelter expenses related to activities and expenses. All expenses must be pre-approved by management and are monitored by their fiscal department on a monthly basis.	**No recommendation or Corrective Action.**
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 – The agency has not purchased any items with FNYFS since the last time on-site.	**No recommendation or Corrective Action.**
d. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. 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: The agency produced Financial Statements, Supplemental Information and Regulatory Reports for Family Resources, Inc. for June 30, 2022 and 2021. The audit is completed by ASSURANCE Dimensions Certified Public Accountants and Associates. Per the audit report, a separate Management Letter requiring a	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						Corrective Action Plan is not required and was not issued by the auditor.	

CONCLUSION

Family Resources-Manatee has met the 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 majority of 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

Family Resources - Manatee
CINS/FINS Program

December 14-15, 2022

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CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of Indicators rated Satisfactory: 66.67 %
Percent of Indicators rated Limited: 33.33 %
Percent of Indicators rated Failed: 0 %

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	**Limited**
3.06 Staffing and Youth Supervision	**Satisfactory**

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: 62.5 %
Percent of indicators rated Limited: 37.5 %
Percent of indicators rated Failed: 0 %

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
Marvin Bliss – Regional Monitor, Department of Juvenile Justice

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the 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 September 1, 2022).

Persons Interviewed

X	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
X	Clinical Director		Volunteer	2	# Other (listed by title): ___
	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	8	# Health Records
X	Logbooks	X	Key Control Log	6	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	6	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	6	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	7	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	4	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts	4	# Other: ___
X	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

Surveys

4	# of Youth	5	# of Direct Staff		# of Other		

Comments

Due to the systemic staffing issues which impact the availability for member agencies to participate in the QI Peer Review team review, this review was conducted using the Modified QI Review Tool.

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/or community counseling services.

Strengths and Innovative Approaches

Family Resources Inc. has their central office located in Pinellas Park, Florida and the program has three CINS/FINS SafePlace2B shelters which are located in Clearwater, St. Petersburg, and Bradenton, Florida. All three Family Resources locations are sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families through the Children In Need of Services/Families In Need of Services (CINS/FINS) program. The agency is currently accredited by the Council of Accreditation (COA) effective through December 31, 2024. Family Resources - Bradenton (Manatee) serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk within the Manatee County region and surrounding areas of Circuit 12. The program is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to run away and homeless youth.

The agency provided the following programmatic updates:

Staffing:

The agency informed the onsite review team of the following significant changes related to staffing. A former SNAP supervisor was promoted to Director of Client Success for the community-based programs in December 2021. A recent shelter supervisor resigned in October 2022, transitioning the position into a full-time Youth Development Specialist role. The agency is still actively searching to fill this position. The SNAP supervisor position is currently vacant, and the agency is actively interviewing to fill this position.

SAFEPLACE2B Youth Shelter: The agency reports ongoing issues with staff turnover. The agency moved the operation work shifts from eight-hour work shifts to 12-hour work shifts for their direct care staff in May 2022 in an attempt to resolve this issue; however, after five months of scheduling, the agency is slowly transitioning back to eight-hour shifts. A residential counselor resigned from the agency in October 2022. Due to this vacancy, the agency's Chief Operating Officer has assisted with conducting assessments on an as needed basis to ensure assessments continue to be provided to youth. The agency has shifted the second counselor position to a Case Manager position. The agency hired a new staff person for this position in November 2022. The agency continues to experience significant turnover in direct care positions.

The agency is actively advertising, screening, and offering employment opportunities to qualified prospects to fill vacancies in Youth Development Specialist and Counseling team member positions until all positions are filled. The agency's Manatee community programs (led by the agency's CERTAIN program with community counselor(s) and Director contribution) are participating in a truancy intervention initiative called the Manatee Truancy Task Force (MTTF), which a local Judge convened. This task force also includes the State's Attorney, Public Defender, DJJ, local police departments, and several community programs. This initiative aims to provide truancy intervention before children reach Tier One, Two, and Three within the school system. MTTF launched in late Fall 2021. The agency began collaborating in early 2022 to develop a uniform process for Manatee County schools to reduce truant children. The agency's program acts as the gatekeeper for these referrals and assists families with navigating the process to get their students back on track and attending school regularly.

Facility:
The agency recently purchased a building and will move its community counseling program office in March 2023. The agency is currently renting the space used for these offices and is excited about the transition. The offices will still be just a short drive from the youth shelter. At the youth shelter, Hurricane Ian caused significant sign damage. The agency has pending financial assistance to have this fixed through federal grant funding (at this time it is uncertain when funding will be released for this repair).
The agency was awarded CDBG funding through the City of Bradenton and will be completing the following improvements in the next year:
o Replacing the roof - the current roof has been repeatedly patched and continues to have leaks.
o Repave the existing parking lot due to 20 years of wear and root damage.
o Install IAQ Air Duct and Evaporator Coil Air Purification System: to eliminate viruses, mold, and "sick building syndrome" and fight against the spread of COVID-19.
o Install seven Dyson touchless hand dryers in all six of the youth bedrooms and the activity room.
o Install two Dyson touchless faucets/hand dryer combo units in staff/guest bathrooms.

Funding/Finance:
The agency's Manatee Programs have not received any new funding. The agency's counseling program remains 100% funded by the Florida Network. The agency's shelter was awarded continued funding through Manatee County Government and Health and Human Services. Additionally, the agency was awarded a Community Development and Block Grant (CDBG) last month, allowing them to make the aforementioned facility improvements.

Governance and Community:
The agency's previous Chair ended his term and is now the Vice-Chair. The agency now has a new Board Chair. In September 2022, a long-time member resigned from the Board, and a new member was voted into the Board. The agency is actively seeking to recruit new members.

External Corrective Action Plans:
Family Resources Manatee does not have any Corrective Action Plans with other funding agencies.

Narrative Summary
Family Resources Manatee agency provides residential and non-residential CINS/FINS services for youth and their families in Manatee County and other areas of Circuit 12. The program, located at 1001 9th Avenue, Bradenton, is under the leadership of a Chief Executive Officer (CEO), a Chief Operating Officer (COO), a Vice President of Impact, and the Director of Client Success for Community and Residential Services. The shelter is licensed as a Child Caring Agency (CCA) for 12 beds by the Department of Children and Families, effective through May 31, 2023. At the time of the Quality Improvement (QI) review, the shelter had a census of four youths who were interviewed by the lead onsite, and none of the youths reported any issues related to threats, harm or safety concerns.

The overall findings for the QI review for Family Resources Manatee is summarized as follows:

Standard 1: Three indicators were reviewed for standard 1: 1.01 Background Screening of Employees/Volunteers, 1.04 Training Requirements, and 1.06 Client Transportation. Indicators 1.01 and 1.06 were rated Satisfactory with no exceptions. Indicator 1.04 received a Limited rating.

Standard 2: One indicator was reviewed for standard 2, Indicator 2.03 Case/Service Plan. Indicator 2.03 was rated Satisfactory with exception.

Standard 3: Two indicators were reviewed for standard 3: 3.01 Shelter Environment, and 3.06 Staffing and Youth Supervision. Indicator 3.01 was rated Limited and Indicator 3.06 was rated Satisfactory with no exceptions.

Standard 4: There are two indicators that were reviewed for standard 4, Indicators 4.02 Suicide Prevention, and 4.03 Medications. Indicator 4.02 was rated Satisfactory with no exceptions and Indicator 4.03 was rated Limited.

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

Standard 1:

Indicator 1.04 - Two of the three staff member training records do not have evidence of completing specific pre-service training courses prior to working independently with youth or within 90 days from their date of hire. One staff member did not complete Civil Rights and Federal Funds with in the 30 day time frame. The required training for all new hire staff was not evidenced consistently in staff training records reviewed.

Standard 3:

Indicator 3.01 – At the time of this onsite program review, perpetual use of chemicals when used by staff members is not being documented. No thermometer was found for the kitchen refrigerator. Light fixture above the youth care workstation is not working as required. Mildew is visible in air conditioning vents in one resident's bedroom. Fire drills were not documented as being conducted on a monthly basis in the last six months. Evidence of nine fire drills were not found. Fire drills not found included two on the first shift, four on the second shift, and none on the third shift. Evidence of two mock drill exercises were not documented as being conducted, at a minimum, of once per shift per quarter for the entire second quarter during the second and third work shifts. Additionally, at the time of the review, there was no evidence demonstrated in the program logbook or other designated method to indicate the agency documents the grievance box is being checked by management or a designated supervisor on a daily basis.

Standard 4:

Indicator 4.03 - There is no evidence shift-to-shift counts of controlled medication is being conducted by the program. Staff are not documenting counts with a witness on all controlled medications. At the time of the onsite review, only two counts of controlled medications could be confirmed as being conducted in the month of December.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator.		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			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: The policy number is 1.01 and is titled Background Screening. This policy was reviewed and approved by A. Coble, Vice President in September 2022.	
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.	**Compliance**	The agency uses the Berke assessment prescreening instrument. The Berke assessment prescreening instrument was found in all five applicable new employee records reviewed. The completed Berke assessment was found in the personnel record of all new employees prior to date of hire.	
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	**Compliance**	A review of five applicable personnel records for new hires was conducted to determine the agency's adherence with ensuring all new hires have successfully completed the background screening process. The review of these five new employee records found, all five contained a background screening completed prior to their start date.	
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.	**No eligible items for review**	Following a review of all applicable personnel records, the agency had no new or returning employees with a break in service. None of the five new employee records reviewed indicated there was a break in service.	
Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	There was one staff member eligible for a five year rescreening. The review of this staff member's employee record indicated the agency completed their five year rescreen prior to the due date as required.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The agency completed an Annual Affidavit of Good Moral Character as required and submitted it to the Florida Department of Juvenile Justice (DJJ) Background Screening Unit on January 22, 2022.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	All five applicable new hire records indicated each staff member's file contained an E-verify document from the Department of Homeland Security.	
Additional Comments: **There are no additional comments for this indicator.**			

1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The policy number is 1.04 and is titled Training. This policy was reviewed and approved by A. Coble, Vice President in September 2022.	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	There were a total of three new staff member training records applicable for the review of this training indicator. One of the three staff member training records contained evidence of completing pre-service training courses, which included Provider Orientation Training, Cultural Humility, Behavior Management, Understanding Youth/Adolescent Development, Child Abuse Reporting, CPR, First Aid, Confidentiality, and Universal Precaution. One staff member's training record contains evidence of completing Florida Network Youth Suicide Prevention training within 90 days of hire.	Two of the three staff member training records do not have evidence of completing specific pre-service training courses within 90 days from their date of hire.
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)*	**Exception**	Two of three staff member training records contained evidence of completing Civil Rights and Federal Funds within 30 days of their date of hire.	One staff member did not complete Civil Rights and Federal Funds within the 30 day time frame.
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	All three staff member training records indicate that all are still within their first year of employment. At the time of this Quality Improvement Review, all new hires in their first year exceed the 80 hours of annual training. The majority of training for first year staff is completed; however, some of the required training is not completed within the required time frames.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	One of the three staff member training records contained evidence of completing all mandatory training courses within the required time frame. One staff member training record contains evidence of completing Florida Network Youth Suicide Prevention training within 90 days of hire. Two staff member training records contain evidence of completing Course #1523 Suicide Awareness and Prevention training within 90 days of hire. One staff member's training record contains evidence of completing Course #125 Trauma-Informed Care as required. Two staff member training records contain evidence of completing Course #1549 PREA Part 1 and Course #1546 PREA Part 2 within 90 days. Two staff member training records contain evidence of completing Course #45 Information Security Awareness. Two staff member training records contain evidence of completing Course #168 Child Abuse: Recognition, Reporting and Prevention as required.	Two of the three staff member training records do not have evidence of completing specific pre-service training courses prior to working independently with youth or no later than 90 days from their date of hire. One staff member's training record did not have evidence of completing Understanding Youth/Adolescent Development within 90 days of hire. Two of three staff member training records indicate not completing Universal Precaution within 90 days of hire. Two staff member training records do not have evidence of completing Managing Aggressive Behavior training within 90 days of hire. One staff member's training record did not have evidence of completing the Managing Aggressive Behavior training course (not found). Two of three staff member training records indicate not completing Florida Network Youth Suicide Prevention training within 90 days of hire. All three staff members' training records did not have evidence of completing Serving LGBTQ Youth/S.O.G.I.E. within 90 days of hire. One staff member training record does not contain evidence of completing #1523 Suicide Awareness and Prevention training within 90 days of hire. Two staff member training records do not have evidence of completing Course #125 Trauma-Informed Care within the required 90-day time frame. One staff member training record does not contain evidence of completing Course #1549 PREA Part 1 and Course #1546 PREA Part 2 within 90 days of hire. One staff member training record does not contain evidence of completing Course #45 Information Security Awareness within 90 days of hire. One staff member's training record does not contain evidence Course #168 Child Abuse: Recognition, Reporting and Prevention within the 90-day time frame. All three staff members' training records did not have evidence of completing Signs and Symptoms of Mental Health and Substance Abuse within the required 90-day time frame. All three staff members' training records did not have evidence of completing CINS/FINS Core within the required 90-day time frame.
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**No eligible items for review**	At the time of the review, there were no new staff hired that met this requirement.	

Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
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).	**No eligible items for review**	No counseling staff were hired by the agency in the last several months.	
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).*	**Compliance**	A random sample of three staff member training records was reviewed for this indicator. All three staff member training records exceed the requirement of 40 hours of annual training. Of the files reviewed, one staff member file had evidence of 66.5 annual training hours; another staff member had evidence of 82 annual training hours; and another had evidence of completing 57.5 annual hours.	
Required Training Documentation			
The agency has a designated staff member responsible for managing all employee's individual training files and completes routine reviews of staff files to ensure compliance.	**Compliance**	The agency has designated a staff person to review staff member training records to ensure required trainings are completed as required. The agency has staff from the Human Resources Department to assist in the process of ensuring all staff members complete all required training.	
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	A review of the current training record process was conducted. The agency does have evidence of maintaining an individual training file for each employee which tracks the course, hours and date of training. The current method of maintaining training includes multiple training logs such as SkillPro, Bridge and an internal training log.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency policy number is 1.10 and is titled Transportation. The policy was reviewed and signed by the A Coble in September 2021.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency provided a copy of staff members appointed as drivers approved by its current automobile insurance carrier. The list of employees covered by the insurance was reviewed and included the names of nine direct care staff members.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	All agency staff members are required to perform driving duties and are required to possess a valid driver's license as a requirement to be hired. A review of three new hire and three ongoing staff member employees files was reviewed to verify each staff member's file contained evidence of a valid driver's license. All new hire and ongoing staff member employee files contained evidence of a valid driver's license. The agency provided a copy the driver's are approved by its current automobile insurance carrier. The list of staff members covered by the insurance policy was reviewed and included the names of all nine direct care staff members.	

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	**Compliance**	The agency's policy for Client Transportation includes provisions in the policy that prohibit transporting a youth alone and includes exceptions in the event a third party is not present in the vehicle. Provisions in the policy require the supervisor be notified and must approve the transportation if a third person cannot be present. There was evidence in the shelter program log and in the transportation log the supervisor approves all 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	**Compliance**	A review of the agency's transportation policy was conducted. The agency's policy states that in the event a third party cannot be obtained for transport, the client's history, evaluation, and recent behavior is considered. There was evidence on the log sheet and transportation log that the supervisor considered the clients' history, current and overall behavior prior to each transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	A review of the agency's policy currently lists a volunteer, intern, agency staff member or other youth as an approved third party to be used by the agency during transportation events.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	A review of all single transport events completed in the last six months was conducted. This review found a total of 79 single transport events documented with prior approval from the program supervisor logged in the agency's Trip Plan/Van Mileage Log binder. All 79 transportation events included documentation to verify the supervisor's prior approval.	
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.	**Compliance**	The agency captures required transportation event information on a Trip Plan/Van Mileage Log form which is located in a binder in each vehicle. The form captures the date, time, driver's name and initials of the staff member and passengers, location, purpose of travel, number of passengers, initials of youth, starting mileage, time of travel and ending mileage.	
Additional Comments: **There are no additional comments for this indicator.**			

2.03 - Case/Service Plan			Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency policy number is 2.03 and is titled Case/Service Plans. The agency's policy addresses all requirements for this indicator. The policy was reviewed and signed by A. Coble in August 2022.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	A random sample of eight open and closed client residential and community counseling records which received services in the last six months was conducted. All residential and community counseling files reviewed contained a service plan developed from information gathered at the initial screening, intake, suicide screening and NIRVANA assessment instrument.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Seven of the eight client files contained service plans developed within seven days of completion of the NIRVANA. One residential youth service plan was not developed because the regularly scheduled appointment was canceled due to emergency disaster planning in preparation for Hurricane Ian. One client was applicable due to early discharge.	
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	**Compliance**	The agency utilizes a service plan format for all client files, which incorporates findings collected during the screening process. This information is then utilized to develop all goals and objectives. The service plan template for each of the six client files includes a format designed to capture multiple goals and objectives, service type, frequency, location, the person responsible, the target date for completion, actual completion date, and the signature of the counselor and supervisor. Four client records contain documented evidence of service plans that were consistent with the requirement. All four have assigned goals, objectives, frequency, persons responsible, signatures of required parties and date the plan was initiated. One client record indicated their family was not able to continue service early in the process due to the client being Baker Acted one week following the initial session. Another client case file following the initial intake session indicates the agency made three telephone attempts to contact the client for services. The client was reached once after three attempts. The challenges with rescheduling this client and parent regarding the client's overall progress are well documented. The client refused to go to school, the truancy issues escalated, and the school absences increased. The client's progress notes indicate that the case was referred for case staffing. One additional client case file did not have evidence of a fully completed service plan due to the client not maintaining contact and making scheduled appointments. This case was also closed due to non-participation by the client and family.	
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	**Exception**	Four client records contained documentation of file review sessions which tracked goal and objective progress and completion. These plan review sessions also obtain the signatures of all required parties. Two of the client files did not contain evidence of reviews due to client not being able to meet consistently and was deemed as non-engagement.	An additional client file did not contain evidence of service plan reviews due to case being closed as a result of the counselor staff member resigning from the agency.
Additional Comments: **There are no additional comments for this indicator.**			

3.01 - Shelter Environment			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		YES If NO, explain here: The agency policy number is 3.01 and is titled Shelter Environment. This policy content addresses all requirements for this indicator. The policy was reviewed and signed in September 2022.	
Facility Inspection	Exception	A tour of the youth shelter was conducted with the agency's Residential Shelter Supervisor. The exterior area of the shelter's front and rear yard are cut and the hedges are trimmed. On day one, the reviewer observed debris and numerous trash items located outside of the trash receptacles. The trash receptacles were closed. On day two of the review, all trash items were picked up, and trash areas were now clean as required. All exterior areas are free from hazards. The agency's sign with the shelter name was blown over and broken into several pieces by the storm that occurred prior to this onsite program review. The agency is in the process of having the sign picked up and repaired. All furnishings are in good order and no graffiti was found in either exterior or interior areas. Exterior lighting is operational and all lights are working as required. The agency has two transportation minivans. Two staff member vehicles were found with doors that were unlocked. The agency COO reported that one of the two vehicles is an agency vehicle with a door that will not lock. The agency reported that a repair order would be generated to repair the van lock. The agency utilizes a keyless entry system to access the shelter. Staff members use a key control system from shift to shift. All keys were accounted for during the two-day review. The agency has a facility map listing all areas of the facility. Egress plans are located in the entry area, day room, kitchen, and program activities room. The client rules, incident and abuse reporting, and contact numbers are posted on the general bulletin board in the day room. The daily activity schedule is posted and includes other client-related rules and expectations. The client store is located in the day room as a component of the agency's behavior management system. At the time of this review, the interior areas were clean as required, including resident bedrooms, bathrooms, day room, kitchen, and eating areas. The reviewer did not observe any leaks, dust, grime, or mildew in each of the bathrooms.	The light fixture above the youth care workstation is not working as required. One staff member's vehicle on shelter property was found unlocked. No thermometer was found in the refrigerator in the kitchen. Mildew is visible in the air conditioning vents in one resident's bedroom. A small kitchen can opener appliance was observed not to be clean. At the time of this onsite program review, staff members' perpetual use of chemicals is not being documented. Fire drills were not recorded as being conducted monthly in the last six months. The evidence of nine fire drills was not found. Fire drills not found included two on the first shift, four on the second shift, and none on the third shift. Evidence of two mock drill exercises was not documented as being conducted, at a minimum, once per shift per quarter for the entire second quarter during the second and third work shifts.
Additional Facility Inspection Narrative (if applicable)	The shelter kitchen, pantry, oven, refrigerator and sinks are clean. All aforementioned kitchen items are in working order. Current kitchen built-in refrigerator thermometer is not working and has tape covering the digital display. The kitchen freezer has a temperature of -10 degrees. The dietitian's menu is posted in the kitchen and the dietician's license is valid. Per the most recent policy update in September 2022, the agency is conducting weekly chemical inventory checks for all chemicals listed and approved for use. Chemicals are stored in a locked closet in the facility's kitchen.		At the time of this onsite program review, the perpetual use of chemicals, when used by staff members, is not being documented. A draft document to capture the perpetual use of chemicals was presented by the agency prior to the close of day one.

Fire and Safety Health Hazards	**Exception**	A review of Material Safety Data Sheets (MSDS) was conducted on a sample of ten chemicals stored at the agency. The annual Fire Inspection was conducted by Manatee Fire and Rescue on December 14, 2022. The tag for the back up stove fire suppression pull system was not updated during the last onsite fire equipment check in February 2022. The agency was advised to call the fire equipment inspection company and request them to return to update the tag missed during the last inspection. Agency inspections including fire alarm inspection, sprinklers and fire extinguishers were conducted as required. Mock Drills documented by the agency included 1st Shift: June 21, 2022 - youth injury with bleach in eye. December 2, 2022 S1 - Staff injury. 2nd Shift: July 29, 2022 S2 - gas smell detected. 3rd Shift: July 28 S1 - emergency drill with staff fainting - unconscious.	Two chemicals were found which did not have evidence of MSDS sheets on day one. This issue was corrected on day two. Lint collector in one dryer was not clean. A wash cloth and book were found behind washer and dryers. These issues were corrected on day two.
Additional Fire and Safety Health Hazards Narrative (if applicable)			
Grievance			
There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	The agency grievance box is locked and affixed to the wall, located in the day room next to the youth shelter activity board. Blank grievance forms are provided in a document tray located directly above the grievance box for youth to complete and submit as needed.	
There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook. All grievances are resolved within 72 hours and documented by program director.	**Exception**	The current program logbook was reviewed to determine if the agency is consistently documenting daily checks of the grievance box by management in the logbook. The agency did not indicate there was another method in which the program was capturing daily documentation of grievance box checks.	At the time of the review, there was no evidence demonstrated in the program logbook or other designated method to indicate the agency documents the grievance box being checked by management or a designated supervisor on a daily basis.

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. 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.	**Compliance**	Youth are provided with the opportunity to complete school work and reading materials specific to their age. Residents are provided with information on the daily schedule of activities during orientation and the schedule is posted on the bulletin board in the day room. Additionally, all youth are provided with the opportunity to participate in faith-based activities. Alternative non-punitive structured activities are provided for residents that do not wish to participate in faith-based activities.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency policy number is 3.06 and is titled Staffing and Youth and Supervision. This policy content addresses all requirements for this indicator. The policy was reviewed and signed in September 2022.	
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	**Compliance**	A review of the agency's staff member work schedules from June 2022 through August 2022 was conducted to determine adherence to the staffing ratio requirements. The review of the following schedules conducted included the May 2022 monthly schedule, June 1 to June 11, 2022, June 12 to June 25, 2022, June 26 to June 30, 2022, July 1 to July 9, 2022, July 10 to July 24, 2022, Jul7 24 to July 31, 2022, August 1 to August 13, 2022, August 14 to August 27, 2022, and August 28 to August 31, 2022, which demonstrated the minimum staffing ratios were met as required.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	All staff member work schedules reviewed contained evidence which indicates two trained staff members meeting minimum training standards are consistently scheduled on all work shifts.	
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	**Compliance**	All staff members listed on the staff work schedules from May 2022 through August 2022 have been background screened prior to working the floor.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff member's work schedule is posted, as well as provided to all direct care personnel. During the tour, the work schedule was observed posted behind the staff member's desk and desk in the lobby area.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The agency produces a holdover roster for staff to be informed when additional coverage on a specific work shift is required. This roster can be accessed Location of the Holdover Rotation Roster/Schedule was observed behind the staff member desk and lobby desk.	

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	**Compliance**	The youth shelter has six bedrooms. At the time of this onsite program review, there are four youths in the shelter. Youth bedrooms contain a minimum of two beds per room. If needed, the shelter can be configured to house a youth in a single room. A review of five randomly selected nights of camera video captured in the last 45 days was conducted. The 15 minute bed checks were conducted on five randomly selected dates. The 15 minute bed checks were conducted on December 11, 2022. Every 15 minute check was completed as required. On December 9, 2022, there were two youth in the shelter, room one and room five was occupied. The 15 minute checks were completed as required. On December 3, 2022, there were three youths in the shelter, rooms four, five, and six were occupied. The 15 minute checks were completed as required. On November 26, 2022, three youths were in the shelter. Rooms two, four, and six were occupied. The 15 minute checks were completed as required. On November 22, 2022, five youths were in the shelter. Rooms two, three, four, five, and six were occupied. The 15 minute checks were completed as required.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency policy number is 4.02 and is titled Comprehensive Master Plan For Suicide Prevention and Response. This policy content addresses all requirements for this indicator. The policy was reviewed and signed by A Coble in October 2021.	
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
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.	**Compliance**	A total of five randomly selected residential client files screened positive for suicide risk were assessed to determine their adherence to the requirements of this indicator. Each of the five client files screened were determined to be positive for suicide on one of the suicide risk screening questions during the admission process. The suicide risk form was reviewed, signed and dated by the supervisor as required.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The agency's suicide risk assessment tool was reviewed, and it was reported it had been previously approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	All five client files contained forms documenting evidence of the youth placed on sight and sound observation based on the suicide risk screening question answered by the youth during the screening process.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	All five client files contained forms documenting evidence of youth placed on sight and sound observation. Each form reviewed contained evidence of staff documenting the client's behavior status, warning signs, and observer's initials. Each client's observation form recorded the youth's status at fifteen minute intervals, exceeding the thirty minute requirement.	

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	**Compliance**	All five client files contained a completed suicide risk screening. Four of the five client files contain an assessment completed by the Licensed Mental Health Counselor (LMHC). The remaining client file was completed by a non-licensed mental health practitioner working under the direct supervision of the LMHC. All five youth were not taken off elevated supervision until each was directed by the LMHC to be stepped down to standard supervision and placed in regular supervision status with the general shelter population.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**No eligible items for review**	There were no community counseling youth identified with suicide risk for the review period timeframe.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**	There were no community counseling youth identified with suicide risk for the review period timeframe.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**	There were no community counseling youth identified with suicide risk for the review period timeframe.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	There were no community counseling youth identified with suicide risk for the review period timeframe.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	There were no community counseling youth identified with suicide risk for the review period timeframe.	
Additional Comments: **There are no additional comments for this indicator.**			

4.03 - Medications			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency policy number is 4.03 and is titled Medications. The policy was reviewed and signed by A Coble in August 2022.	
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	At the time of this program review, the agency has a Registered Nurse (RN) who oversees the medication distribution process. A review of the nurse's credentials found the RN license was current and deemed to be valid as required.	
Medication Storage			
a. All medications are stored in a Pyxis ES 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 Pyxis ES 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	**Compliance**	A review of the current medication distribution practice was conducted to determine the agency's adherence to the indicator's requirements. The Pyxis cabinet is located in a locked room near the lobby area. All controlled and non-controlled medications including oral, topical, and over-the-counter medications are stored separately in individual storage pockets within the cabinet. Epi-pens, when applicable, are also secure in the medication cabinet. The facility has a small refrigerator dedicated to medication which is equipped with a thermometer and a lock. The refrigerator is kept in the same locked room as the medication cabinet and the temperature is kept within the required limits of 36-42 degrees. The staff members have access to the keys, for the Pyxis cabinet, in the event of a power outage. Keys that permit access to the medication cabinet are in a clear bag behind the touchscreen panel.	

Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) 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 three methods listed in the FNYFS Policies & Procedures 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	**Compliance**	The agency reported a total of three Super Users and six Regular Users. The agency utilizes a practice which only allows Users on the list to be to access and assist in the delivery of medications to youth. The agency utilizes a medication distribution log (MDL) to assist in the delivery of medications to each youth. Each medication distribution session is required to be documented utilizing the MDL. The agency requires all staff members to verify medications by using one of three approved methods in the policy and procedure manual. The agency's Registered Nurse distributes all medication to youth when on duty. The Nurse also conducts reviews of all health and admission screening records on youth when on duty. Further the Nurse performs follow interviews with youth to check on the status of all acute health symptoms or conditions. No youth requiring injectables are eligible for residential services, except those with Epi-pens. All residential staff members receive medication training 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 c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Exception**	The agency requires all controlled and narcotic medications to be verified with a witness and documented each work shift. A review of the agency's control substance verification and documentation practice was conducted on a sample of shift to shift counts required to be conducted in the last 60 days. The agency has documented evidence of conducting inventory of over the counter medication on a weekly basis and when given. There is evidence of controlled substance counts documented, however counts are not consistent. There are no sharps at this facility except for scissors, which are counted weekly as required. A review of sharps counts over the last six months was conducted. There is documented evidence of scissors being counted weekly. The reviewer observed a staff member giving medications to one youth. This staff member was observed providing the youth with the two medications. The staff member used bio-metric fingerprint scan and passcode to access the Pyxis medication cart as required. The staff member followed the medication pass as required. This youth had one day of medication remaining and the youth's medication have been ordered, but parent has not picked up the medications yet.	Shift to shift counts of controlled medications are not being performed by any staff members on a consistent basis. Staff are not documenting counts with a witness on all controlled medications. As of the date of this onsite review, only two counts of controlled medications could be confirmed as being conducted this month.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	A review of the agency's current practice of documenting monthly Pyxis reports over the last six months was conducted. The agency documentation practice does indicate consistent documentation related to reviewing Pyxis reports on a monthly basis.	
Medication discrepancies are cleared after each shift.	**Compliance**	A review of the agency's practice regarding reviewing and clearing medication discrepancies was conducted. At the time of the onsite review, the Pyxis cabinet display terminal was clear of all discrepancies.	
Additional Comments: **There are no additional comments for this indicator.**			