Florida Network for Youth and Family Services
Compliance Monitoring Report for

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

January 25-26, 2023

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 on January 25-26, 2023, for Lutheran Services Florida – Northwest (LSF-NW) Currie House for the FY 2022-2023 at its program office located at 4610 West Fairfield Drive West Pensacola, Florida 32505. Forefront LLC (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. The LSF-NW Currie House 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, 2022 through June 30, 2023.

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 from CDS Family and Behavioral Health Services included Sherri Kirkpatrick, Regional Director, Cindy Freshour, Quality Services Manager, Jaime LaPointe, Outreach Coordinator, Sherry Kuss, Residential Supervisor, and Howard Jordan, Sr. Administrative Assistant. The last onsite QI visit was conducted March 30-31, 2022.

In general, the Reviewer found that LSF-NW Currie House has met all compliance monitoring contract requirements FY 2022-2023. LSF-NW – Currie House **received an overall compliance rating of 100% for achieving full compliance** with all five 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 recommendations were 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 01-25-26-2023

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): January 25-26, 2023**

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. **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 & adv injury, $3,000,000 general aggregate, $3,000,000 products, effective 06/01/2022-06/01/2023. Workers Compensation and Employer's 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 06/01/2022-06/01/2023. Automobile liability insurance is provided through Florida Insurance	**No recommendation or Corrective Action.**

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						Trust Company for combined limits of liability/property damage for $1,000,000 combined single limit. The policy is effective 06/10/2022-06/10/2023. Umbrella Liability is provided by Century Surety Company for $4,000,000 for each occurrence and $4,000,000 aggregate. The policy is effective 06/01/2022-06/01/2023. Professional Liability Insurance is provided by Markel Global Reinsurance Company for $1,000,000/$3,000,000. The policy is effective 06/01/2022-06/01/2023. Abuse Molestation limits are set for $1,000,000/$3,000,000. The policy is effective 06/01/2022-06/01/2023. At the time of this compliance monitoring review, the Florida Network is listed on the Certificate of Insurance as the certificate holder.	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with Generally Accepted Accounting Principles and provide sound internal controls. Agency maintains fiscal files that are audit ready. **D**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in the agency's Financial Services Policy and Procedures Manual. The manual is divided into 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.	**No recommendation or Corrective Action.**
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 March 2022. Petty cash is reconciled on a monthly basis by the Petty Cash Custodian. At the time of this program review, the agency's Sr. Administrative Assistant	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						is the steward of the agency's petty cash. The reviewer observed the Petty Cash Custodian provide documentation of all petty cash reconciliations from September 2022 through January 2023. The petty cash was reconciled on site on day 2 January 26, 2023, of all cash on hand in the shelter. The petty cash fund with 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 know by the Petty Cash Custodian, 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 purchased property inventory items with Florida Network funds. Specifically, the agency purchased a Heating and Air Conditioning system (7.5 Ton HVAC and a 5 Ton HVAC) with $28,420 in FNYFS funds during the Fiscal Year 2022-2023 via a purchase order in September 2022.	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						The agency also provided equipment inventory of computers and office equipment.	
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: Financial audit was conducted for the fiscal year beginning June 30, 2021 – 2021 by RSM US LLP. A letter dated December 22, 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. 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.

SUMMARY OF RECOMMENDATIONS

Recommendation
There were no Corrective Action or recommendations needed as a result of this review.

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 NW - Currie House
CINS/FINS Program

DATE: January 25-26, 2023

Compliance Monitoring Services Provided by

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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	Satisfactory

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 87.5 %
Percent of indicators rated Limited: 25 %
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
James Philips – 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

	Chief Executive Officer	X	Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
	Chief Operating Officer		Advocate	2	# Case Managers
X	Executive Director	X	Direct – Care Full time	2	# Program Supervisors
	Program Director	X	Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern	1	# Maintenance Personnel
X	Clinical Director		Volunteer	3	# Other (listed by title): ___
X	Counselor Licensed	X	Human Resources		

Documents Reviewed

X	Accreditation Reports	X	Table of Organization	X	Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	6	# Health Records
X	Logbooks	X	Key Control Log	6	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log		# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	9	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	5	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

X	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		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

3	# of Youth	14	# 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

The agency provided an update on the current management structure which includes a Regional Director (RD) who is responsible for overseeing all operations and services delivered by the agency in Escambia and Okaloosa Counties. A Shelter Manager reports to the Regional Director and supervises all Youth Care Specialist Supervisors and Life Skills Coaches. The Counselor Supervisor reports to the Regional Director and supervises the residential and non-residential counselors in Escambia/ Santa Rosa Counties.

At the time of this onsite program review, LSF-NW Currie House reported staff member vacancies, including two full-time positions. In one of these full-time positions, one is a candidate who is currently in the screening process. The agency also reported that there are three vacant part-time positions. Of the part-time positions, two of the three positions are going through the screening process. The agency also reported hiring one of their student interns as a Community Counselor. The agency reported that the background screening process continues to be a factor that impacts its ability to secure staff in a timely manner. The agency reported that in many cases, by the time applicants are approved, the agency is consistently being informed that the applicant has already taken another position.
In May 2022, the agency hired a new Shelter Manager who oversees both Currie and HOPE House residential programs. The residential counselor position became vacant in November 2022. One of the agency's previous Community Counselors filled this previously vacant position.
The agency's Regional Director and Counselor Supervisor are Licensed Mental Health Counselors. The Shelter Managers are Certified Food Handlers through SERVSAFE. The agency reports that the Registered Nurse is a full-time employee who works a total of 20 hours at both residential youth shelters.

The agency provided the following programmatic updates:

The agency is accredited by the Council of Accreditation (COA) through February 2026. The agency's Counselor Supervisor has worked to strengthened its relationship with a local university to increase the agency's internship placements. The agency has also partnered with the university by conducting Stop Now And Plan (SNAP) session two night per week for clinical groups. The university also provides volunteers to assist with groups and provide referrals for the program.
The agency primarily provides its services face to face to clients and families. However, in some instances, virtual sessions are available for families who are not able to come to the office. The agency utilizes paper client files to provide services to clients and the agency uses NIRVANA for its needs assessments. The assessments are printed and maintained in a paper file along with an integrative summary.
Lutheran Services Northwest Currie House serves primarily clients who are 10-17 years old who reside in Escambia and Santa Rosa Counties, however the agency also serves out of county youth from Okaloosa and Walton Counties when HOPE House is at capacity. The residential program also serves Domestic Violence and probation respite youth, who are referred by their Juvenile Probation Officers and with approval from the Florida Network.

The agency reported it has replaced the subfloor and stabilized the floor joist at the landing of the stairs inside the administration building. The project involved the agency also fully replacing the subfloor. The agency replaced two heating and air condition units in the shelter and added an access door in the dining room area. The agency participated in the United Way's Day of Caring. During this event, the agency added hand railings outside the office. The agency reported it removed a dilapidated deck located in the rear of the youth shelter. The agency is seeking donors to help fund a replacement deck.
The agency reported it received a $3,000 donation from Cox Cable to assist in the purchase a shed for its outreach closet. The agency reported it partners with the Baptist Hospital Emergency Room for Baker Act services. The agency reported it Outreach Coordinator securing community partnerships with Escambia County School District to provide Community Counseling services on site at a couple of alternative schools. Further the agency reported it is in the process of signing Cooperative Agreements, organizing space, and getting referrals with an expected start date of February 1, 2023. In addition, the agency reported it is providing Community Counseling services at a private school through community relations event in its SNAP in Schools program. The agency reported it already received referrals for more than 20 Ninth and Tent graders to start groups in this school.

Narrative Summary

Lutheran Services Northwest Currie House serves primarily clients who are 10-17 years old who reside in Escambia and Santa Rosa Counties; however the agency also serves out of county youth from Okaloosa and Walton Counties when HOPE House is at capacity. The residential program also serves domestic violence and probation respite youth, who are referred by their Juvenile Probation Officers and with approval from the Florida Network. The agency is licensed to serve 12 residents and the current census is eight residents.

The overall findings for the QI Review for Lutheran Services Florida NW Currie House are 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. Indicator 1.01 Background Screening was rated Satisfactory with no exceptions. Indicator 1.06 Transportation was rated Satisfactory with exceptions. Indicator 1.04 Training received a Limited rating.

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

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 Suicide Prevention and 4.03 Medications was rated Satisfactory with exceptions.

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

Standard 1: Indicator 1.04 - 1) Three of four new hire staff did not complete CINS/FINS CORE training within the required timeframe. Three out of four staff did not complete Signs and Symptoms of Mental Health and Substance Abuse training within the required timeframe. One staff did not have the In-Service training component completed. One staff did not have evidence of completing medication distribution training. Two staff did not complete LGBTQ training within the required timeframe. 2) Two of the five staff reviewed for annual training did not have evidence of Human Trafficking, Child Abuse Reporting, Trauma Informed Care, and Information Security Awareness training for calendar year of 2022. One of four applicable staff reviewed did not have updated CPR/First Aid Training.

Standard 3: Indicator 3.01 - 1) There were no fire drills found for December 2022 on the third shift. Two additional required mock drills are missing for this period on first and third shifts for July 2022 - September 2022 on second shift. Two additional mock required for this period are missing for first and the third shifts for October 2022 - December 2022. 2) Five separate chemical products maintained onsite in the laundry room were reviewed. Three showed the amount of each product on hand did not correlate with the ending count in the inventory binder. For the hygiene closet, one product was not on the inventory form and one product did not have the accurate number of items present. There is no current method being used by the agency to track perpetual real-time use of chemicals in the youth shelter. 3) The documented daily grievance box checks by the Residential Supervisor or other designated staff member is not consistent in the program logbook.

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 of Employees and Volunteers. This policy was reviewed and approved by S. Kirkpatrick, LSF-NW Regional Director on October 3, 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**	Currie House utilizes the Predictive Index Assessment Tool for new direct care staff hires. All applicable staff member employee records reviewed have documented evidence of a completed assessment with a passing score.	
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**	Eleven of eleven staff were reviewed and received an eligible screening prior to hire. Four of eleven were considered direct care, and each had a completed and passing pre-employment assessment tool. According to the staff roster and interview with the Human Resources Manager, there have been no mentors, volunteers, interns applicable for requiring a five-year or initial background screening for the scope of this annual compliance review.	

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**	No staff member employee files reviewed had a break in service less than ninety days.	
Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	One staff member record was eligible and had a completed re-screening done.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	An Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Florida Department of Juvenile Justice (DJJ) on January 9, 2023.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Eleven of eleven staff member files reviewed contained proof of E-Verify results documented 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 Requirements. This policy was reviewed and approved by S. Kirkpatrick, LSF-NW Regional Director on October 3, 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 four new staff member training records applicable for the review of this training indicator.	Two of the four staff members did not have evidence of Civil Rights and Federal Funds training. Three of four staff members did not have documented evidence of completing Cultural Humility training within the required timeframe. Three of the four staff members did not have evidence of completing CPR training. Three of the four staff members did not have evidence of completing First Aid certification training. Confidentiality training was also not completed within the required timeframe for one staff reviewed. Universal Precautions training was also not completed within the required timeframe for one staff reviewed.

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 four staff member training file records contained evidence of completing Civil Rights and Federal Funds within 30 days of their date of hire.	Two of four staff had evidence the Civil Rights and Federal Funds training was not completed within the 30 day time frame. One was nine days late, and the other was two months late.
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**	Four total first year staff members training records were reviewed. Three of four staff member training records reviewed were still within their first year of employment. The one remaining applicable staff member training record had a total of 128.5 hours.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	A total of four direct care staff member training records were reviewed for pre-service training requirements. One of the four staff member training records contained evidence of completing the majority of mandatory training courses within the required time frame.	Three of four staff did not complete CINS/FINS CORE training within the required timeframe. Three out of four staff did not complete Signs and Symptoms of Mental Health and Substance Abuse training within the required timeframe. One staff did not have the In-Service training component completed. One staff did not have evidence of completing medication distribution training. Two staff did not complete LGBTQ training within the required timeframe. The following trainings were not completed within the required ninety-days from the date of hire timeframe: Information Security Awareness for one staff, Understanding Youth and Adolescent Development for two staff, Managing Aggressive Behavior training for three staff, Suicide Prevention for three staff, Suicide Awareness for one staff reviewed, Fire Safety Training for two staff reviewed was late and this training was not found for one staff reviewed. Human Trafficking was not completed within the required timeframe for one staff. SOGIE training was not completed within the required timeframe for two staff reviewed. One of the four total staff reviewed was still within their first ninety-days of hire; therefore, still had time to complete the required trainings.
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.	**Not Applicable**	The four staff member training records reviewed for pre-service training requirements were not applicable for this review.	
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).	**Compliance**	One staff member training record was applicable for review. The program provided documentation of the completed training signed by the licensed mental health professional providing supervision of this staff member.	
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).*	**Exception**	Five staff member training records reviewed for in-service training requirements. Four of five were considered direct care staff.	Two of the five staff reviewed for annual training did not have evidence of Human Trafficking, Child Abuse Reporting, Trauma Informed Care, and Information Security Awareness training for calendar year of 2022. One of four applicable staff reviewed did not have updated CPR/First Aid Training.
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 requires the program employees, a quality service manager, as well as the shelter services manager as being responsible for monitoring the review and completion of shelter staff training requirements.	
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**	Nine out of nine training records reviewed which include sign-in sheets, SkillPro documentation, and training tracking information for each employee.	
Additional Comments: **There are no additional comments for this indicator.**			

1.06: Client Transportation		**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06	**YES**	
	If NO, explain here:	
	The policy number is 1.06 and is titled Client Transportation. This policy was reviewed and approved by S. Kirkpatrick, LSF-NW Regional Director on October 3, 2022.	

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency requires all direct care staff members to be utilized as drivers and listed as approved to drive all official transportation vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency direct care staff members to have evidence of possessing valid Florida driver's license. The agency's current insurance coverage provides coverage for all direct staff performing transport events.	
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 protocol for these single transportation events states in the event a single client needs to be transported, and no staff or youth are available to be the third person, staff must obtain authorization from the Shelter Supervisor or a manager prior to transport. Documentation of prior approval must be documented in the shelter log book.	
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**	The agency protocol for these single transportation events states in the event a single client needs to be transported, and no staff or youth are available to be the third person, staff must obtain authorization from the Shelter Supervisor or a manager prior to transport. Documentation of prior approval must be documented in the shelter log book.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	A review of the agency's vehicle transportation logs were assessed to determine if the agency is documenting the presence of an approved third party participant during transportation events.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	The agency provided an automated log report of all documented single transport events from July 2022 to present. This review resulted in a total of 56 logged single transport events. Of this 56, a total of six did not have evidence of supervisor approval prior to transport occurring.	Of this 56 logged transportation events documented over the past six months, a total of six did not have evidence of supervisor approval prior to single transport event.

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**	A review of the current month of January 2023 and past five months of vehicle transportation logs were reviewed for two agency transportation vehicles. Each van utilizes the agency's standard Lutheran Services Florida Currie House Daily Vehicle Usage Log which requires drivers to document the Month/Year; Vehicle/Year/Make; Date; Destination/Purpose; Time In/Out; Number of Passengers Staff/Clients; FFN Only; Mileage; Fuel; Oil; Maintenance Costs; Driver Initials; and Comments. Both vans have evidence of staff members / drivers completing the van logs during each transportation event as required. Each vehicle's transportation log contains evidence of agency staff member documenting in the vehicle log for the past six months as required.	
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 policy number is 2.03 and is titled Case/Service Plan. This policy was reviewed and approved by S. Kirkpatrick, LSF-NW Regional Director on October 3, 2022.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	A random sample of 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 onsite contained evidence of 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**	Eight of eight client file records contained service plans developed within seven days of completion of the NIRVANA.	

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	**Exception**	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 service plan goals and objectives. Client information obtained during screening and NIRVANA process is also used to develop all service plan goals and objectives. Eight client file records have evidence of completed NIRVANA assessments. Eight client file records have evidence of completed service types. Eight client file records have evidence of identifying persons responsible for completing goals. Eight client file records have evidence of completed frequency and location of goals. Eight client file records have evidence of documented target dates for completion for the assigned goals. Six client file records have evidence of actual completion dates of assigned goals. Eight client file records have evidence of completed signatures of youth and counselors. Four client records have documented evidence of parent / guardian signatures on the service plan. Seven client file records have documented evidence of signatures of counselors. Eight client records have documented evidence of dates each service plan was initiated.	One client record does not have evidence of documented target dates of completion for the three assigned goals. Two client records did not have documented evidence of actual completion dates for the assigned goals documented in the client record, indicating whether or not the youth made progress in completing planned goals. Four client records did not have documented evidence of parent / guardian signatures on the service plan. One client file did not have documented evidence of the Supervisor's signature.
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	**Compliance**	Four applicable client records have evidence of documentation of plan review sessions for 30, 60 and 90 day review sessions.	
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 policy number is 3.01 and is titled Shelter Environment. This policy was reviewed and approved by S. Kirkpatrick, LSF-NW Regional Director on October 3, 2022.	

Facility Inspection	**Exception**	Ongoing review of the shelter environment was conducted throughout the onsite visit on January 25-26, 2023. The agency's Department of Children and Families Child Care Agency - Runaway/Emergency Shelter is effective through September 27, 2023. The shelter grounds were cut, trimmed and landscaped. The trash dumpster lid is closed and no debris, trash or hazards were found on the grounds of the property. The facility has two outside locked storage sheds which house maintenance items. The facility is has egress maps posted of the layout of the building which included exits. The facility had no visible insect infestation and no graffiti on walls, doors or windows. All lighting is working and not outages were observed. All bathrooms were clean and operational and not leaks, mildew or dirt was found. The shelter sleeping areas have a total of six bed rooms and three bath rooms. Each bed room is equipped with a dresser drawer for each resident. There is a commons areas which called a day room where all major social inside activities such as groups and meetings occur. All interior areas are free from contraband and hazardous unauthorized metal or foreign objects. All doors are locked and secured. The facility has two washers and the lint collectors of both dryers are free of lint. The shelter kitchen is clean and the refrigerator temperature for refrigerator number one is 38 degrees and refrigerator number two is 42 degrees. The freezer temperature is zero degrees. Fire Drills for all shifts July 2022, August 2022, September 2022, October 2022 and November 2022 are documented. Quarterly mock drills were found for the three month period of July 2022-September 2022. Quarterly Mock Drills were found for the 3 month period October 2022-January 2023.	There were no fire drills found for December 2022 on the third shift. Two additional required mock drills are missing for this period on first and third shifts for July 2022 - September 2022 on second shift. Two additional mock required for this period are missing for first and the third shifts for October 2022 - December 2022.

Additional Facility Inspection Narrative (if applicable)	The program reported chemicals are maintained onsite for cleaning purposes in three locations which include a cabinet within the laundry room, kitchen, hygiene closet. Each of these areas were observed and found secured and inaccessible to youth. Each area has a corresponding chemical log binder which includes the Material Safety Data Sheets (MSDS) and inventory. Inventory was documented as completed monthly. Assessment of each secured area was observed and a random selection of chemicals was selected and compared the actual number of items present with the ending count on the inventory form. Eleven total products were reviewed. Five of the eleven had exceptions identified.		Five separate chemical products maintained onsite in the laundry room were reviewed. Three showed the amount of each product on hand did not correlate with the ending count in the inventory binder. For the hygiene closet, one product was not on the inventory form and one product did not have the accurate number of items present. There is no current method being used by the agency to track perpetual real-time use of chemicals in the youth shelter.
Fire and Safety Health Hazards	**Compliance**	The Escambia County Fire-Rescue Office of Fire Prevention conducted an inspection of the facility on Tuesday, January 24, 2023. The agency inspection revealed no violations from the Florida Fire Prevention Code 6th Edition. The agency was issued a 2023 inspection no violation notice. The Hiller Companies performed an annual fire extinguisher inspection on a total of 10 fire extinguishers onsite on July 18, 2022. Security Engineering, Inc. conducted an annual fire alarm system on March 22, 2022. The inspection resulted in three issue being listed as updated during the visit which included duct detectors, no glass at pull station and NAC terminal. The Department of Health conducted a County Health Department Food Service Inspection on August 1, 2022. The inspection resulted in one item observed as not occurring a the time of inspection (hot holding temperature).	
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 has a grievance box which is affixed to the wall by the television in the day room. Blank grievance forms are available in a tray next to the grievance box. The grievance process is explained to the youth during the orientation process.	

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**	A review the program logbook was conducted for the last six months. There is evidence starting in November 2022 of some daily checks of the grievance box by management. Grievance box checks are inconsistent from November 2022 - January 2023.	Grievance documentation in the program logbook on a daily basis is inconsistent. Documented daily grievance box checks by the Residential Supervisor or other designated staff member is not consistent. The Supervisor is only staff person completing this daily task. The agency has not designated another staff person to complete this task when the Supervisor is not present.
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**	The agency has a daily activities schedule which is posted on the bulletin board in day room in the youth shelter. Life Skills services are provided during the day and evening by the agency. Youth are given a Life Skills Planner who asks the youth to give insight on what they want and desire to achieve. For example the Life Skills planner works with the youth on how to type and writing checks and balancing a check book, etiquette, etc. Youth are also required to provide the top three Life Skills goals they desire to achieve. Life skills group sessions are conducted one session per week and cover topics such as self-care night (facials, meditation, etc.). Youth have to complete book reports on a topic of their choice and present it in group meetings. The agency works with youth on a talent show which is also performed in front of the group to demonstrate a Life Skill. Constructive and healthy debates are also done in meetings. Life Skills Planner also sets up volunteer opportunities to community service hours), groups, sports. Therapy Games sessions are also conducted by the Life Skills Planner. Youth when not at school, make jewelry, chores and participate in scheduled outings. Youth are also require to follow a daily schedule of activities which includes a minimum of one hour a day of outdoor activity. The agency is a faith-based organization and offers the ability for youth to participate in religious activities. Youth who do not desire to participate in religious activities can choose other options. Youth are provide time on the schedule for school and home work to be completed. Youth are also provided reading materials and given free and reading time to read.	
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 policy number is 3.06 and is titled Staffing and Supervision. This policy was reviewed and approved by S. Kirkpatrick, LSF-NW Regional Director on October 3, 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**	The agency currently operates on three work shifts. The staffing schedule was provided and reviewed for the past six months August 2022 - January 2022. The schedule reviewed noted at least two staff provided for youth supervision on each shift as required. The schedule did indicate the program was closed from September 9, 2022 until September 11, 2022. Further explanation given by the shelter manager found the closure was due to a staff outbreak of COVID during this time. Random days, afternoons, and nights were selected and reviewed via video. Each period reviewed found at least two staff present as required for supervision of youth. Staff indicated for the shifts were also noted in the program's electronic logbook.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	The agency currently operates on three shifts. The staffing schedule was provided and reviewed for the past six months. The schedule reviewed noted at least two staff were provided for youth supervision on each shift as required.	
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**	The agency staff schedule included direct case and counseling staff persons which were trained and properly background screened.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	According to an interview with the shelter supervisor and shelter manager, the schedule for staff members is completed every two weeks. The schedule is maintained in a binder marked 'Passdown'. This binder was observed in the shelter area accessible 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	**Compliance**	The agency maintains an on-call board located in the staff office of Youth Care Specialist office. The board notes staff members available to assist in supervision in the event of an emergency. Counselors on call are also noted on this board. Numbers for staff, as well as emergency numbers, are maintained in the Passdown binder also accessible to shelter staff.	
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 physical layout of the shelter area consists of six youth bedrooms. The program allows for two youth per room, unless restrictions warrant a single room is required for a particular youth. Video review of three randomly selected nights was completed to confirm fifteen minute observation checks were being conducted as required for youth during sleeping hours. Based on video observations made, for each night observed, there were at least two staff present in the shelter. Checks were observed done within fifteen minutes consistently. Staff was observed opening youth room doors and looking in to observe them. The checks done were also confirmed documented in the program's electronic logbook, which also confirmed the time of each check. The shelter supervisor was interviewed and stated she conducted fidelity monitoring of the bed checks randomly. Samples of the documentation of these fidelity checks were observed completed within the electronic logbook.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The policy number is 4.02 and is titled Suicide Prevention. This policy was reviewed and approved by S. Kirkpatrick, LSF-NW Regional Director on October 3, 2022.	
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 six randomly selected residential client files screened positive for suicide risk were assessed to determine their adherence to the requirements of this indicator. All six client files records screened were determined to be positive for suicide on one of the suicide risk screening questions during the admission process. There is evidence of all six client records possessing documentation of the suicide risk form being 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 six client files contained forms which documented evidence of youth placed on a 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	**Exception**	All six client file records have documented evidence of youth being placed on a sight and sound observation. Each form reviewed contained evidence of staff documenting the client's behavior status, warning signs and observer's initials. Five of six client's observation forms documented the youth's status every fifteen minute intervals, exceeding the thirty-minute requirement.	One of six client's observation forms was not found to verify all documented times of the youth's status every fifteen minutes.

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	**Exception**	All six client file records have evidence of a completed suicide risk screening. All six client file records contain an assessment completed by a non-licensed masters level counselor working under the direct supervision of the Licensed Mental Health Counselor (LMHC). All six files have documented evidence of the LMHC's credentials. All six 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 within the general shelter population. Training records reviewed showed the mental health professional (MHP) completing Assessment of Suicide Risk training and which includes 20 hours of required training in suicide and crisis assessments under the direct supervision of a licensed mental health practitioner.	At the time of this onsite program review, four of the six client files did not have documented evidence of clear times documented in the logbook when youth are placed and taken off sight and sound supervision.
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			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The policy number is 4.03 and is titled Medications. This policy was reviewed and approved by S. Kirkpatrick, LSF-NW Regional Director on October 3, 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**	The program employs a part-time registered nurse (RN) (license number RN9474365) whose certification has an expiration date of April 30, 2023.	

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**	The program uses the Pyxis Med-Station 4000 cabinet system. The cabinet was observed secured and inaccessible to youth. Inspection of the cabinet found items considered topicals were stored separate from oral medications. The program currently has no injectables or epi-pen on-site. Controlled medications are also stored in the secured cabinet. A refrigerator is used for medications required to be stored cooled. Currently the program has no such medications on-site. The refrigerator was observed locked. The inside was inspected and found the thermometer which maintained a temperature noted between thirty-six and forty-six degrees. The Pyxis keys were observed stored in the staff desk, and are accessible by designated staff in the event of a power outage or device malfunction. Keys were labeled with easy deification as required.	

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 program maintains three Super Users for the Pyxis Med-Station 4000. These individuals include the registered nurse (RN) and a designated House Supervisor, and Staff Leader. Only designated staff members have access to secure medications. According to the RN, the nurse conducts the medication processes when on duty. Delivery of medications is consistent with FNYFS Medication Management and Distribution Policy. Evidence of training forms completed and signed by non-licensed staff members were observed when receiving training in the use of Epi-pens. The training was facilitated by the program's RN. The RN reported medication pass occurs twice daily, at 7:00AM and 9:00PM. A medication pass was observed at the 7:00AM interval during the annual compliance review. The RN was observed disseminating medications. Youth were seen approaching the RN and medication cart one at a time. Verification was done so by the RN verifying the youth name, date of birth, correct medication and dosage. Both the youth and RN were observed signing the medication administration record noting the medication was received. No refusals of medication by the youth were observed.	

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 program maintains inventories for medications and items considered sharps. Controlled medications are to be inventoried on a shift-to-shift count system. Over-the-counter medications are inventoried weekly, maintaining a perpetual inventory. Over-the Counter medications are inventoried using the Pyxis Med-Station 4000 system. These weekly inventory counts were observed printed and maintained in an inventory binder. Sharps are also inventoried weekly, and maintained in a separate inventory binder. A total of three over-the-counter medications were randomly selected. Inventory numbers observed matched the actual count of the items observed for all three medications reviewed. The program currently has a total of two controlled medications. These two medications were counted and compared with the final inventory count documented on the medication distribution log, which found both items to have matching count numbers. Three items considered as sharps were also counted and compared with the final count numbers on the inventory form. All items matched as indicated.	A review of two controlled medication inventory counts for the month of January 2023 was completed and found the second-to-third shift count was missing for Vyvanse on January 1, 2023 and January 20, 2023. The second-to third shift count was also not documented for Adderall on these same dates, and including January 6, 2023. For the sharps reviewed, there was no documentation of the weekly inventory for Scissors between December 6, 2022 and January 14, 2023. No weekly inventory was documented for nail clippers between December 13, 2022 and January 4, 2023. No documentation of weekly inventory was found for tweezers since December 6, 2022.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The program conducts monthly reviews of medication management practices through the Knowledge Portal of the Pyxis Med-Station reports observed.	
Medication discrepancies are cleared after each shift.	**Compliance**	An interview with the registered nurse (RN) revealed medication discrepancies were cleared after each shift. A discrepancy notebook is maintained by the RN and corrections were observed made prior to the shift ending.	
Additional Comments: **There are no additional comments for this indicator.**			