Florida Network for Youth and Family Services
Compliance Monitoring Report for

CDS Interface Youth Program Central
1400 NW 29th Street
Gainesville, FL 32605

May 31, 2023 – June 1, 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) Compliance Monitoring visit on May 31, 2023 – June 1, 2023 for the FY 2022-2023 CDS-Interface Youth Program Central (CDS-IYP Central) CINS/FINS program at its program office located at 1400 NW 29th Street, Gainesville, FL 32605 location. 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 CDS-IYP Central agency is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 1, 2022 through June 30, 2023.

The review was conducted by Keith Carr, Consultant for Forefront LLC, and Renette Crosby, Operations Review Specialist, North Region, Florida Department of Juvenile Justice. Agency representatives from CDS-IYP Central present for the entrance interview were Phil Cabler, Chief Executive Officer, Cindy Starling, Chief Operations Officer, Gonzellas Whitter, Regional Director, Jessica Bechtold, Regional Director, and Brian Smith, Residential Supervisor. The last QI visit was conducted March 16-17, 2022.

In general, the Reviewer found that CDS-IYP Central is in compliance with specific contract requirements. The CDS-IYP Central agency **received an overall compliance rating of 100% for achieving full compliance** with 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 Recommendations were made.

The following report represents the results of the 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 05-31-2023-6-1-2023

Agency Name: CDS-IYP Central	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 1400 NW 29th Street, Gainesville, FL 32605**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 31, 2023 – June 1, 2023**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:**	**Notes**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**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. **PTV**	☐	☐	☒	☐	☐	Documentation: The Commercial General Liability Insurance is provided through Berkshire Hathaway limits include coverage for $1,000,000 each/$1,000,000; $3,000,000 General Aggregate; $1,000,000 personal injury; $1,000,000 damage to rented property; $3,000,000 Products-Comp/Op Agg; $1,000,000 Employee Benefits; Policy Effective 01/10/2023-01/10/2024. Automobile Liability Insurance is provided through Berkshire Hathaway Specialty Insurance Company, with combined single limits of $1,000,000 and PIP Basic $10,000; Each Occurrence $1,000,000; Aggregate $1,000,000 effective 01/20/2023-01/10/2024.	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						Workers Compensation and Employers' Liability is provided by Bridgefield Employers Insurance Company $500,000 each accident, $500,000 per each employee; and $500,000 for policy limitations. Effective dates are 5/01/2023 - 5/01/2024. Umbrella Liability is provided through Berkshire Hathaway Insurance for each occurrence $1,000,000 and $1,000,000 aggregate effective 01/20/2023-01/10/2024. Florida Network of Youth and Family Services is listed on the Certificate Of Liability Insurance as certificate holder.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in the CDS and Behavioral Health Services' Financial Management Policy. The procedures reviewed appear to be consistent with generally accepted accounting principles. The most recent update and revision is related to	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						Fiscal policies and procedures October 2019.	
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 reported no change in petty cash practice was reported for the agency since the last onsite program review in March 2022. A review of the petty cash Policy and Procedure was conducted on day 2 of the program review. At the time of the program review, the petty cash is stored in a secure locked location in the building known to the Regional Director / Petty Cash Custodian. An onsite reconciliation was conducted onsite on day 2 with an ending amount of $150. The petty cash is reconciled on a consistent basis (monthly/quarterly) by the Residential Supervisor and reviewed by the Regional Director, Comptroller/Chief Financial Officer and Chief Operations Officer. Disbursements and invoices are approved by the Regional Director.	**No recommendation or Corrective Action.**
c. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag.	☐	☐	☐	☐	☒	Interview/Documentation: The agency has not purchased any property with	**Not Applicable.**

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Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**						FNYFS funds for the current fiscal year.	
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 conducted for year ending June 30, 2022, and 2021 was completed by James Moore, C.P.A. and Consultants and dated December 6, 2022. Per the audit report, a separate Management Letter requiring a Corrective Action Plan is not required and was not issued by the auditor.	**No recommendation or Corrective Action.**

CONCLUSION

The CDS-IYP Centrale program has met the requirements for the CINS/FINS contract as a result of full compliance with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. A fifth indicator was not applicable due to the provider not having any current inventory purchased with DJJ/FN funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective action items cited during this compliance monitoring review. The agency is not required to take any actions related to Corrective Actions or Recommendations 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 described in the report findings.

SUMMARY OF RECOMMENDATIONS

Corrective Action or Recommendation: None.

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. A Corrective Action form is available upon request. The Forefront Lead assigned to this review 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) business 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.

Florida Network of Youth and Family Services
Quality Improvement Program Report

CDS Family and Behavioral Health Services, Inc. - Central
1400 NW 29th Street
Gainesville, Florida 32605

May 31, 2023 - June 1, 2023

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

Percent of Indicators rated Satisfactory: 100 %
Percent of Indicators rated Limited: 0 %
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: 12.5 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Renette Crosby - Operations Review Specialist, North Region, Florida Department of Juvenile Justice

Methodology

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

Persons Interviewed

X Chief Executive Officer	X Case Manager		Nurse – Full time
Chief Financial Officer	X Counselor Non-Licensed	X	Nurse – Part time
X Chief Operating Officer	Advocate	2	# Case Managers
Executive Director	X Direct – Care Full time	1	# Program Supervisors
X Program Director	X Direct – Part time		# Food Service Personnel
Program Manager	Direct – Care On-Call		# Healthcare Staff
Program Coordinator	Intern		# Maintenance Personnel
X Clinical Director	Volunteer	4	# Other (listed Cook, Maintenance
Counselor Licensed	Human Resources		

Documents Reviewed

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	12	# Health Records
X Logbooks	X Key Control Log	6	# MH/SA Records
X Continuity of Operation Plan	X Fire Drill Log	28	# 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	6	# Youth Records (Closed)
X Egress Plans	X Program Schedules	3	# Youth Records (Open)
X Fire Inspection Report	List of Supplemental Contracts	6	# Other: Suicide - Sight and Sound
X Exposure Control Plan	X Vehicle Inspection Reports		

Observations During Review

Intake	X Posting of Abuse Hotline	X Staff Supervision of Youth
X Program Activities	X Tool Inventory and Storage	X Facility and Grounds
X Recreation	X Toxic Item Inventory & Storage	X First Aid Kit(s)
X Searches	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	25 # 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 following programmatic updates were provided by the agency:

CDS Interface Youth Central Residential Program

The Regional Director of the CDS Interface Youth Central (CDS-IYP Central) program provided an update to the Quality Improvement (QI) team at the entrance interview. The CDS-IYP Central staff facilitated a retirement celebration event for Regional Director at the facility on May 4, 2022. The agency honored her with a variety of gifts for 37 years of dedicated service to the agency. On May 8, 2022 the Residential Supervisor was promoted as the New Regional Director for CDS-IYP Central. The CDS-IYP Central Senior Youth Care Worker was promoted on July 27, 2022 as the new Residential Supervisor for CDS-IYP Central. The CDS-IYP Central Residential Counselor received the “Employee of the Year Award” for IYP-C at the CDS Annual Meeting on November 7, 2022.

The CDS-IYP Central program conducted a successful 2022 Summer Enrichment Program. The program reported the Summer A Session started on May 30, 2022 and ended on July 1, 2022. Summer B Session started on July 4, 2022 and ended on August 5, 2022.

On August 21, 2022 the program notified DREYER’S DKI related to a Building Emergency due to a major plumbing incident at IYP-C. DRYER’S DKI completed the first phase of the “restoration process” and RR Construction completed the final phase of this project concerning the “remodeling process” which was needed pertaining to those damaged areas within the facility. The CDS-IYP Central re-opened for Residential Services on September 19, 2022.

The Alachua Board of County Commissioners declared November 2022 to be "National Runaway Prevention Month" in Alachua County at the Alachua County Board of Commissions Meeting on November 8, 2022. The CDS-IYP Central program was provided with the Official Proclamation by the Board of County Commissioner Ken Cornell. The CDS President of the Board, CDS CEO Phil Kabler and CDS-IYP Central Regional Director were in attendance to receive the Official Proclamation.

Mount Carmel Baptist Church Members provided a hot delicious Christmas Dinner Meal for program participants and staff members in the CDS-IYP Central dining room on December 22, 2022. The Mount Carmel Baptist Church Members sang a melody of Christmas Songs with the assistance from program participants and staff members.
CDS-IYP Central program participants enjoyed a Christmas Gift Day Celebration in the dining room on December 23, 2022. The CDS Christmas Gift Day Celebration was facilitated by several staff members. The program reported it was appreciative and thankful to Community Partners for their generous Christmas donations. The community partners facilitating this event included Planned Parenthood, Mount Carmel Baptist Church, and Ridgeview Baptist Church. The program also received an individual Christmas donation from a donor.

The CDS-IYP Central purchased a new clothes dryer in order to enhance the ability to manage the needs of the participants as it relates to their clothing which also includes the drying of all other shelter program required items.

The CDS-IYP Central program reported a total of ten (10) staff members were terminated or resigned. An additional seven (7) staff members were hired. At the time of this QI program review report, the program reported there are currently 22 staff members. The staff members include Regional Director, Residential Supervisor, two Full Time Residential Counselors, one Senior Youth Care Worker (YCW), one Residential Administrative Assistant, one Part Time Cook, one Part Time House Manager, one Part Time Registered Nurse, four Full Time YCW's, five Part Time YCW's and 4 On-Call/PRN YCW staff members. The program reported additional YCW staff members are needed in order to operate the best program and participant management possible.

The program reported the impact of the pandemic continues to put a tremendous strain on attracting qualified individuals to work in this environment. Further, the program reported hiring individuals just to have a body would have a negative impact on "staff development." The program reported its ongoing goal is to hire people who want to be there in order to produce the best program and participant management possible. The CDS-IYP Central Regional Director reported it is the goal of the program to continue provide residential service to children at risk and the families who are in crisis. The agency strives to provide quality services to participants and their families in a safe and friendly manner.

The program reported it is thankful to the Sunrise Rotary Club of Gainesville for their generous donation to CDS-IYP Central for providing new Duffle Bags for those participants who successfully completed their Residential stay at this facility. This donation will allow CDS-IYP Central to provide approximately 250 new Duffle Bags to our successful participants. The program reported the items in the New Duffle Bags include CDS Behavioral Management System (FACE BOOK) which includes the Social Skills, school supplies, a copy of the poem "See It Through", CDS Program Swag, and a University of Florida Gators T-Shirt.

Family Action-Central Community Counseling
The CDS-IYP Family Action-Central Community Counseling program reported challenges with staff member retention and hiring, but also reported many opportunities to adapt and excel throughout the year despite some of the changes.
The CDS-IYP Family Action-Central Community Counseling program reported joining forces with a long standing community partner, Teen Court and the Alachua County Sheriff's Office in order to explore the possibility of conducting group work. The Family Action Community Counseling program reported being able to continue to facilitate groups with the Sherriff's office and with Westwood Middle School. In addition, the program reported being able to finally hold Case Staffing's once again with much success. Further, the Family Action Community Counseling reported having cultivated a wonderful Case Staffing Committee comprised of members of the Sherriff's Office, the school board, DJJ, DCF, Shelter staff, Partnership and HOPE Florida, truancy officers, a CDS board member and CDS/Family Action Central Staff (CINS/FINS). The Family Action Community Counseling reported Truancy Court has been postponed as the School Board continues to look for an attorney to fill the role. The program reported it has been able to hire a previous intern and community partner as a PRN Counselor to further enhance groups and individual services alike in community counseling. In addition, the Family Action Community Counseling program has one open Counselor/Case Manager position and has filled the Administrative Assistant position. Also in 2022, the Family Action-Central program had to work through multiple system changes to the suicide assessment process and in 2023 the Florida Network migrated from NetMis 2 to NetMis 3.

Narrative Summary

The CDS-Interface Youth Program Central (CDS-IYP Central) is a sub-contracted service provider of Childrens In Need of Services and Families In Need of Services (CINS/FINS) with the Florida Network of Youth and Family Services (FNYFS). The agency is headquartered in 3615 SW 13th Street, #4, Gainesville, FL 32608. The CDS-Interface Youth Program - Central agency is located at 1400 NW 29th Street, Gainesville, FL 32605 and provides services to Judicial Circuits 8 which include services to Alachua, Baker, Bradford, Gilchrist, Levy, and Union Counties. The residential and non-residential CDS-IYP Central programs holds an accreditation from CARF which is valid through April 30, 2024 and is licensed by DCF Child Caring License/Runaway/Emergency Shelter for 20 beds. CDS-IYP Central recently completed a re-licensure audit with DCF and is licensed until March 31, 2024.

The overall findings for the QI Review for **CDS-Interface Central Youth Program** 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 was rated Satisfactory with no exceptions. Indicator 1.04 was rated Limited. Indicator 1.06 was rated Satisfactory with no exceptions.

Standard 2: One indicator was reviewed for standard 2, Indicator 2.03 Case/Service Plan. Indicator 2.03 was rated Satisfactory with no exceptions.

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

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

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

Standard 1: Indicator 1.04 was rated Limited due to One staff member who completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training late and did not received the required training within thirty days of hire. Four out of four new hire staff training records reviewed had three or more late trainings. One out of four annual staff training records reviewed was missing one required training.

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 is called Background Screening, Finger Printing for Personnel, Volunteers or Interns and was reviewed and approved by Cindy Starling on January 11, 2023.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.	**Compliance**	The agency utilizes a prescreening assessment for all direct staff members. Background screening related to Twelve staff members/volunteers were reviewed. Twelve staff members were direct-care and were applicable. Five new hire staff member files were for this indicator. Each of the five staff member files reviewed contained evidence documenting a passing score on the prescreening assessment.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors	**Compliance**	The agency completes a background screening prior to start/hire date. Twelve employees/volunteers were reviewed for background screening. A background screening was documented in each of the five applicable new hire records. Five new hire staff member files reviewed contained eligibility documentation to indicate each background screening was completed and deemed Eligible prior to their respective hire date.	

Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.	**No eligible items for review**	No employees reviewed for annual compliance review were applicable to a break in service.	
Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	The agency completed a five year rescreening for employees. Two of the twelve were applicable for five year rescreens. The agency had two applicable employees for five year rescreening. Documentation was provided for each of the two applicable employees.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The Annual Affidavit of Compliance with Level 2 Screening Standard form was provided and was submitted on January 11, 2023. An email was provided to document submission to the background screening unit on January 11, 2023.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Twelve employees/volunteer records were reviewed. The agency provided documentation of the E-verify for each of the thirteen applicable employees viewed.	
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		**N/A** If NO, explain here: The agency policy number is P-1030 and is called Training Policy. The policy was reviewed and approved by the agency's Chief Operations Officer on January 11, 2023.	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	The agency provided four new hire training files for review. The documentation provided indicates all four staff have completed new hire pre-service training.	
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**	Four new hire training files were reviewed. Three staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within thirty days of hire.	One staff member completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training late and did not received the required training within thirty days of hire.

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 new hire training files were reviewed. All four direct care staff members demonstrated a minimum of 80 hours of training for the first full year of employment.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	The agency requires all staff members receive mandatory training during the first ninety-days of employment. Four staff training records were reviewed. There were inconsistencies observed in all four files with staff completing the training within the required timeframe.	One staff had ten trainings completed late outside of the required timeframe of ninety days. One staff had thee trainings completed late and not withing the required timeframe. One staff had four trainings completed late and not within the required timeframe. One staff had thirteen trainings completed late and not within the required timeframe.
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**	No staff reviewed which required NIRVANA training.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	No staff reviewed which required NIRVANA training.	
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**	The agency requires direct care staff complete forty hours of mandatory refresher training annually. A review of four in-service staff members found three staff completed all trainings as required.	One staff member was missing one required 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 has a designated staff member responsible for managing all employee's individual training files.	

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 designated staff member provided eight training files for review. Each individual file includes annual employee training hours in a tracking form with related documentation such as, electronic record/transcript, training certificates, and sign-in sheets.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: Policy number 5.07 Transportation of Youth, was signed and approved by Chief Operations Officer on January 11, 2023.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The program's policies and procedures were reviewed and found to be compliant with all requirements pertaining to driver eligibility. The agency produced a list of approved drivers for this service region.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency maintains a process to screen each driver's record to ensure each staff member has a valid driver's license. The agency produced a list of approved driver's for this service region. Nineteen staff have valid drivers licenses and nine staff are authorized to transport clients.	
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 policy requires that all resident's not be allowed to be transported in a single transport situation with the exception of the approved third party not being available.	
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 policy requires the agency to assess the resident's behavior, evaluations and assessment information prior to deeming them appropriate to be in a single transport situation. The agency utilizes a multi-phase process to evaluate the resident prior to granting third party status. The agency conducts an assessment process which includes Facility Activities Communication Effectively (FACE) process in individual client sessions.	

The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	Per the agency's policy, Third party transport is defined as staff members, volunteers, interns and residents. A review of the Vehicle Travel Log/Van log form over the last six months found evidence of staff, residents and volunteers listed in the Transportation log on outings.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	The total number of single transport events over the last 6 months were reviewed. The agency documents all single transport events on the Single Transport Finder Document. The agency established the use of this form on July 1, 2022. Single transport events over the last six months include: November 11, 2022, at 7:03am prior approval granted by Supervisor. May 8, 2023, at 7:03am prior approval granted. May 9, 2023 at 7:01 am prior approval granted. May 10, 2023, at 7:03am pm prior approval granted. May 11, 2023, at 7:00am prior approval granted. May 12, 2023, at 7:00am prior approval granted. May 15, 2023, at 6:58am prior approval granted. May 16, 2023, at 7:00pm prior approval granted. May 17, 2023, at 7:00am prior approval granted. May 18, 2023, at 6:59am prior approval granted. May 19, 2023, at 6:55am prior approval granted. May 22, 2022, at 7:03am prior approval granted. May 23, 2023, at 7:01am prior approval granted. May 24, 2024, at 7:00am prior approval granted. All events have evidence documenting the program's Regional Director is made aware and grants approval prior to the single transportation 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**	The agency utilizes a Travel Log/Van form to document all general transport events. The form includes Destination/ purpose, Departure time, Start of Trip-Mileage, End of Trip return time, Ending Mileage, and Name and Number of Adults.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory**
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 P-1162 and is called Individual Plan. The policy was reviewed on January 11, 2023, and approved by the agency's Chief Operations Officer.	

The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	A random sample of nine open and closed residential and community counseling client records serviced by the agency in the last six months was conducted onsite. All residential and community counseling client files reviewed contained a service plan. The agency develops all service plans with client information obtained the initial screening, intake, suicide screening and administration of the NIRVANA assessment instrument process.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All nine client files service plans reviewed onsite contained evidence confirming each was developed within seven days of completion of the NIRVANA assessment.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Compliance**	Of the nine client files, all nine have evidence of having service plans for each client case file includes the documentation of multiple goals and objectives, service type, frequency, location, persons responsible, target dates for completion, actual completion dates, and the signatures of the client, parent/guardian, counselor and supervisor. Nine client file records contain documented evidence of client service plans which were consistent with the requirement of the indicator. The case progress notes are documented on Service Tracking forms called the Behavior, Intervention, Response, Plan (BIRP) format.	
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**	The nine client files reviewed onsite all have client records which contained evidence of documentation of file review sessions which include documented goals and objectives tracking 30 day plan review sessions and general progress. These service plan review sessions include the signatures of all required parties.	
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Exception**
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 P-1293 and is called Shelter Environment. The policy was reviewed on January 11, 2023, and approved by the agency's Chief Operations Officer.		

Facility Inspection	**Exception**	The agency's CDS-IYP Central holds an accreditation from CARF which is valid through April 30, 2024 and is licensed by Department of Children and Families Child Caring License/Runaway/Emergency Shelter for 12 beds. The DCF Child Caring Agency License is in effect and expires on March 31, 2024. A tour of the youth shelter was conducted on the first day of the QI program review. The youth shelter is located off of a commercial road and located near a residential community. The exterior area of the shelter has a traditional front door and a side entrance. The outside of the shelter has parking spaces with gravel and some sparsely located trees. The shelter has a limited areas for physical activity due to basketball court that is currently not accessible due to storm damage. The exterior of the shelter is surrounded by trees and some perimeter fencing. The front entry receiving area has all the agency's major certifications listed such as the DCF and CARF License which are posted. The front entry way has receiving rooms to meet and conducts sessions with clients and parents/guardians. A tour of both the boys and girls sleeping, eating, common and study areas of the shelter was conducted. The sleeping areas were toured and found to be clean and sanitary. In general, all the interior furnishings are in good order and no broken or non-functioning items were observed. During the facility tour no graffiti was found on the interior furniture or in interior areas including the main day room, male and female day rooms and sleeping and bathrooms. The program does not have any visible signs of insect infestation. The outside trash receptacle was clear. The trash receptacle lid were observed closed. All youth have personal storage bins located adjacent to each resident's bed. These personal storage bins house each resident's items during their shelter stay. All parked vehicles on	On day one, the reviewer observed interior deficiencies including evidence of light spotting of mold growth and mildew in one male bathroom on air conditioning vents and one female bathroom near corner of shower near ceiling (3-4 inch total area). Two emergency lights were identified as not working on day one. Both emergency lights have been repaired and were operational prior to the close of the program review. The agency is maintaining weekly chemical counts as required. There were additional bottles in Control Room storage area that did not match count on the inventory sheet. The agency is not conducting perpetual documentation of chemicals outside of the routine weekly inventory count.
Additional Facility Inspection Narrative (if applicable)	Reviewed the Florida Department of Health Group Care inspection on February 23, 2023. Satisfactory ratings and no findings were reported. Reviewed the Florida Department of Health Group Care inspection on Food December 21, 2022. Satisfactory ratings and no findings were reported. There are twenty cameras mounted in various areas of the shelter. None of the cameras are mounted in client sleeping or bathing areas.		

Fire and Safety Health Hazards	**Compliance**	The fire inspection is completed Gainesville Fire and Rescue. The last Fire department inspection was completed on February 22, 2023. All requirements were met and are in compliance at the time of this inspection. Fire drills: 1st Shift: November Day shift 11/11/022 at 9:15am with/ 6 participants in 60 seconds. Evening - 11/30/2022 at 7:10pm w/6 participants in 42 seconds. Overnight 11/7/2022 at 8:49am w/1 participants in 60 seconds. DECEMBER Day shift 12/27/022 at 1:2pm with/ 12 in 50 seconds. Evening - 12/28/2022 at 7:00pm w/9 participants in 4 seconds. Overnight 12/18/2022 at 8:08am w/10 participants in 52 seconds. JANUARY Day shift 1/123/203 at 11:37am with/ 6 in 57 seconds. Evening - 1/24/2023 at 4:50pm w/7 participants in 58 seconds. Overnight 1/14/2023 at 8:20am w/7 participants in 49 seconds. FEBRUARY Day shift 2/4/2023 at 8:38am with/ 10 participants in 55 seconds. Evening - 2/7/2023 at 9:20pm w/11 in 56 seconds. Overnight 2/5/2023 at 8:30am w/10 participants in 60 seconds. MARCH Day shift 3/5/2023 at 9:00am with/ 16 in 60 seconds. Evening - 3/10/2023 at 8:00pm w/16 in 58 seconds. Overnight 3/7/2023 at 7:30am w/15 participants in 55 seconds. APRIL Day shift 4/15/2023 at 1:30am with/ 11 participants in 53 seconds. Evening - 4/8/2023 at 8:40pm w/7 in 40 seconds. Overnight 4/7/2023 at 7:00am w/13 participants in 51 seconds. MAY Day shift 5/6/2023 at 9:18am with/ 11 in 58 seconds. Evening - 5/8/2023 at 9:00pm w/12 participants in 59 seconds. Overnight 5/18/2023 at 6:00am w/11 participants in 57 seconds.	
Additional Fire and Safety Health Hazards Narrative (if applicable)	Mock drills completed as required by the agency and were reviewed onsite. DECEMBER : Day shift 12/9/2023 at 3:45am with/ 17 - Threatening Situation. Evening - 12/18/2023 at 10:45pm w/14 - Safety for Violent Safety Threatening Situation. Overnight 12/25/2023 at 7:30am w/2 - Safety for Violent Safety Threatening Situation. APRIL : Day shift 4/16/2023 at 10:30am with/14 - Natural Disaster. Evening - 4/12/2023 at 10:30pm w/9 - Natural Disaster. Overnight 4/18/2023 at 2:15am w/9 - Natural Disaster.		
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**	A review of the agency's grievance system was conducted onsite. The agency provides a program orientation to all eligible residents upon admission to the program. The orientation process requires all residents be informed of the grievance process and where grievances are to be submitted and how grievances will be resolved. Residents have multiple locations to access grievance forms and submit them as needed.	

There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook. All grievances are resolved within 72 hours and documented by program director.	**Exception**	A review of the agency's Grievance practice was conducted. There is evidence of Grievances in the last six months. A total of three grievances are documented. Minimal evidence of grievances being checked and documented. in the logbook prior to April 2023.	There is minimal evidence of grievances being checked and documented in the logbook prior to April 2023.
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**	At the time of this onsite program review, staff members were observed monitoring youth in general program activities that are scheduled throughout the day. Staff were observed engaging youth appropriately and implementing the behavior management plan when applicable. Youth were observed participating in arts and crafts, groups and eating meals. During the review, Counselors were also observed meeting with youth and youth were also performing minor chores. The agency's daily schedule includes a broad listing activities for morning, afternoon/evening, Saturday and Sunday. The activities includes Morning: Wake Up/Hygiene, Linen Change, Breakfast/Chores, Receive School Progress Reports/Transport to School, Life Skills Training, Academics/Study Hall, and Journaling/Reading (Continue Academics if not completed). Afternoon/Evening: Lunch, Chores, School Pick Up/Check-in/Progress Reports/Reading/ Study Hall, Life Skills Training for all Participants, Group Counseling Session, Afternoon Snack/ Leisure Time, Outdoor/Indoor, (LMA) Recreational Activity, Dinner, Chores, Showers/Phone Calls/Leisure/Role Plays/ Total Up Time. Sunday-Thursday: Evening Snack (boys and girls), Prep for Next Day/Leisure Time/Journaling, Bedtime/Lights Out. Friday and Saturday: Evening Snack (boys and girls), Prep for Next Day/Leisure Time/Journaling, Bedtime/Lights Out. The agency's daily schedule includes an hour of recreational activity. At the time of this onsite review, the basketball court in rear area of the shelter is not accessible due to storm damage. The youth are taken to a nearby park area for access to open space for recreational activities. In addition, youth are also provided opportunities to participate in faith-based activities. Youth are also provided with opportunities to participate in other non-faith based activities.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency policy number is P-1121 and is called Supervision and Staff Ratio and/Schedule. The policy was reviewed on January 11, 2023, and approved by the agency's Chief Operations Officer.	
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 maintains minimum staffing ratios as required by Florida Administrative Code and contract. A review of four weeks of scheduling confirmed the agency utilizes appropriate staffing levels as required.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	A review of four weeks of scheduling confirmed the agency utilizes a minimum of two direct care staff members that have met the minimum training requirements.	
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**	Agency staff members included in staff-to-youth ratio includes only staff that are background screened and properly trained. A review of eight training files confirmed training levels were met per policy. A review of eighteen employee records confirmed all had received a background screening.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff member schedule is posted in the master control room and is visible to all staff.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The staff member schedule includes a holdover or overtime roster which includes all telephone numbers of staff members who may be accessed for additional coverage.	
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**	A review of the indicator was conducted to determine if the agency was completing 15 minute bed checks as required. A review of five randomly selected nights of video camera coverage was conducted for May 1, 9, 10, 12, and 16, 2023. Staff members were observed connecting all bed checks every 15 minutes during the sleeping hours as required. Times are documented in real time.	
Additional Comments: **There are no additional comments for this indicator.**			

4.02 - Suicide Prevention			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency policy number is P-1144 and is called Mental Health, Substance Abuse and Suicide Risk Screening. The policy was reviewed on January 11, 2023, and approved by the agency's Chief Operations Officer.	
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 review of the agency's suicide risk practices including prevention, observations and assessment was conducted. A review of five randomly selected residential client files were reviewed to determine the agency's adherence to the requirements of the indicator. There was evidence documented to indicate all five residential client files were screened and contained a positive response for suicide on one of the suicide risk screening questions during the admission and screening process. The suicide risk form is maintained in all six client files and was reviewed, signed and dated by the supervisor as required.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The agency's suicide risk assessment tool was reviewed. The agency 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**	A total of five client files reviewed onsite were residential client files. All five of these residential client files contained evidence the youth being placed on sight and sound observation was based on a positive indication of at least one positive suicide risk screening question being answered by the youth during the initial screening process.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	All five residential client files contain evidence of staff members documenting each status including behavior, warning signs, and observer's initials. Additionally, the client's observation form recorded the youth's status at the thirty minute requirement.	

Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	All five residential client files contained a completed suicide risk screening and suicide risk assessment. All client files have an assessment completed by a non-licensed mental health staff member working under the direct supervision of the Licensed Mental Health Counselor (LMHC) or completed by the LMHC. All five youth were not removed from elevated supervision status until each was directed by the LMHC to be stepped down to regular supervision status and placed in regular supervision status with the general shelter population. Youth being removed from the sight and sound status is also documented in the program logbook.	
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.	**Compliance**	The program reports were one youth which met this criteria over the past year. Any youth with an identified suicide risk that the agency could not assist are referred to the local mental health receiving facility for higher level care or assessment. The client was screened for Suicide and indicated a positive response on 2 out of 5 questions related to having thoughts of suicide and self harm. An assessment was completed . This client was assessed as required by a non-licensed staff overseen by the licensed clinician. Parent was notified in real-time following the intake session.	
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.	**Compliance**	Safety plan and other prevention strategies were also provided to the parent.	
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.	**Compliance**	Parent was provided with information on local service providers such as Meridian, Alachua Crisis Center, and Life Line.	

If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	Parent was at office during intake process and immediately informed following intake session.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	The screening was not performed at school.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Satisfactory**
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 P-1120 and is called Medication Provision, Storage, Access, Inventory and Disposal. The policy was reviewed on January 11, 2023, and approved by the agency's Chief Operations Officer.	
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**	Agency has a Registered Nurse (RN) with verified credentials.	

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 agency Pyxis ES Medication Cabinet is inaccessible to youth. The Pyxis machine is stored in accordance with guidelines and policy on Medication Management. Oral medications are stored separately from injectable epi-pen and topical medications. All medications requiring refrigeration are required to be stored in a small dedicated refrigerator that has a thermometer. The Pyxis holds all narcotics and other prescription medications. The Pyxis medication cart keys are accessible to staff members in the event of an emergency.	

Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	**Compliance**	The agency maintains two site managers for Pyxis. Only one staff members has access to secured medications with limited access to controlled substances. A medication distribution log is utilized for all documentation of distribution of medication by non-licensed staff. Agency verifies medication per policies and procedures. The RN delivers all medication to clients when on site and training to staff. The delivery process of medications is consistent with policy. Non-licensed staff have received training in the use of epi-pens provided by the registered nurse.	

Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	A perpetual inventory with running balances is maintained, as well as a shift-to shift count. A review the agency's medication storage practices was conducted. A review of all weekly, perpetual and controlled medication counts was reviewed for the last six months for the period covering November 2022 through May 2023. All controlled and other medication counts were counted on a weekly basis as required. The program does not utilize needles or syringes. The agency does maintain weekly counts for knives and scissors. A review of all weekly counts for sharps was reviewed for the last six months for November 2022 through May 2023. There is documented evidence of a weekly count for knives being conducted as required.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The RN primarily completes monthly reviews of Pyxis reports to monitor medication management practices.	
Medication discrepancies are cleared after each shift.	**Compliance**	A review for medication discrepancies during the period of review for the past 6 months was conducted and it was observed that the agency is adhering to the requirement of clearing the discrepancies after each shift as required.	
Additional Comments: **There are no additional comments for this indicator.**			