Florida Network for Youth and Family Services
Compliance Monitoring Report for

CDS Interface Youth Program Northwest
1884 SW Grandview Street
Lake City, Florida 32055

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the FY 2022-2023 for CDS-Interface Youth Program Northwest (CDS-IYP NW) CINS/FINS program at its program office located at 1884 SW Grandview Street Lake City, Florida 32055 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 NW 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 from July 1, 2022 through June 30, 2023.

The review was conducted by Keith Carr, Consultant for Forefront LLC, and Department of Juvenile Justice Peer Reviewer, Cedrick Prince, Regional Monitor. Agency representatives from CDS-IYP NW present for the entrance interview were, Cindy Starling, Chief Executive Officer, Sabriena Williams, Regional Director, Kathy Hardee, Registered Nurse, Tonda Nelson, Counselor, Jennifer Bedenbaugh, Counselor and Walter Dishbrow, Administrative Assistant. The last QI visit was conducted December 16-17, 2021.

In general, the Reviewer found that CDS-IYP NW is in compliance with specific contract requirements. The CDS-IYP NW agency **received an overall compliance rating of 80% for achieving full compliance** with four 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 recommendation was made.

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

2022-2023 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-19-20-2023

Agency Name: CDS-IYP NW	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 1884 SW Grandview Street Lake City, Fl 32055**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 19-20, 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 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	**No recommendation or Corrective Action.**

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Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): April 19-20, 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)
						and revision is related to 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 December 2021. A review of the petty cash Policy and Procedure was conducted on day two of the program review. A reconciliation was conducted onsite. The Petty Cash fund does not exceed the established minimum of $150. At the time of the program review, the petty cash is stored in a secure locked location in the building known to the Administrative Assistance and Regional Director. 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.**

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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		
c. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**	☐	☒	☐	☐	☐	N/A – The agency has purchased a Dell Optiplex 3020m S/N 580QHB2. desktop computer with FNYFS funds since the last onsite program review.	**Corrective Action 1):** Contact the Florida Network and inform them of this computer purchase and request a Florida Department of Juvenile Justice property identification tag. Once the property tag is received, place it on the computer and update the annual property inventory list accordingly.
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 NW 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 five indicators were applicable. Consequently, **the overall compliance rate for this contract monitoring visit is 80%.** There is one corrective action item cited during this compliance monitoring review which included the agency maintaining inventory in accordance with a written policy and FNYFS contractual requirements. The agency is required to is made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF RECOMMENDATIONS

Corrective Action 1):
It is recommended the agency request a property inventory tag for the personal computer purchased with Florida Network funds.

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 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. - Northwest
1884 SW Grandview Street

April 19-20, 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
Cedirc Prince – 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	X	Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed		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	1	# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer		# Other (listed by title): ___
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports		Table of Organization	X	Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan		Youth Handbook
X	CCC Reports		Grievance Process/Records	8	# Health Records
X	Logbooks		Key Control Log	4	# MH/SA Records
	Continuity of Operation Plan		Fire Drill Log	9	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	9	# Training Records
X	Contract Scope of Services		Precautionary Observation Logs	5	# Youth Records (Closed)
X	Egress Plans		Program Schedules	5	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts	4	# Other: ___
X	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

Surveys

4	# of Youth	6	# 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:

The agency's CEO reported on the governance board of the agency that the board has expanded and added seven additional new members. The agency reported it focused on increasing the number of board members and diversity among the makeup of the board. Further, the agency has recently completed a rebranding exercise and it has a new logo and other marketing strategies. This will allow the agency to incorporate these new branding components into its outreach efforts.

The Stop Now and Act Program (SNAP) is also now active in the CDS-Northwest service region. This is a new program for the agency in this service area that will start this spring. Currently the agency is providing training on the SNAP program this week. The agency has also hired a new SNAP supervisor. The agency reported that it has also partnered with several local organizations. The agency reported the CDS-Interface Youth Program Northwest (CDS-IYP NW) has partnered with the Columbia County District Library for TWEEN groups. The youth participating in this program attend a structured group on-site, as well as the librarian visiting the youth shelter to conduct activities and lessons.

In addition, the CDS-IYP NW program reported it has partnered with the Hanley foundation. The Foundation provides a facilitator to visit the youth shelter twice a week and facilitates groups on vaping, substance abuse, prescription pill abuse, and other pertinent topics.
The agency reported on December 9, 2022, the CDS-IYP NW program was awarded $5,000 from the United Way Suwannee Valley to make Youth Survival After-Care kits which the youth can take home following their shelter stay. The kits include a duffel bag, clothing, personal hygiene items, school supplies and other items.

The CDS-IYP NW had a successful 2022 Summer Enrichment Program. Summer Sessions started on May 30, 2022 and ended on August 5, 2022. The agency reported having an average of seven youth participate on a weekly basis for the entire summer. The youth participated in college tours, visits to the Santa Fe Zoo, Harn Museum, Dudley Farms, and other sites. The CDS-IYP NW Youth Care Worker Carlton Jones received the "Employee of the Year Award" at the CDS Annual Meeting on November 7, 2022.

The CDS-IYP NW program had to have partial building siding replaced due to severe weather in August 2022 and recently in February, 2023 the siding was damaged by weather again. Due to increased bad weather the wood fencing at the facility has been damaged multiple times. The agency has several quotes from fencing companies to replace the fencing and they are working at this time to secure grant funding to address the repair.

At the time of this onsite program review, there were a total of seven residents being served in the youth shelter. The agency reported three CDS-IYP NW staff members were terminated and or resigned. Further, the agency reported four (4) CDS-IYP NW staff members were hired. Currently, CDS-IYP NW has 16 employees, the current list of employees includes: one Regional Director, Residential Supervisor- (vacant), one Full Time Residential Counselor, one Senior Youth Care Worker (YCW), one Residential Administrative Assistant, House Manager (position acquired by Regional Director), one Part Time Registered Nurse, five Full Time YCWs, one Part Time YCW, and five PRN YCWs. The program reported it is in need of two PRN staff members for weekends (evenings and midnight). The former Residential Supervisor was separated from the company on March 13th, 2022. The position of Residential Supervisor is currently being advertised. The agency reported the current workforce shortage continues to place a tremendous strain on attracting qualified individuals to work in this environment.

Narrative Summary

The CDS-Interface Northwest (CDS-NW) 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 agency is headquartered in 3615 SW 13th Street, #4, Gainesville, FL 32608. The CDS-NW agency provides services to Judicial Circuit 3, Columbia, Dixie, Hamilton, Lafayette, and Suwannee Counties. The agency reported its Department of Children and Families Child Caring License is active until April 23, 2023 for 12 beds. The agency reported it continues to maintain their Council On Accreditation status.

The overall findings for the QI Review for **CDS Lake City** 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 Satisfactory with exceptions. Indicator 1.06 was rated Satisfactory with an exception.

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

Standard 3: Two indicators were reviewed for standard 3: 3.01 Shelter Environment, and 3.06 Staffing and Youth Supervision. Indicator 3.06 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 exceptions.

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

None.

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: Policy 5.03 Background Screening, was signed and approved by Chief Operations Officer on November 1, 2022.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.	**Compliance**	Five out of five client files reviewed for suitability prescreening were completed prior to the date of hire and received a passing score.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors	**Compliance**	A total of 12 employee files were reviewed, five out of 12 files reviewed were applicable. All five of the initial new hires completed background screenings prior to 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**	The agency had no applicable employees with a break in service for less than 90 days.	

Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	Seven out of seven of the files reviewed completed re-screening every five years from initial hire dates.	
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 Standards was completed and sent to Background Screening Unit via email message on January 10, 2023.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	A total of five of the five files reviewed contained proof of E-Verify for all new employees 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 agency policy number is P-1030 and is called Training Policy. The policy was reviewed and 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**	Four new hire staff members were reviewed for pre-service training. Three of the four client files contained evidence of completing the agency's required pre-service safety and supervision 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**	A total of four applicable new hire client files were reviewed. Of these files, three of the four new hire files were reviewed within the required 30 days from the hire date timeframe.	One new hire staff did not complete Civil Rights and Federal Funds training within the required timeframe.
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 staff members were reviewed to verify completion of 80 hours of training. Three of the four client files contained evidence of completing the agency's required 80 hours of training within the required timeframe. One of the four new hires staff members files selected was still within the one year time frame to complete the 80 hours of required training courses.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Four new hire staff members were reviewed for pre-service training. Four of the four staff did have evidence of completing the majority of the required training courses within 90 days of hire.	The four new hire staff members had evidence of multiple late trainings completed past the required 90 day time frame.

Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**No eligible items for review**	No applicable new hire reviewed were required to complete the required training topic.	
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**	The agency had no applicable non-licensed staff required to complete this Suicide Risk form training topic.	
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 training records were reviewed for in-service training. Each staff member received over 40 hours of training, with staff receiving between 49 and 110 hours of annual training hours. The first staff member reviewed had training records with evidence of completing 49 training hours. The second staff member had training records with evidence of completing 110.5 training hours and no missing or late trainings. The third staff member had training records with evidence of completing 98 training hours and no missing or late trainings. The fourth staff member had training records with evidence of completing 79 training hours.	
Required Training Documentation			
The agency has a designated staff member responsible for managing all employee's individual training files and completes routine reviews of staff files to ensure compliance.	**Compliance**	The agency has appointed the Administrative Assistance to coordinate and manage the completion of all staff training and the overall reviewing of training hour compliance for all staff members.	
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	Nine staff member training records were reviewed (4 pre-services, 4 In-service and 1 Clinical). All records contained a training log form that tracks training topics, hours, date completed on, and confirms training was completed.	

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: 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 program provided a list of four staff authorized to transport clients in agency's vehicle.	
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.	
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 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	According to the program's policies and procedures, a third party presence may be another direct care staff if available but also can be volunteers, interns, clinical or administrative staff, 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 the agency's transportation logs in the last six months was conducted. This review revealed there was a total of 163 single youth transports, of which 157 had documented supervisor approvals, primarily due to taking the youth to assigned schools.	A review of the transport logs since the last six months found a total six single youth transports which did not have documented prior supervisor approvals of the transport events.
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 indicated documentation of the name of authorized driver, date and time, mileage, number of passengers, purpose of travel and location.	
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.	**Compliance**	A random sample of ten open and closed client residential and community counseling records serviced by the agency in the last six months was conducted onsite. All residential and community counseling files reviewed contained a service plan. The agency develops all service plans with client information obtained the initial screening, intake, suicide screening and NIRVANA assessment instrument process.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All ten 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	**Exception**	All ten client files have evidence of a service plan for each client case file includes the documentation of multiple goals and objectives, service type, frequency, location, the person responsible, the target date for completion, actual completion date, and the signature of the counselor and supervisor. Ten client file records contain documented evidence of client service plans which were consistent with the requirement of the indicator. All client service plans have assigned goals, objectives, frequency, persons responsible, most signatures of required parties and date the plan was initiated. Progress notes are documented on Service Tracking forms called the Behavior, Intervention, Response, Plan (BIRP). One closed residential file contained two goals of three goal which were not completed due a resident being discharged early by a family member. One closed community counseling file indicated the client's parent service plan signature confirming the plan review sessions was obtained by telephone. One open community counseling file indicated the client's evidence of service plan signatures of participant in person at school and the grandparent's by telephone.	One open residential client file is missing a client signature. One open residential and one closed community counseling file is missing a parent/guardian signature. One open residential client file is missing a counselor signature. One open residential and one closed residential client file is missing a supervisor's signature.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	Ten client records contained documentation of file review sessions which include evidence of documentation of goals and objectives tracking 30 day plan review session and general progress. These service plan review sessions include the signatures of all required parties. Two client files did not contain evidence for the entire service period due to the residential and community counsel clients being discharged early.	
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 DCF Child Caring Agency License is in effect and expires on April 23, 2023. The agency is licensed to serve up to 12 residents. The date of the last DCF inspection was February 28, 2023. A tour of the youth shelter was led by a direct care staff member on day one of the program review. The youth shelter is located in a residential 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 a backyard area. One side of the youth shelter has a very small retention pool or water overflow. On day one, the reviewer observed interior deficiencies which were identified and reported. All the interior furnishings are clean and in good order. During the facility tour no graffiti was found on the interior furniture or in interior areas including the main dayroom, male and female dayrooms and sleeping rooms. bathrooms, and multi-functional room adjacent to kitchen. All interior lighting is functioning, except an emergency light in the main common room and in the office area. Both lights were repaired on day one of the program review. Exterior lighting is functioning properly and all lights are 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, first aid kits are included in each van. A road hazard kit is also in each van. All keys were accounted for during the two-day onsite program review. The agency has egress plans posted throughout the youth shelter. The agency's egress plans are posted in the front entry area, the area adjacent to the kitchen, the main day room, male and female dayroom, male and female sleeping areas, youth care office and hallways. The trash receptacles in the interior areas were clear, however, the exterior trash dumpster lid was open and the dumpster was full and overflowing on day one of the program review. The trash bin was emptied by a commercial waste disposal truck on day two of the program review. The trash receptacle lids were observed on the afternoon of day two and all lids were closed.	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. On day one of the program review, the exterior observations of the perimeter fence currently have dilapidated weathered panels that are in need of repair or replacement. Current status of fence has missing panels which allow access to shallow water recess area adjacent to the youth shelter. The exterior fence posts which have fallen and provide access to the water retention overflow pool on the side of the facility. On day one, the agency provided an estimate from February 2023 pertaining to cost estimated for replacing the perimeter fence.
Additional Facility Inspection Narrative (if applicable)	The resident information observed onsite include 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 area. 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. The daily activity schedule is posted and includes wake time, preparation for school, breakfast, chores, groups, life skills, study time, recreation time, free time, chores, showers, preparation for the evening, reading time and lights out. Per the most recent policy revision, the agency is conducting inventory checks for all chemicals listed and approved for use on a weekly basis. Chemicals are stored and locked in the facility's storage area.		

Fire and Safety Health Hazards	**Exception**	Observations of the exterior areas revealed hazards or items which are not secured. The shelter has a fence around the perimeter of the property. Fire Drills: OCTOBER: Shift 2 October 1, 2022, with 6 participants and lapse time was 1 minute documented 6:40pm. Shift 2 October 6, 2022 with 4 participants and lapse time was 50 seconds documented 1:35pm. October Shift 3 October 5, 2022, with 5 participants and lapse time was 49 seconds minute documented 5:33am. NOVEMBER: Shift 3 November 4, 2022, with 10 participants and lapse time was 1 and 30 seconds documented 5:32am. Shift 1 November 5, 2022, with 5 participants and lapse time was 5 minutes and 2 seconds documented 2:06am. Shift 2 November 13, 2022, with 8 participants and lapse time was 1 minute documented. DECEMBER: Shift 1 December 5, 2022, with 1 participant and lapse time was 1 minute at 2:20pm. Shift 3 December 4, 2022, with 4 participants and lapse time was 1 minute documented 7:09am. Shift 2 December 13, 2022, with 4 participants and lapse time was 1 minute documented 7:30pm. JANUARY: Shift 3 January 3, 2023, with 4 participants and lapse time was 35 seconds documented 7:12am. Shift 1 January 4, 2023, with 5 participants and lapse time was 1:40 seconds documented 11:15am. Shift 2nd January 12, 2023, with 5 participants and lapse time was 1:20 seconds documented 7:12am. Shift 3 February 2, 2023, with 8 participants and lapse time was 1 minute documented 6:00am. Shift 1 February 3, 2023 with 3 participants and lapse time was 1 minute documented 2:55pm. Shift 2 February 11, 2023, with 7 participants and lapse time was 1 minute documented 4:22pm. Shift 3 March 15, 2023, with 7 participants and lapse time was 1 minute documented 12:53pm. Shift 3 March 10, 2023, with 6 participants and lapse time was 1 minute documented 7:06am. Shift 3 March 13, 2023, with 6 participants and lapse time was 1 minute documented 8:50pm. Shift 3 April 3, 2023 with 5 participants and lapse time was 47 seconds documented 6:27am. Shift 1 April 4, 2023, with 7 participants and lapse time was 1:50 seconds documented 10:07am. Shift 3 April 12, 2023 with 7 participants and lapse time was 1 minute documented 7:50pm.	There was a lack of evidence of a fire drill completed for Shift 1 in October.

Additional Fire and Safety Health Hazards Narrative (if applicable)	Mock Drills: OCTOBER: 1st Shift: Shift 1 October 9, 2022, Severe Weather Warning with 4 participants and documented 11:00am. Shift 2 October 15, 2022, Tornado/Thunderstorm Warning with 5 participants and documented 8:15pm. Shift 3 October 27, 2022 Hurricane Warning with 5 participants documented 3:00am. NOVEMBER: Shift 1 November 8, 2022, Seizure Medical Event with 4 participants documented 7:30am. Shift 2 November 10, 2022, Fainting/Passed Out Event with 5 participants documented 4:00pm. Shift 3 November 20, 2022, High Fever Medical Event with 5 participants and documented 1:00am. FEBRUARY: Shift 1 February 6, 2023, Utility Failure Event with 6 participants and documented 7:06am. Shift 2 February 16, 2023, Utility Failure with 9 participants documented 5:30pm. Shift 3 February 24, 2023, Utility Failure with 9 participants documented 1:17am. A fire inspection was conducted by the Lake City Fire Department on October 27, 2022. The findings of this report stated the agency meets all safety requirements and was approved. Fire safety plan was also approved on the same date. The Fire equipment was completed by Stafford Fire Extinguisher Service for fire extinguishers on July 26, 2022 (kitchen, dining area and vehicles). The overhead hood suppression system inspection was conducted on August 31, 2022. The Fire alarm system was inspected by the Security Safe Company on July 29, 2022. The Residential Group Care inspection was conducted on July 28, 2022. Satisfactory rating was documented for this inspection. Findings from the inspection included a reminder for the refrigerator temperatures to be lower, post kitchen basin wash, rinse and sanitize sign.		
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 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 and Residential Supervisor ensure all grievances are resolved with the required 72 hour timeframe.	The agency does not have evidence of consistently documenting daily checks of the grievance box in the program logbook.

Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	The agency has a program model which includes activities consistent with providing a broad range of services to properly meet all needs of the residents during their shelter stay. The daily schedule is posted in each male and female dayroom, as well as the main day room. The agency ensures all youth have access to a clean shelter environment and individual bedding with storage for personal items. Each youth has a dedicated counselor which provides weekly counseling and many residents are provided daily counseling. The direct care staff provide youth services which includes transportation to school, other required medical, and school-related appointments. Direct care staff members were observed engaging youth during meals and following returning from school. Direct care staff conducted post-school group meetings during the onsite program review. Further direct care staff were observed interacting and participating with youth during their outside recreational activities. The agency schedule provides the opportunity for youth to participate in religious activities on a weekly basis. Youth are also not required to participate in religious activities. The residents were also observed interacting with direct care staff and other residents during their free time. The residents are also provide books which are accessible to them any time during their reading time and free time. The residents were also observed completing school work and given a snack following their arrival from school. The residents were also observed conducting phone calls to family members.	
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 Ration 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**	A review of direct care staff schedules from October 2022-April 2023 were reviewed onsite to determine the agency's adherence to the requirements of this indicator. Direct care staff member schedules were reviewed and were found to provide documented evidence of each work shift which had a minimum of 2 staff members per work shift. This number of staff scheduled per shift was sufficient to ensure the program maintains ratio.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	A random sample of the direct care staff member training files across multiple works shifts was conducted. This review of staff training topics and hours completed found the eight staff member files reviewed contained documented evidence in the employee's individual training file indicating staff have met minimum training requirement to be placed in the shelter to supervise and engage residents.	

Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Compliance**	The back ground screening documents of staff members on the schedule were reviewed to ensure all were properly screened and met the eligibility requirement to be hired by the agency. All staff on the agency schedule were background screened and had received the required training to conduct direct care duties.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule was observed and posted in the direct care staff office.	
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**	A review of the agency's back-up or call out process was conducted. An interview with management staff members indicate the agency does have a hold over process for staff. The agency does contact staff to report in to work when there is a staff person not able to perform work duties as scheduled. Direct care staff and management staff are also contacted to work shifts as needed when employees are not able to work their scheduled shift. All work shifts were covered and there was evidence of management staff working on shifts on an as needed basis to provide necessary 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 agency's bed check practice was conducted onsite. A total of six randomly selected nights of completed bed checks over the last 30 days were selected to review. Specifically, the following days were reviewed. The Male Room 3/27/23 12:03am, 12:17am, 12:32am; 4/9/23 12:01am, 12:16am, 12:31am; 4/20/23 12:00am, 12:16am, 12:31am. Female Room 3/31/23 3:03am, 3:18am, 3:33am; 4/11/23 5:00am, 5:14am, 5:29am; 4/19/23 1:31am, 1:46am, 2:01am. The reviewer conducted camera reviews with the agency Regional Director utilizing the agency's camera system. The review of the aforementioned days was conducted onsite, and the reviewer did not observe and inconsistencies in documentation regarding bed checks completed on camera and the corresponding written entry documented in the program log book.	
Additional Comments: **There are no additional comments for this indicator.**			

4.02 - Suicide Prevention			Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The 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 practice related to the execution of suicide risk prevention, observations and assessment was conducted. A review of four randomly selected residential client files were reviewed to determine their adherence to the standard. Each of the four residential client files screened were determined to be positive for suicide on one of the suicide risk screening questions during the admission and screening process. The suicide risk form is maintained in each client file 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**	All client files reviewed onsite were residential client files. All four residential client files contained evidence the youth being placed on sight and sound observation was based on a positive indication of at least one suicide risk screening question answered by youth during the initial screening process.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Exception**	All four residential client files have the required forms documenting evidence of youth placed on sight and sound supervision. Each form captures information observed of the client's status by staff on the corresponding work shift. All information reviewed contains 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.	Shift supervisor signature is present on Observation Log, but no date and time found on log. Two observations sheets were not signed by the Shift Supervisor. The Shift Supervisors signature areas were blank and did not include the required signature and date which verify observations of the client's status, while on sight and sound supervision, were conducted every 30 minutes or less by a designated staff member.
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Exception**	All four residential client files contained a completed suicide risk screening and suicide risk assessment. All client files contain an assessment completed by a non-licensed mental health staff member working under the direct supervision of the Licensed Mental Health Counselor (LMHC) or it was completed by the LMHC. All four 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.	No clinical credentials documented on the Suicide Assessment Form reviewed by the Licensed Clinician in one client file.

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 agency reported no non-residential clients were positive for suicide risk since the last QI review.	
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 agency reported no non-residential clients were positive for suicide risk since the last QI review.	
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 agency reported no non-residential clients were positive for suicide risk since the last QI review.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	The agency reported no non-residential clients were positive for suicide risk since the last QI review.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	The agency reported no non-residential clients were positive for suicide risk since the last QI review.	
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**	During the time of the program review, the organization utilizes the services of a Registered Nurse (RN) to administer medication when she is on duty. The RN also reviews the health admission charts and interviews each resident for acute, past and existing medical and health issues.	
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 stores all medications in a pyxis cabinet in a secured area near the day room. Every individual needs a key to access the medicine cabinet. The agency stores oral and injectable drugs separately. Refrigerated medications are stored according to facility guidelines. A small dedicated refrigerator stores medications that need refrigeration. A thermometer in the refrigerator keeps the medication at the right temperature. The Pyxis holds all narcotics and other prescription medications. The Residential Supervisor keeps the Pyxis medication cart keys. The Pyxis medication cart keys are accessible to staff 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**	According to the findings obtained from an evaluation of the agency's policies regarding medication, all medications are kept in the restricted pyxis medication cabinet. All individuals are only allowed limited access to the pyxis and require a key to access. The onsite review of medication practice indicates the agency has two staff identified as Super Users and the RN. The agency also has a list of staff trained to use and access the medication cabinet. The agency utilizes the approved verification medication method when receiving medications from the client's parents/guardian. The agency staff use a paper medication distribution log to document all medication given to all residents and to count and document medication counts on each shift and when given. The agency is not accepting youth which require injections, excluding epi-pens. The agency's RN provides all medication distribution training including epi-pens to non-licensed staff members approved and trained to distribute medication.	
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 review of the program's medication practices found all controlled and over the counter medications are counted and inventoried regularly. The program does not utilize and needs 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 October 2022 through April 2023. The agency has a dedicated binder for the sharps which require counting. There is documented evidence of knives being housed in the kitchen counted weekly as required. There is documented evidence of a weekly count for small and large scissors and scissors in the first aid kits being conducted as required.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	According to facility's logs, monthly reviews of the pyxis are conducted to monitor medication management practice.	
Medication discrepancies are cleared after each shift.	**Compliance**	According to program's policies and procedures, medication discrepancies are cleared after each shift. There were no uncleared discrepancies reflected in the system during the program review.	
Additional Comments: **There are no additional comments for this indicator.**			