Florida Network for Youth and Family Services
Compliance Monitoring Report for

CDS Interface Youth Program East
2919 Kennedy Street
Palatka, Florida 32177

May 3-4, 2023

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit on May 3-4, 2023 for the FY 2022-2023 CDS-Interface Youth Program East (CDS-IYP East) CINS/FINS program at its program office located at 2919 Kennedy Street, Palatka, Florida 32177 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 East 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 LeAnn Gruntzel, Deputy Supervisor Monitoring Quality Improvement, Florida Department of Juvenile Justice. Agency representatives from CDS-IYP East present for the entrance interview were, Cindy Starling, Chief Executive Officer, Alex Culbreth, Regional Director, LaToya Robinson, Residential Counselor, Lyntinia McCullough, Community Counselor, Monica Heinecker, Senior Youth Care Worker, Karen Bethel, Administrative Assistant. The last QI visit was conducted April 20-21, 2022.

In general, the Reviewer found that CDS-IYP East is in compliance with specific contract requirements. The CDS-IYP East agency **received an overall compliance rating of 100% for achieving full compliance** with five out of five applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. There were no Corrective Actions as a result of the monitoring visit and no Recommendations were made.

The following report represents the results of the 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 05-3-4-2023

Agency Name: CDS-IYP East	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2919 Kennedy Street Palatka, Florida 32177**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 3-4, 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.**

Agency Name: CDS-IYP East						Monitor Name: Keith Carr, Lead Reviewer	
Contract Type: CINS/FINS						Region/Office: 2919 Kennedy Street Palatka, Florida 32177	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): May 3-4, 2023	
	Explain Rating					Ratings Based Upon:	Notes
Major Programmatic Requirements	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)
						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 05/01/2022 – 05/01/2023. 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.**

Agency Name: CDS-IYP East						Monitor Name: Keith Carr, Lead Reviewer	
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Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): May 3-4, 2023	
	Explain Rating					Ratings Based Upon:	Notes
Major Programmatic Requirements	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)
						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 April 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 and Administrative Assistance. An onsite reconciliation was conducted onsite with an ending amount of $150. The petty cash is reconciled on a consistent basis (monthly/quarterly) by the Administrative Assistant and reviewed by the Regional Director. 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. In the event the provider has purchased computer	☐	☐	☐	☐	☒	Interview/Documentation: The agency has not purchased any property with FNYFS funds for the current fiscal year.	**No recommendation or Corrective Action.**

Agency Name: CDS-IYP East						Monitor Name: Keith Carr, Lead Reviewer	
Contract Type: CINS/FINS						Region/Office: 2919 Kennedy Street Palatka, Florida 32177	
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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		
equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**							
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 East program has met the requirements for the CINS/FINS contract as a result of full compliance with all five applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. All four applicable indicators were met. One item was not applicable due to the agency not purchasing any property with FNYFS funding. 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.

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

Review of CDS Family Behavioral Interface East (Palatka)
CINS/FINS Program

DATE: May 3-4, 2023

Compliance Monitoring Services Provided by

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CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of Indicators rated Satisfactory: 100 %
Percent of Indicators rated Limited: 0 %
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: 100 %
Percent of indicators rated Limited: 0 %
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
Nitara LaTouche - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
LeAnn Gruentzel – Regional Monitor, Department of Juvenile Justice

Methodology

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

Persons Interviewed

X	Chief Executive Officer	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		# Program Supervisors
X	Program Director	X	Direct – Part time		# Food Service Personnel
	Program Manager	X	Direct – Care On-Call	1	# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer	3	# Other (listed by title): ___
X	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	10	# Health Records
X	Logbooks	X	Key Control Log	10	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	12	# 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	7	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	1	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
X	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

	Intake	X	Posting of Abuse Hotline	X	Staff Supervision of Youth
X	Program Activities	X	Tool Inventory and Storage	X	Facility and Grounds
X	Recreation	X	Toxic Item Inventory & Storage	X	First Aid Kit(s)
X	Searches		Discharge	X	Group
X	Security Video Tapes	X	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

6	# of Youth	14	# of Direct Staff		# of Other		

Comments

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

Monitoring Purpose

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

Strengths and Innovative Approaches

The CDS-Interface East (CDS-IYP East) is a sub-contract 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 CDS agency is headquartered in 3615 SW 13th Street, #4, Gainesville, FL 32608. The CDS-IYP East agency is located at 2919 Kennedy Street, Palatka, Florida 32177 and provides services to Judicial Circuits 7 and 8 which include services to Putnam and Bradford Counties.

The following programmatic updates were provided by the agency:

Staffing:
The agency reported its prior Comptroller remained with the agency on a part-time or as needed basis. The agency promoted its Fiscal Assistant to Fiscal Administrator, who functioned as Interim Comptroller, with support from the prior Comptroller. The agency has engaged a new Comptroller. Additionally, the agency has promoted its Gainesville Stop Now And Plan (SNAP) Case Manager as the Program Supervisor of its new established Circuit 3 SNAP program.

Facility:
The CDS-IYP East shelter received another grant from Clay Electric and this has been utilized for the perimeter fence. Funds will also assist with purchasing the equipment for the new security camera system. Further, the agency reported the addition of new bunk beds for the Boy's Bedroom. The agency is also hoping to acquire additional funding to purchase new beds for the Girl's Bedroom.
The agency reported that it is preparing to start building a new 20-bed Gainesville CINS/FINS youth shelter. The agency reported plans for the new shelter have been developed and the official ground-breaking is scheduled for May 2023. The youth shelter is projected to be completed by the end of the calendar year. The agency has begun planning for the transition between the two facilities and its Board of Directors is engaged in the process.

Funding/Finance:
The agency reported its Board of Directors and its new Development Committee are actively engaged in a number of fundraising initiatives. The agency has engaged an independently contracted Grant Writer to work on identifying and preparing applications for larger-scale private and public grants. The agency is a participating agency in the U.F. Campaign for Charities and its Board of Directors has an ongoing internal donation campaign. Additionally, the agency reports that is has received funding from the following sources, among others: ARPA – City of Gainesville; Community Foundation of North Central Florida - Amazing Give; Amazon Smile; Clay Electric Foundation (for the IYP-Palatka shelter); Downtown Gainesville Rotary Club (in-kind for IYP-Gainesville); Facebook campaigns; Fairstead Realty NY; First Federal Foundation (from a private donor for the IYP-Lake City shelter); Gainesville Eagles Club; Giving Tuesday; Palatka Ladies of the Moose Club; Rotary Club of Gainesville Sunrise (for the IYP-Gainesville shelter); and United Way of Suwannee Valley (for the IYP-Lake City Shelter).

At the time of this onsite program review, there were a total of eight residents being served in the youth shelter. The agency reported three (3) vacant CDS-IYP East full time employment staff member positions which included 1.0 Residential Supervisor and 2.27 Youth Care Workers. Currently, CDS-IYP East currently employs 10 full-time employees, including 1 of each of the following, Regional Director, Administrative Assistant, Residential Counselor, Outreach/Safe Place Specialist, Life Skills Educator, Senior Youth Care Worker, Family Action Case Manager, and 3 Youth Care workers. The CDS-IYP East agency also employs a House Manager, Registered Nurse, and 7 part-time Youth Care Workers. Since the last QI program review, the agency has been without a Residential Supervisor due to the termination of the previous one and the inability to find one qualified to fill the position. The position remains vacant at the time of the review. The agency reports that it has been fortunate enough to hire two youth care workers. The vacant positions of Residential Supervisor and Youth Care Workers are currently being advertised.
The agency lost the previous Registered Nurse (RN) during the year. The agency was able to hire another RN and decided to hire only one for 20 hours a week. The agency's long-time House manager is retiring soon, and the agency has thoroughly trained several staff to take on these duties. Regarding licensure, the Regional Director holds an Master's Degree in Social Work in Advanced Clinical Practice and is a Licensed Clinical Social Worker (LCSW). The Residential Counselor is a Master's level Counselor and is currently an intern in the process of earning her License in Professional Counseling (LPC) credential, and the nurse is an RN. The RN was hired in July 2022 and has a flexible schedule and comes into the shelter during intakes to complete the health screening and to process and log in any medicines the youth may have.

The CDS-IYP East Regional Director reported that in the beginning of the year the agency faced challenges with staffing and trying to find good and qualified candidates for the youth care worker positions and for the Residential Supervisor position. The agency reported it continues to be challenging to recruit candidates with the qualifications to be eligible for the positions and also capable of completing such rigorous demands for training.

Narrative Summary

The CDS-IYP East shelter provides counseling and case management services through its residential and non-residential programs and some services are available virtually to accommodate families on a case by case basis. The residential program provides groups, family, and individual counseling sessions for our participants in the shelter. The non-residential program provides services in schools, in home, and virtually, as needed. CDS-IYP East holds an accreditation from CARF which is valid through April 30, 2024 and is licensed by DCF Child Caring License/Runaway/Emergency Shelter for 12 beds. CDS-IYP East recently completed a re-licensure audit with DCF and received an extension on our license but we are still waiting to receive their official full license renewal.

The program maintains paper files for all youth records that are kept in a locked cabinet marked confidential behind a locked door. Services are primarily provided in home or at school and can be virtual when necessary. The Community Counseling Supervisor advised that truancy court or the residential shelter are the primary source for referrals. The truancy court defines 15 unexcused absences to be considered truant. A truancy coordinator can also send referrals prior to truancy court intervention. The program attends Student intervention Team (SIT) meetings to look at potential youth needing assistance. The program is only staffed with one individual for the all youth served within the Community Counseling program.

The overall findings for the QI Review for **CDS Interface East** are summarized as follows:

Standard 1: Three indicators were reviewed for Standard 1: 1.01 Background Screening, 1.04 Training, and 1.06 Transportation. Indicator 1.01 was rated Satisfactory and Indicators 1.04 and 1.06 were rated Satisfactory with exceptions.

Standard 2: One indicator were reviewed for Standard 2: 2.03 Case/Service Plan and was rated Satisfactory with exception.

Standard 3:Two indicators were reviewed for Standard 3: 3.01 Shelter Environment, and 3.06 Staffing and Youth Supervision. Both indicators were rated Satisfactory with exceptions.

Standard 4: There are 2 indicators that were reviewed for Standard 4, indicators 4.02 Suicide Prevention, and 4.03 Medications. Both indicators were rated Satisfactory with no exceptions.

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

None of the indicators reviewed were rated Limited or Failed.

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 last revision of the policy was in November of 2022. The policy 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 program hired three new staff members during the compliance review period. Two of the three staff received a passing score on the prescreening assessment. One of the staff scored low on the prescreening assessment however, the program obtained a written exception letter for authorized approval to hire staff.	
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**	Each of the three hired staff members had a completed and eligible background screening which was added to the Clearinghouse prior to being hired.	
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**	None of the three hired staff members had indications of a break in service and were all new hires for the provider.	
Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	Six staff members were applicable for a five year re-screening and each had a completed rescreening withing the required timeframe and prior to the fingerprint expiration date.	

Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The program submitted their Annual Affidavit of Compliance with Level 2 Screening Standards within the required timeframe on January 13, 2023 via email.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Each of the three hired staff records contained proof of E-Verify obtained from the Department of Homeland Security.	
Additional Comments: **There are no additional comments for this indicator.**			
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The last revision of the policy was in November of 2022. The policy was reviewed and approved by Cindy Starling 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.	**Exception**	Three of the four reviewed staff members training records for pre-service training indicated all required training within the required timeframes.	One staff member did not complete all required pre-service training within the required timeframes.
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**	Each of the four of the reviewed pre-service staff members training records confirmed completion of Civil Rights and Federal Funds training within the first thirty days of employment.	
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**	Each of the four of the reviewed pre-service staff members training records confirmed each staff member completed at least the minimum mandatory eighty hours of training during the first year of employment.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Three of the four reviewed pre-service training records indicated each staff member completed of all mandatory training during the first ninety days.	One of four reviewed pre-service training records indicated the staff member did not complete six trainings within the required timeframe. One staff member completed cultural humility, understanding youth/adolescent development, managing aggressive behavior, CINS/FINS core training, fire safety equipment, and SOGIE after the first ninety days of hire.
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**	None of the pre-service staff members are responsible for entering NIRVANA or data into the Florida Department Juvenile Justice Information System (JJIS).	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**Compliance**	The program had one new applicable non-licensed clinical shelter staff member during the annual compliance review. Reviewed documentation on the Department's Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk confirmed the staff member completed all required trainings in Assessment of Suicide Risk (ASR), provided by a licensed mental health professional.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Compliance**	Four in-service training records were reviewed and each staff member completed all required in-service trainings as required.	
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 program has a designated staff member responsible for managing individual training records. A review of eight training records confirmed the designated staff completed routine reviews of staff member records to ensure compliance.	

The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	A review of eight training records confirmed the program maintained individual records for each staff member which included all required training documentation.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency policy number is P-1013 and is called Transportation. The policy was reviewed on January 11, 2023, and approved by the agency's Chief Operations Officer.	
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 program provided a list of four staff authorized to transport clients in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	According to the program's policies and procedures, all transporting personnel must possess a valid Florida driver's license. The agency provided a list of all staff members covered under the agency's automobile insurance coverage. A random selection of four staff member names were selected. The agency provided valid Florida drivers license records for all four employees being approved to perform all transportation duties.	
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**	According to the program's policies and procedures, the program director must be notified prior to the practice of individual staff transporting a single client. The transporting employee shall check in by phone at agreed upon intervals with the senior program leader.	

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**	According to the program's policies and procedures, in the event that a third party cannot be obtained for transport, the client's evaluations, history, personality, recent behavior, and length of stay are all criteria to be considered. The agency approves a list of staff members eligible to drive and includes verification that the participant's history, evaluation and recent behavior is considered. The agency updates and approves this list of participants (staff and youth) every seven days.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	A review of the agency's current practice was conducted. The reviewer assessed the Travel Van Log form for the past six months (November 2022 - May 2023). A review of the Travel Van Log forms indicated evidence of a third party presence being documented as an additional direct care staff member, volunteers, interns, clinical or administrative staff members, or other youth.	
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 transportation events for the past six months was conducted. There was documented evidence of single transport events in October 2022: 22 transports; November 2022: 13 transports ; December 2022: 21 transports; January 2023 22 transports; February 2023: 35 transports; and March 2023: 27 transports. A review of agency travel log information was reviewed. There was evidence documenting a total of 140 single transport events in the last 6 months.	Of these events, two of the 140 did not have accurate documentation of prior approval from the designated authority as required.
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	A review of the program's vehicle log called the Travel Van Log form indicated documentation of the name of authorized driver, date and time, mileage, number of passengers, purpose of travel and location as required.	
Additional Comments: **There are no additional comments for this indicator.**			

2.03 - Case/Service Plan			Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The 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.	**Exception**	Eight client records were reviewed for this indicator. Five residential (One open, four closed) and three community counseling (three closed). Seven out of eight files reviewed indicated that the case plan was developed based on information gathered during the initial screening, intake, and NIRVANA assessment.	One file reviewed indicated that substance abuse was not included in the service plan, but was originally noted as the presenting problem.
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All eight records reviewed contained case service plans that were completed with 7 days of the NIRVANA.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	Seven out of eight records reviewed contained case service plans that included individualized and prioritized need(s) and goal(s) identified by the NIRVANA; service type, frequency, and location of services; person(s) responsible; target and completed date(s) for completion of goals; and date the plans were initiated. Progress notes are documented in the youth record to indicate when intake and NIRVANA is commenced clearly. All required signatures of youth, parent/guardian, counselor, and supervisor were evident in eight of the eight records. The internal policy describes 'objectives' as being measurable, time-specific and achievable. Based on internal policy, goals are not always written to allow measurement of progress (increase or decrease) of specific behavior(s). One file reviewed noted the service plan review was conducted via phone and the program was able to obtain a signature from the parent, however the timeframe couldn't be established without a date or progress notes to indicate when plan was actually signed.	One file missing one of the prioritized needs of youth reporting 'vaping' as a substance abuse issue as reported in the NIRVANA Self Report assessment during the intake for one residential 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**	Five out of eight files were applicable for progress reviews every 30 days and all five service plans demonstrated compliance within the required timeframes.	
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 East 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 day one of the program review with both reviewers. The youth shelter is located in mixed use residential and commercial area of family homes. The exterior area of the shelter's front of the building has a single door to the front entrance. The outside of the shelter has a parking lot adjacent to the youth shelter that is equipped with a basketball goal and an expansive backyard area. The exterior of the shelter includes a recently built new wood fence that surrounds the rear and side areas of the facility. The front entry receiving area has all the agency's major certifications listed such as the DCF and CARF License posted. The entry way also incudes camera on premises and a universal language indicating the agency serves all youth. A tour of both the boys and girls sleeping areas was conducted. Both areas were clean and did not have unsanitary or broken items. In general, all the interior furnishings are in good order. 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. All youth have secure storage bins located adjacent each bed. Bins house all personal items of each youth during their shelter stay. On day one, the reviewer observed interior deficiencies including water stain on the ceiling of the boy's dorm. The program does not have any visible signs of insect infestation. All facility doors are secure, in and out access is limited to staff members. Key control is in compliance and all facility keys were accounted for during the two-day onsite program review. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. The agency has egress plans posted throughout the youth shelter. The agency's egress plans are posted in the front entry area, the kitchen, the main day room, male and female day rooms, male and female sleeping areas, youth care office and hallways. The washer and dryer are operating and the lint collector was clear of lint. The trash receptacles in the interior areas were clear. The trash receptacle lids were closed.	

Additional Facility Inspection Narrative (if applicable)	All interior lighting is functioning, except an emergency light. The light was repaired on day one of the program review. Exterior lighting is working as required. The agency has two transportation cargo vans which were both locked and secured. All safety equipment including fire extinguishers, seat belt cutters, glass breakers, first aid kits are included and up to date in each van. The 2016 van did not have eye wash in the first aid kit. The 2003 van contained eyewash that was expired. The program placed new eyewash bottles in each van. All cold food in the refrigerator is properly stored and marked as required. Refrigerators/Freezers are clean and maintained at required temperatures. Small and medium sized kitchen appliances are clean. The licensed dietician approved menu was reviewed and approved for January 2023 - January 2024 by the licensed dietician. The dietician's license expires on May 31, 2023. Resident information informing them of all major facility requirements was observed onsite. Information posted by the agency for residents included resident rules, abuse reporting, and contact numbers which are posted on the general bulletin board in both the male and female dayrooms and the main day room area. At the time of this onsite program review, the agency is counting chemicals once per week. The agency is not counting chemicals on a perpetual basis.		The agency does not have evidence of maintaining a perpetual inventory of chemicals, however, a draft of a chemical inventory form was developed and presented on day two for perpetual use of chemicals by staff members.
Fire and Safety Health Hazards	**Compliance**	The fire inspection is completed Palatka Fire Department. The last Fire department inspection was completed on October 13, 2022. All requirements were met and are in compliance at the time of this inspection. Fire drills: 1st Shift: October 8, 2022 at 1:30pm duration 30 seconds. November 1, 2022 at 8:30am duration 15 seconds. December 2, 2022 at 12:00pm duration 30 seconds. January 1, 2023 at 3:30pm duration 15 seconds. February 27, 2023 at 8:45am duration 30 seconds. March 17, 2023 at 9:00am duration 30 seconds. April 10, 2023 at 10:30am duration 30 seconds. 2nd Shift: October 2, 2022 at 4:30pm. November 17, 2022 at 5:30am. December 2, 2022 at 6:30pm duration 11 seconds. January 3, 2023 at 8:00pm duration 10 seconds. February 2, 2023 at 9:10am duration 20 seconds. March 6, 2023 at 8:43am duration 40 seconds. April 3, 2023 at 8:15pm duration 10 seconds. As applicable 3rd Shift: October 3, 2022 at 6:40am duration 23 seconds. November 1, 2022 at 8:00am duration 12 seconds. December 1, 2022 at 6:30am duration 28 seconds. January 1, 2023 at 7:35am duration 10 seconds. February 1, 2023 at 6:50am duration 26 seconds. March 11, 2023 at 6:55am duration 19 seconds. April 1, 2023 at 7:58am duration 8 seconds.	
Additional Fire and Safety Health Hazards Narrative (if applicable)	Mock drills completed by the agency were reviewed onsite. 1st Shift: October 10, 2022 at 9:30am - Natural Disaster Drill -Tornado Warning. March 3, 2023 at 11:30am - Bomb Threat Drill. 2nd Shift: October 1, 2022 at 8:40am - Natural Disaster Drill - Hurricane . March 29, 2023 at 6:01pm - Empty box outside of shelter -bomb Threat Drill. As applicable 3rd Shift: October 4, 2022 at 7:00am - Natural Disaster Drill - Flood Warning; March 2, 2023 at 7:00am - Letter of Threat of harm Drill. The annual Group Care Inspection was conducted by the Department of Health by January 25, 2023. No food storage or preparation, sanitation or other issues related to food were noted.		

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.	**Compliance**	A review of existing grievances found the agency conducting checks of each grievance box located in each female and male day room and the main day room. All grievances were address in less than the 72 hour requirement. The Program Director ensures all grievances are resolved with the required 72 hour timeframe.	
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 review, youth were observed completing school work on a desktop computer in boy's dayroom while being supervised by a staff member. The program's daily schedule was observed. 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 between 6:00pm and 7:00pm. Youth are provided opportunities to participate in faith-based activities. Youth are also provided with opportunities to participate in alternative activities other than faith-based activities and are not punished for doing so.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Exception
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-1133 and is called Staffing and Supervision. The policy was reviewed and approved by the Chief Operations Officer on January 11, 2023.	
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	A review of logbooks for the last six months verified the program maintained at least the minimum one staff to six youth ratio for awake hours and one staff to twelve youth ratio for overnight hours. A video review of six days confirmed ratio was maintained 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 staff member schedules and logbooks during the annual compliance review period confirmed the program provided a minimum of two staff on each shift. A video review of six days confirmed at least two staff were on shift as required.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Compliance**	A review of documentation confirmed staff-to-youth ratio included staff members who were background screened and properly trained.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff members schedule is maintained in the control room and is accessible to 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 program does not maintain a holdover or overtime rotation roster. Holdover or overtime shifts are covered by other staff members or PRN staff called in. A staff members contact list is available to all staff if needed and any changes are communicated to supervisors.	

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	**Exception**	Six random days of video were reviewed 4/9, 4/11, 4/20, 4/23, 5/1, and 5/4 for compliance with bed checks. Three of six days reviewed found all checks were completed within the required timeframe. All of the bed checks completed in the male dorms were observed to be in compliance. The girls dorm had some inconsistencies regarding the checks being conducted every 15 minutes as required. A form/documentation review was conducted of 14 random days during the review period (December - April). A random selection of times were reviewed within the documentation and 10 out of 14 days observed the fifteen minute checks were completed within the required timeframes. Five out of nine days of documentation for the female dorms reviewed were consistent with 15 minute bed checks. All documentation reviewed for the male dorms were consistent with 15 minute bed checks. Three additional random days were reviewed for the girls dorm and found no exceptions noted.	Five out of twenty days reviewed for 15 minute checks contained evidence of late bed checks. One form was missing evidence of bed checks between 3:49am-4:20am, however, video confirmed the bed checks did occur and only the documentation was missed. One day observed three fifteen minutes checks being conducted late. Four days reviewed found nine checks completed late, four on February 4, 2023, three on March 17, 2023, and two on April 23, 2023 specific to the girls dorm only. The late checks observed appeared to be associated with one specific staff member on certain days of the week, therefore, did not appear to be a systemic issue across the program.
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**	Six files were reviewed for suicide risk screening. Three closed residential and three closed community counseling records. Each of the six screenings was completed by the appropriate staff and reviewed/signed by a supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program utilizes the standard screening tool that was previously approved by the Florida Network for suicide risk assessment.	

Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	All three files demonstrated that youth were placed on the appropriate level of supervision based on the results of the assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	There was documentation that reflected suicide precaution observations were conducted of youth at 30 minute intervals and signed by the regional director.	
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 three files demonstrated that youth remained at the appropriate level until the licensed staff or regional director could complete a further assessment of the youth.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**No eligible items for review**	The program reports no youth met this criteria over the past year. Any youth with an identified suicide risk would be referred to SMA Healthcare for higher level care or assessment.	

During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**	The program reports no youth met this criteria over the past year.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**	The program reports no youth met this criteria over the past year.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	The program reports no youth met this criteria over the past year.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	The program reports no youth met this criteria over the past year.	
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 last revision of the policy was in March of 2023. The policy was reviewed and approved by Cindy Starling on January 11, 2023.	
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The program maintains a full-time registered nurse (RN). A review of the RN's license credentials reflected each of the nurses have a clear and active license, in the State of Florida, according to the Florida Department of Health.	

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 a Pyxis ES Medication Cabinet located in the control room, is inaccessible to youth, and stored in accordance with Florida statute and the program's policy. The Pyxis machine stores all prescription medications, over the counter, injectables, and topicals in individual containers, therefore keeping all medications separate. The program maintains a mini refrigerator specifically designated for medication requiring refrigeration, though no on-site medication is needing to refrigerated at this time. The refrigerator has a temperature gauge to maintain the required temperature range. The Pyxis keys are accessible to staff in the event they need to access medication if there is a Pyxis malfunction.	

Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	**Compliance**	The program maintains a minimum of two site-specific system managers for the Pyxis machine. The system managers are delegated with user permissions to access secure medication. A review of documentation confirmed a Medication Distribution Log is used for the distribution of medication by all staff. The registered nurse (RN) verifies all medication using one of the three methods required by the Florida Network manual. The RN provides medication management if on-site. All medication management procedures adhere to the Florida Network medication management policy. Except youth requiring Epi-pens, the program does not accept youth prescribed injectable medications. Documentation reviewed confirmed all non-licensed staff have received training in the use of Epi-pens.	
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**	Reviewed documentation confirmed the program maintained a perpetual inventory for all controlled substances, including witnessed shift-to-shift counts. Documentation confirmed all medications are inventoried weekly. The program does not utilize syringes or medical sharps.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Documentation confirmed the program reviewed Pyxis reports monthly to monitor medication management practices.	
Medication discrepancies are cleared after each shift.	**Compliance**	Documentation confirmed the program cleared all medication discrepancies after each shift, if applicable.	
Additional Comments: **There are no additional comments for this indicator.**			