Florida Network of Youth and Family Services
Compliance Monitoring Report for

Lutheran Services Northwest – Hope House
5127 Eastland Street
Pensacola, Florida 32539

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Lutheran Services Florida – Northwest (LSF-NW) Hope House for the FY 2022-2023 at its program office located at 5127 Eastland Street, Crestview, Florida 32539. 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 Florida region program 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 2022 through June 30, 2023.

The review was conducted by Keith Carr, Lead Reviewer/Consultant for Forefront LLC, and Onazina Washington, Regional Monitor, Florida Department of Juvenile Justice. Agency representatives in attendance at the Entrance Interview from LSF-NW – Hope House included Sherri Kirkpatrick, Regional Director; Cynthia Freshour, Quality Services Manager; Billie Kendrick, Youth Care Specialist Supervisor; and Jaime LaPointe, Outreach Coordinator. The last onsite QI visit was conducted December 8-9, 2021.

In general, the Reviewer found that LSF-NW – Hope House has met all compliance monitoring contract requirements FY 2022-2023. LSF-NW – Hope House **received an overall compliance rating of 100% for achieving full compliance** with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. There were no corrective actions as a result of the monitoring visit and no recommendation was made.

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

2022-2023 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 10-5-6-2022

Agency Name: Lutheran Services Florida-NW Hope House	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 5127 Eastland Street , Crestview, FL 32539**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): October 5-6, 2022**

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

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						$1,000,000 combined single limit. The policy is effective 06/10/21-06/10/22. Umbrella Liability is provided by Century Surety Company for $4,000,000 for each occurrence and $4,000,000 aggregate. The policy is effective 06/01/22-06/01/23. Professional Liability Insurance is provided by Markel Global Reinsurance Company for $1,000,000/$3,000,000. Abuse Molestation limits are set for $1,000,000/$3,000,000. Abuse/Molestation Insurance is provided by Markel Global Reinsurance Company for $1,000,000/$3,000,000. Abuse Molestation limits are set for $1,000,000/$3,000,000. At the time of this compliance monitoring review, the Florida Network is listed on the Worker's Compensation certificate as certificate holder.	

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Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
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 a change in the method or practice related to petty cash counts and reconciliation since the last site program review in December 8-9, 2021. Petty cash is reconciled on a consistent basis (monthly/quarterly) by designated Residential Supervisor and reviewed by the Regional Director. The Petty Cash fund with cash on	**No recommendation or Corrective Action.**

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Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): October 5-6, 2022	
	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						hand, total petty cash slips and outstanding petty cash does not exceed the established amount of $600. Petty cash is stored in a secure locked location known by the Residential Supervisor and the Regional Director.	
c. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – At the time of this onsite compliance monitoring site visit, the agency reported that they have not purchased any property inventory items with Florida Network funds.	**No recommendation or Corrective Action.**
d. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit was conducted by RSM US LLP for the Financial Position of LSF June 30, 2021 and 2020. A letter dated February 10, 2022 from RSM 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 – Hope 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. A fifth indicator 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.

SUMMARY OF RECOMMENDATIONS

Recommendation
There were no recommendations 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

Lutheran Services Northwest - Hope House
CINS/FINS Program

October 5-6, 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	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: 75 %
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
Onazina Washington– 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 August 1, 2021).

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	1	# Program Supervisors
	Program Director	X	Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call	1	# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
X	Clinical Director		Volunteer	3	# Other (listec Direct Care Staff
X	Counselor Licensed		Human Resources		

Documents Reviewed

X	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	4	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	7	# 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	8	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	3	# 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	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

4 # of Youth	10 # of Direct Staff	# of Other	

Comments

Due to COVID-19, this review was conducted using the Modified QI Review plan.

Monitoring Purpose

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

Strengths and Innovative Approaches

Lutheran Services Florida Northwest (LSF-NW) operates residential and community counseling services in Okaloosa and Walton Counties. Lutheran Services Florida celebrated their 40th Anniversary and HOPE House reached 25 years. The agency operates the Hope House youth shelter in the aforementioned regions. The agency reported they are still experiencing staffing shortages. At the time of this onsite program review, the agency reported securing seven new staff members including five Youth Care Specialists (YCS), one Life Skills Coach and a YCS intern. All staff have started in their new positions within the last two and a half months. The agency reported the time frame for the background screenings has improved somewhat, but they have lost several candidates because of the long period of time it takes to get them through the screening process.

The agency reported several major staffing changes since this year. Beth Deck, former NW Regional Director, retired and Sherri Kirkpatrick accepted the position as LSF-NW Regional Director in the first quarter of this year. Angereia Bridges was hired on May 31, 2022. Ms. Bridges is the Shelter Manager overseeing both Currie House and Hope House. After a year of effort, on August 8, 2022, the agency hired a Life Skills Coach through funding from Health Human Services.

In July 2022, the agency secured two new leased vehicles to replace the old transportation vans at Hope House. The van utilized and in the best mechanical condition was retained for use for the community food pantry program. The agency replaced several appliances-- the kitchen stove, dishwasher, microwave and ice maker. In addition, the agency replaced an air conditioning unit in the freezer room and an LED sensor light on the back porch.

The agency reported COVID-19 is still a great concern and is still causing ongoing operational issues. The agency has created several different structured activities for clients. These activities are designed to ensure clients are exposed to a variety of events and outings. Residents were able to conduct a visit to the Baker Fire Department. They were able to learn about how the fire department works. Clients attended a

World War II Reenactment, a car show, and a Juneteenth Celebration in Crestview, Florida. The agency has also focused on exploring new activities for clients to participate outdoors. Clients have been participating in badminton, basketball, volleyball, and frequent walks in the neighborhood. The agency reported it has made movies, weekly Bible study, baking bread, and library outings available to help the clients enjoy a variety of events which not usually part of their daily lives.

The LSF-NW Hope House location continues to provide food through its community food program. The program has increased the amount of food it provides for their clients and families in their service region. The agency reports it has outgrown this current youth shelter space and is in the process of looking to secure a new property in the city to accommodate its future needs. If the agency is not able to find a suitable option, they will renovate to accommodate its plans for growth.

Narrative Summary

Lutheran Services Florida – (LSF) operates six emergency youth/crisis shelters in the State of Florida which are contracted with the Florida Network of Youth & Family Services, Inc. (FNYFS). LSF-Northwest (LSF-NW) Hope House is located in Crestview, Florida. The LSF-NW Currie House is located in Pensacola. The LSF-Southeast operates three locations located in Fort Lauderdale, Miami and Homestead. LSF-Southwest is located in Ft. Myers, Florida. LSF-NW Hope House is contracted to provide Children In Need of Services and Families In Need of Services (CINS/FINS) in Circuit 1: which encompasses Okaloosa and Walton Counties. The LSF-NW Hope House's shelter is licensed for eight beds and offers 24-hour availability, youth supervision, food and clothing, life skills education, crisis counseling, individual and family counseling, recreation and leisure activities, and case management services. Youth are provided educational services at their home schools and transportation is arranged and provided by local school bus and by LSF-NW Hope House staff members as needed. LSF-NW Hope House provides Community Counseling/non-residential counseling services in the aforementioned service regions. The services provided under the non-residential CINS/FINS contract with the FNYFS allow the agency to serve all eligible youth between the ages of ten to seventeen-years-old in its residential program and six to seventeen-years-old in their community counseling program who are runaway, ungovernable and/or truant, locked out and homeless. The program also serves youth which require temporary shelter due to abuse and neglect. The agency also provides specialized services to eligible youth with other profiles such as Staff Secure shelter, Domestic Minor Sex Trafficking, Domestic Violence, and Probation Respite, Family/Youth Respite Aftercare Services (FYRAC) and the Stop Now And Plan (SNAP) program.
Lutheran Services Florida NW HOPE House residential program is led by a Quality Services Manager and a Youth Care Specialist (YCS) III. The shelter is open 24 hours per day across three staff work shifts. The YCS III oversees each shift. The youth shelter is a residential home which has been converted into a temporary youth shelter. There are three bedrooms upstairs; one of the bedrooms sleeps four youth and the other two bedrooms sleep two youth each. The bedroom which sleeps four youth is primarily used for the boys' room and the other two bedrooms are primarily used for the girls. The facility is licensed by the Department of Children and Families (DCF) for eight beds.

The overall findings for the QI Review for Lutheran Services Florida Northwest are summarized as follows:

Standard 1: This standard has a total of three indicators regarding management accountability. Indicators 1.01 and 1.06 were rated Satisfactory with exceptions and Indicator 1.04 was rated Limited.
Standard 2: This standard has a total of one indicator which addresses the agency's adherence to intervention and case management. The indicator 2.03 Case/Service Plan was rated Satisfactory with exceptions.
Standard 3: This standard has a total of two indicators regarding shelter care. One indicator was rated Satisfactory with exceptions (3.06) and one was rated Limited (3.01).
Standard 4: This standard has a total of two indicators regarding mental health and health services. Both indicators were rated Satisfactory with exceptions (4.02 and 4.03).

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

Standard 1: Indicator 1.04 Training Requirements – Limited
One first year staff member failed to complete multiple training topics within the first 30 and 90 days of employment. One in-service staff member failed to obtain a required training topic (Fire Safety). Two in-service staff members failed to complete the forty hour annual training requirement.
Standard 3: Indicator 3.01 Shelter Environment – Limited
- Chemicals observed onsite did not contain evidence of an inventory where chemicals are stored. The agency did not initially at the start of the onsite program review have an established procedure that demonstrated evidence of chemicals being documented on a perpetual basis.
- There was no evidence of fire drills conducted in June 2022 and September 2022 on second shift.
- No initial documentation (at the start of the onsite program review) of a daily check by management or a designee is being completed and documented in a daily logbook.
- Floor trim around base of the entertainment center on the first floor has sharp edges that present a major hazard on flooring in the day room.
- Bathrooms trim alongside of shower has exposed edges of the tile that require being finished. A paper towel holder affixed to the wall in one of the upstairs bathrooms appears to be possibly cracked and has blue tape holding the holder together.
- A ceiling leak measuring 3' by 1' was observed in the ceiling area in the kitchen area.

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			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: The agency policy number is 1.01 and is called Background Screening of Employees and Volunteers. The policy content addresses all requirements for this indicator. The policy was reviewed and signed by the Lutheran Services Northwest (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.	**Exception**	A total of six eligible direct care file staff member personnel records were reviewed to determine if there was evidence of a completed Predictive Index screening assessment on each employee. Of the six files reviewed, five contained evidence of a Predictive Index prescreening assessment which was completed prior to new staff being hired.	Exception: One of the six eligible direct care staff member records reviewed did not contain evidence of a completed Predictive Index prescreening assessment. This staff member was a previous intern and the agency did not administer the Predictive Index prescreening assessment on this staff member prior to officially hiring them as a Youth Care Specialist.
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**	Seven staff member personnel records were reviewed for this indicator. A review of the background screening records indicated all seven staff were determined to be rated as eligible. All dates of hire were verified and all records contained evidence of eligible rating from the Florida Department of Juvenile Justice (DJJ) Background Screening Unit prior to date of hire.	

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**	This portion of the indicator is determined to be no eligible items to review due to none of the seven files reviewed meeting the criteria for employees who have had a break in service.	
Five-year re-screening completed every 5 years from initial date of hire	**No eligible items for review**	This portion of the indicator is determined to be no eligible items to review due to the agency having no five year background re-screenings due to be conducted on any in-service staff members.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	At the time of this review, the Annual Affidavit of Compliance Level 2 Screening Standards were completed by the Program Director and sent to the Background Screening Unit by January 12, 2022. The program submitted this form via email.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Exception**	Seven staff member records were reviewed for this indicator. Of the seven personnel files, six files did contain evidence of the E-verify rating and was verified by a review of the employees background section of the employees personnel file. One file reviewed was not applicable because the staff was an intern.	Exception: One of the six eligible direct care staff member records reviewed did not contain evidence of a completed E-verify screening. This staff member was a previous intern and the agency did not administer the E-verify on this staff member prior to officially hiring them as a Youth Care Specialist.
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 agency policy number 1.04 is Training requirements. This policy content addresses all requirements for this indicator. The policy was reviewed and signed by the 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**	Five staff member records were reviewed to assess the program's adherence to the training requirements. One file was applicable for this review item. The remaining four still have time to meet their pre-service training requirements and are not applicable.	Exception: Of the files reviewed, one out of five applicable files does not have evidence of completing the required training topic within the specified timeframe. This employee file did not have evidence of training topics and hours required to be completed within the first ninety days that includes Program Orientation, Cultural Humility, Behavior Management. Understanding Youth Development, CPR, First Aid, Confidentiality, Universal Precautions, Managing Aggressive Behavior, CINS/FINS Core, Signs and Symptoms of Mental Health, Fire Safety, SOGIE and Serving LGBTQ.

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)*	**Compliance**	During this onsite program review, five staff member training records were reviewed. All five files were in compliance and completed the required training within thirty days of hire for this requirement.	
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**	Per policy, direct care staff, in residential programs licensed by DCF, are required to have eighty hours of training per year after the first year. Five staff were reviewed for in-service training. All five staff files that were reviewed did have evidence of training being completed toward the 80 hours requirements.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	A total of five staff member files were reviewed. Four of the five staff members are still within the ninety-day requirement and appears to be on target to complete the remaining training in correlation to their hiring dates.	Exceptions: One of the five reviewed staff records demonstrated evidence of not completing all required training within the first ninety days. The training topics that the staff member missed were Program Orientation, Cultural Humility, Behavior Management, Understanding Youth/Adolescent Development, Child Abuse Reporting, CPR, First Aid, Confidentiality, Universal Precautions, Managing Aggressive Behavior, CINS/FINS Core Training, Signs and Symptoms of Mental Health and Substance Abuse Fire Safety, Sexual Orientation and Gender Identity and Expression, and Serving LGBTQ.
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**	A review of staff members hired since the last onsite program review was conducted. (Last review conducted was on December 8-9, 2021.) There were no new staff members hired which were designated responsbile for entering NIRVANA or DJJ JJIS since February 2021.	
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**	There were no non-licensed mental health clinical shelter staff members within their first year of employment at the time of the program review.	

In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, Skill Pro, and job-related training annually (40 hours if the program has a DCF child caring license).	**Exception**	Five staff member training records were reviewed. Four staff member training records contained evidence of forty hours of annual in-service training. One training file contained evidence of twenty-four hours of annual in-service training. Three of the four staff applicable for forty hours of training completed their required training hours. The one staff member applicable for twenty-four hours of in-service training completed training as required.	Exception: One of the four staff members required to complete forty hours of in-service training only completed 35.8 hours of training. The staff member was missing training in Fire Safety.
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**	During this program review, the agency identified the staff member in the role of the Quality Services Provider as the official liaison for managing all employee's individual training files and completes routine reviews of staff records to ensure adherence to training standards.	
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**	The agency maintains an individual training file for each staff member. The agency had an individual training file for all ten pre-service and in-service staff member files reviewed onsite. The current training files include a training log for the Florida Department of Juvenile Justice (DJJ) and an internal MS Excel training log. The files also included certificates and sign-in sheets.	
1.06: Client Transportation			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**NO** The current policy does not include the required procedure for staff to obtain permission prior to the transport event. Due to the policy missing the directive to request permission prior to the transportation event, the policy does not fully meet all of the 1.06 indicator requirements. The agency policy number is 1.06 and is called Client Transportation. The policy was reviewed and signed by the 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's process for administrative review requires the agency to approve all drivers who will be conducting transportation duties. The agency conducts a review of all direct care staff driver's records during the background screening process. The review of the driver's record requires that all agency drivers do not have any infractions that prohibit them from being able to drive for the agency. If there are no infractions, the staff member is deemed an eligible driver for both general and single transportation events.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	All five first year employee files reviewed onsite during this program review contained evidence of a valid State of Florida driver's license and verification that they had been screened and approved to drive in general and single 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	**Exception**	The agency's process for administrative review requires the agency to approve all drivers that will be conducting transportation duties. During the onsite program review on Day 1 the policy only states that the transport event must receive permission.	Exception: At the time of this onsite program review, the current policy does not include the required procedure for staff to obtain permission from the supervisor of designee prior to the transport event.
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's Clinical Supervisor and Residential Supervisor review and consider the client's history, assessments, evaluations regarding behavior and other factors in order to be eligible to participate in single transport events. A review of each current client's past history, behavior, evaluation information and recent behavior was reviewed during the assessment process. All current clients were deemed as being eligible for single client transport events.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency's policy describes a third party participant as a staff member, intern, volunteer, or youth that has been pre-approved. The agency assesses the past history and current behavior of clients in order to approve them eligible for single client transport events. The agency assesses the past history and performance of staff members and interns in order to approve them eligible for single client transport events. All current clients, employees and interns were deemed as being eligible for single client transport events. No volunteers were reviewed for this indicator.	

The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	A review of logged transportation events completed in the last six months from April 2022 to October 2022 was conducted. Of these events, there were 47 out of the 53 single youth transport events reviewed which had documented evidence of supervisor approval.	Exception: There were six single transport events that did not have evidence of supervisor approval prior to the transportation occurring.
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 logged transportation events completed in the last six months from April 2022 to October 2022 was conducted. The current transportation log used for all transportation events includes: date, destination; time in/out; number of passengers; purpose; mileage; driver's initials; and comments.	
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 titled Case/Service Plan requirements. This policy content addresses all requirements for this indicator. The policy was reviewed and signed by the 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**	Six randomly selected client files served in the last six months from April 2022 to October 2022 were assessed to determine their adherence to the requirements of this indicator. Six of the six client files contained an initial case plan based on presenting problems obtained during the initial screening, intake and NIRVANA assessment process.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	The aforementioned six randomly selected client files served in the last six months were reviewed. The reviewer identified the date of assessment in all six client case files to determine their adherence to the case plan being developed. Six of the six client files contained evidence that the initial plan was developed with the 7 working days of NIRVANA process.	

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**	Six randomly selected client files served in the last six months from April 2022 to October 2022 were reviewed to assess the status of case plan services provided by the agency. Five of the six client files were reviewed and found to have individualized case plan which addressed the goals identified during the screening, intake and in the NIRVANA assessment. Six of six client files contained evidence of each file documenting the service type, frequency, and location associated with addressing each client's goals in their respective service plans. Six of six client files contained evidence of the designated person responsible for completing each goal documented in each file. Four of six client files contained evidence documenting the scheduled target dates. Three of four eligible client files contained evidence of the actual date of completion of goals. At the time of this onsite program review, two of six client files were open ongoing cases and not required to be completed. Five of the six client files contained evidence of client signatures documented in each file. Four of the six client files contained evidence of parent/guardian signatures documented in each file. Three of the four eligible client files contained evidence of the supervisor's signature documented in each file. Two of these cases were recently opened and are scheduled to be reviewed by the supervisor.	Exceptions: One of the six client files reviewed did not have evidence of an individualized case plan which addressed the goals identified during the screening, intake and in the NIRVANA assessment. This client record was screened for truancy and counseling problems. Truancy services were documented as being provided. No counseling services were documented as being provided. Two of the four client files did not contain evidence of each client file documenting the scheduled target dates. One out of six client files did not contain evidence of client signatures documented in each file. Two of the six client files did not contain evidence of parent/guardian signatures documented in each file.
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**	Six randomly selected client files served in the last six months from April 2022 to October 2022 were reviewed to assess the status of case plan services provided by the agency. Two of the six client files were eligible to be reviewed for adherence to the requirements of this indicator. Two of the two eligible client files contained evidence of case plans which were reviewed for progress by counselor and parent/guardian every 30 days.	
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 (Shelter Environment). This policy content addresses all requirements for this indicator. The policy was reviewed and signed by the LSF-NW Regional Director on October 3, 2022.	

Facility Inspection	**Exception**	A tour of the shelter environment was conducted day one of the review. The youth shelter is an older modified home located in a residential community. The facility was found to be secure and most areas clean. The furnishings in the shelter on the first floor contain the administrative offices, counseling rooms, kitchen, dining room, and day room. The furnishings in areas which children frequent are in good repair. There was no observation of insect infestation found during this program review. The bathrooms, bedrooms and bathing/showers are located on the 2nd floor. The sleeping areas are clean and contain 3-4 beds in each of the two rooms upstairs. The bathing and showering areas are functioning properly. There are no leaks or odors at the time of this review. All lighting in the shelter is adequate and functioning properly. All doors are locked and secured on both the first floor and second floor balcony area. Facility key controls are in place and accounted for on each shift. There are building layout and egress plans of shelter located on the first floor in the day room, youth care station, upstairs bedrooms and the Youth Care Specialist office between the bedrooms. There is a bulletin board that lists all activities and client rules. There is a locked grievance box and forms located in the day rooms on the first level. All chemicals in main storage area are listed and have material safety data sheets. There were no hazardous chemicals accessible to residents nor other metal or foreign objects. The chemical inventory is being maintained on a weekly basis. The washer and dryer are operational and the lint collectors in the dryers are clean.	Exceptions: The grass in the front yard of the facility is not well maintained. The grounds in these areas have black liners in the grass that are not level to the ground. These present a potential trip and fall hazard to youth, staff and visitors. Mulch was being placed on grounds on day two and work to correct this issue was in progress. Floor trim around base of the entertainment center on the first floor has sharp edges which present a major hazard on flooring in the day room. Bathrooms tile trim alongside of shower has exposed edges of the tile which required being covered and finished. A paper towel holder affixed to the wall in one of the upstairs bathrooms appears to be possibly cracked and has blue masking tape holding the holder together. Exhaust fans in the upstairs bathrooms have dust accumulating on them. A ceiling leak measuring 3' by 1' was observed in the ceiling area in the kitchen area. Chemical inventory is being conducted once per week. However, the agency has chemicals stored in more than one location (2nd floor). The initial review of the facility found five areas where chemicals are stored do not have a method of tracking chemicals specific to the location in the building where the chemicals are stored. The agency began to develop a chemical inventory by storage location on day two. No date was found on a food (lettuce) item found in the refrigerator. The food item was removed from its original package and was not marked with a date.
Additional Facility Inspection Narrative (if applicable)	The DCF license is displayed in entry area of the shelter. Each resident has clean bedding and access to clean sheets, comforter and pillows as required. Each resident also has a wood drawer for their clothes. The agency places personal belongings in a plastic zip lock bag with the client's name that is stapled locked in the safe or 2-drawer file cabinet. The vehicles on the property were secured and locked. The agency vehicles are new, were clean and contained safety equipment. The facility does have a digital camera system with sixteen camera views and backup of 30 days. During the onsite tour, the refrigerator was observed at a temperature of 37 degrees and the freezer at four degrees. The majority of food storage practices are being performed as required. The agency has acquired 2 new Chrysler Pacifica mini vans.		

Fire and Safety Health Hazards	**Exception**	At the time of this program review, there were a total of ten extinguishers and one kitchen extinguisher on the property and in the shelter and transportation vehicles. All fire extinguishers were inspected, tested and maintained on March 15, 2022 by B & C Safety. An annual fire safety inspection was conducted on August 26, 2022 of the residential facility by the Okaloosa County Fire and Life Safety. At the time of the inspection, there were no violations documented by the Fire Inspector. The most recent Florida Department of Health Group Care Inspection report was conducted on September 7, 2022. The agency's report indicates 2 violations that include Warewashing/Cleaning (identified the need for 3 compartment sink); and Maintenance (bathroom tile, metal edge on step in dayroom and ceiling leak). The agency did not provide evidence of completing these repairs. A minimum of one fire drill per month was conducted within two minutes or less from April 2022 - October 2022. First Shift: (6-3): 3/31/22/AM; 4/23/22AM; 5/28/22AM; 6/26/22AM; 7/10/22AM; 8/31/22AM; 9/14/22AM Second Shift: (2-11): 3/31/22PM; 4/30/22PM; 5/13/22PM; NO JUNE; 7/31/22PM; 8/30/22PM; NO SEP.; Third Shift: (10-7): 3/11/22PM; 4/7/22AM; 5/3/22AM; 6/17/22PM; 7/31/22AM; 8/13/22PM; 9/16/22PM. The agency provided evidence of completing one mock emergency drill per shift per quarter between April 2022 - October 2022. First Shift: 7/31/22 Choking Emergency; 8/6/22 Heat Related Emergency; 8/14/22AM Thunder Storm Emergency; 5/28/22 Choking Emergency; 6/13-17/2022 Hurricane; 4/23/22 Shortness of Breath; 2nd Shift: 9/16/22PM Unconscious Person; 7/31/22 Youth Disturbance Emergency; 6/13-17/2022 Hurricane; 3/20/22 Bomb Threat.	Exceptions: There was no evidence of fire drills conducted in June 2022 and September 2022 on second shift. These fire drills were not completed as required.

Additional Fire and Safety Health Hazards Narrative (if applicable)	Third Shift: 9/20/22PM-Hazardous Waste; 6/29/22 Seizure Emergency; 6/13-17/2022 Hurricane; 3/29/22 Suicide Attempt Emergency.		
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 process for residents to report issues during their shelter stay. The agency's grievance box and grievance forms are located by the telephone in the dayrooms. Forms are located in the grievance binder. Also listed are additional forms for grievances and other concerns.	
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 of the agency's current documentation process related to documentation of grievances was conducted. The reviewer interviewed the Residential Supervisor YCS III staff person. The interview resulted in the supervisor reporting that all grievances are checked by the supervisor daily or no more than every other day. The grievance box is checked by the YCS Supervisor daily.	Exception: The recent change in the policy which requires the agency document checking for grievances submitted by residents is not in place. The agency did not provide documentation of a daily check by management or a designee is being completed and documented in a daily logbook. The agency is in the process of documenting that the grievance box is checked.
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 detailed daily activity schedule posted in the youth dayroom in the youth shelter. The schedule is posted on the bulletin board in the day room area. The program conducts a daily activities schedule that includes caring for all general needs and a broad range of daily activities. These daily activities include chores, education, physical activity, groups, free time, quiet time, homework, counseling and numerous life skills. The schedule specifically provides for daily physical activity and weekly faith-based activities. The environment is abuse free and does offer non-punitive activities to those youth who do not participate in faith-based activities. The agency has a behavior management system (BMS) that each direct care staff member is trained to use when engaging with residents during their shelter stay.	

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, Staffing and Youth Supervision. This policy content addresses all requirements for this indicator. The policy was reviewed and signed by the 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's program director was interviewed and provided information in regards to staff scheduling and the ratio being maintained across the work shifts. The scheduling timeframe reviewed entailed viewing agency members on schedule on the overnight work shift in the last thirty days. Review of video surveillance footage was conducted on random nights, evenings, and days. During all the observations of video surveillance footage, the program maintained two staff members on the work shift. The staff work schedule indicated two staff were on duty on July 27th on first shift. The staff work schedule indicated two staff members were on shift on August 13, 2022. The staff work schedule indicates two staff members were on duty on September 7, 2022. The program's staffing schedule was verified by a review of staff schedule from April 2022 through October 2022. The program supervisor's signature was found on each employee's monthly schedule. Logbook entries were reviewed for a three month time period and found the program met the ratio of one staff to six youth ratio during awake hours and one staff to twelve youth ratio during overnight hours.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	The agency's policy states there must be two staff on shift. During this review, the staffing ratio requirements were met at all times. Staff were properly supervising the youth. The observation timeframes that were reviewed were during recreational time, during lunch period, and at dinner time. At the time the observations were conducted, there were always two staff members on shift who met the minimum training requirements. A review of video surveillance footage was conducted on July 27, 2022, of the first shift; August 13, 2022 for the third shift; and September 7, 2022 during second shift. During the review of video surveillance footage, there were always two direct care staff with supervising youth at all times.	

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's policy states if new staff were on the floor and didn't have proper required training, the staff member would not be allowed to be left alone and would be with trained staff at all times. All staff observed supervising youth by video surveillance, were found to have completed a background screening and are properly trained youth care workers, supervision staff, and/or treatment staff. The program's staffing schedule was verified by a review of staff schedule from April 2022 through October 2022. All new hires were scheduled with existing trained staff until training requirements were completed.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	At the time of this program review it was noted and observed that the staffing schedule was visible and on display on the bulletin board for all staff to see.	
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 Youth Care Specialist Supervisor was interviewed and stated the holdover schedule for staff was located in the pass down binder. A review of the binder found documented evidence of all direct care staff and contact telephone number.	
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 supervision practice executed by the agency was observed by video surveillance footage. Video surveillance footage dates reviewed included July 27, 2022, in which youth were observed during daytime activity, and two youth were observed by one staff in the dayroom watching television; August 13, 2022, in which two staff members on duty were observed doing ten minute bed checks; and September 7, 2022, in which staffing ratio was met and staff were observed issuing out snacks to youth. Two additional staff members entered the dining area with a new youth. A review of supervision practice at bedtime routine was observed. The times of the activities reviewed matched the entries logged in the program's logbook.	

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 titled Suicide Prevention. This policy content addresses all requirements for the indicator. The policy was reviewed and signed by the 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**	Four randomly selected client records served in the last six months from April 2022 to October 2022 were assessed to determine their adherence to the requirements of this indicator. Four of the four client files contained documented evidence of the client indicating a yes on a suicide risk screening to at least one of the five suicide questions. Each direct care staff member is trained and asks all residential clients the five suicide risk screening questions during the intake process. Each of the four client files reviewed contained evidence of the supervisor's signature confirming the review of the screening results. All four client files answered yes to a minimum of 1 or more suicide risk screening questions.	
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**	Four of the four client files contained documented evidence of a completed screening form in the file indicating the youth being placed on sight and sound supervision status. A review of the program electronic logbook found that all four clients were documented in the electronic logbook as being placed on the appropriate level of elevated supervision. All four client files contained a yes response on the suicide risk form which required immediate placement on sight and sound status.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	All direct care staff are required to document the status of the client every fifteen minutes or less while on duty. Four of the four client files contained documented evidence of the client's status being observed on sight and sound observation sheets every fifteen minutes or less by direct care staff across all three work shifts until receiving orders from the clinician to remove them from sight and sound status.	

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**	Four of the four client files contained documented evidence of the client's sight and sound status not being changed unless given directions by the licensed clinician to keep them on or remove them from the sight and sound status. All sight and sound observations are consistently documented by direct care staff without interruption unless ordered by the licensed clinician to remove them from the sight and sound status. Each of the four client records reviewed had documented evidence in the electronic log, as well as the observation sheets indicating the clients were removed from the signt and sound status by order of the licensed clinician.	
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.	**Not Applicable**	This section of the indicator is only applicable to Community Counseling service providers.	
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.	**Not Applicable**	This section of the indicator is only applicable to Community Counseling service providers.	
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.	**Not Applicable**	This section of the indicator is only applicable to Community Counseling service providers.	

If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Not Applicable**	This section of the indicator is only applicable to Community Counseling service providers.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	This section of the indicator is only applicable to Community Counseling service providers.	
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 agency policy number is 4.03, titled Medications. This policy content addresses all requirements for the indicator. The policy was reviewed and signed by the 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**	During the time of this review, the agency has a part-time Registered Nurse (RN). The RN possess all required credentials which were verified by viewing their certified licensure. The RN works at this location part-time for 20 hours per week.	

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 utilizes the Pyxis ES Station Medication Cabinet. This Pyxis ES Station is inaccessible to youth and stored in accordance with guidelines in F.S. 499.0121 and policy section of medication management. The medication cabinet is located in the youth care specialist work area. As observed during the review, oral medications are stored separately from injectable epi-pens and topical medications. The refrigerator used for storing medication was observed at the required temperature, but no youth currently has any medication requiring refrigeration. The RN was interviewed and demonstrated where all narcotics and controlled substances are stored in the Pyxis ES Station. One youth has a current prescription for medications. Two reviewers observed the Youth Care Specialist III assist in the delivery of the PM medication to one youth during the evening shift. The Pyxis ES Station keys are stored in the desk accessible to staff in the event they need to access medication if there is a medication Pyxis ES Station malfunction or power outage.	

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**	During the time of this review, medication pass was observed. The prescribed medication was separated from the oral medication, topical medication and cream. A review of the Medication Log displayed each time a medication for the identified youth used was properly documented. The program maintains a minimum of two System Managers for the Pyxis ES Station. The program has only designated certain staff permissions to have access to secured medications, with limited access to controlled substances. The program utilizes a medication distribution log for distribution of medication by a non-licensed and licensed staff member. The agency verifies medication using one of the three methods listed in the Florida Network of Youth and Family Services (FNYFS) policy and procedure document. The delivery process is consistent with the FNYFS medication management and distribution policy. The program does not accept youth who are prescribed injectable medications, excluding epi-pens. When on duty, the registered nurse is the primary staff member assisting with the delivery of medications to clients.	

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	**Compliance**	During this review sharps are secured, counted, and documented weekly. Over the counter medications are inventoried weekly and documented in the inventory log. Controlled substances accessed regularly were maintained, in which a shift-to-shift count of the medication is verified by the nurse or designated staff who have access in User Permissions.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Exception**	The program is not conducting monthly reviews of medication management practice via Knowledge portal or Pyxis Med-Station reports.	Exception: The RN was interviewed during the program review and reported not being familiar with how to access and produce Pyxis ES Station reports on a routine basis.
Medication discrepancies are cleared after each shift.	**Compliance**	During a review of the over-the-counter medications and other prescribed medications, medication pass was observed at the facility during the night shift in which one youth was observed being administered their medication. A review of the facility nurse's logbook indicated that there were no medication discrepancies during the time period that was reviewed.	