Florida Network for Youth and Family Services
Compliance Monitoring Report for

Family Resources - Clearwater
1615 Union Street
Clearwater, FL 33755

April 26-27, 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 for Family Resources - Clearwater for the FY 2022-2023 at its program office located at 1615 Union Street Clearwater, FL 33755. 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. Family Resources - Clearwater 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 Marcia Tavares, Consultant for Forefront LLC, and Peer Reviewer Marvin Bliss, Department of Juvenile Justice Quality, Improvement Regional Monitor. Agency representatives from Family Resources - Clearwater present for the entrance interview were Andrew Coble, Chief Operations Officer, Nicole Leslie, Vice President of Impact, and Jarma Morgan, Residential Supervisor. The last QI visit was conducted March 16-17, 2022.

In general, the Reviewer found that Family Resources - Clearwater is in compliance with specific contract requirements. Family Resources - Clearwater received an overall compliance rating of one hundred percent (100%) for achieving compliance with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. There were no corrective actions as a result of the monitoring visit and no recommendation was made.

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

2022-2023 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-26-2022-2023

Agency Name: Family Resource Clearwater	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 1615 Union Street, Clearwater FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 26-27, 2023**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: General Liability through Alliance of Nonprofits for Ins. RRG, for limits of coverage $1,000,000 each $3,000,000 aggregate and medical expenses of $20,000 for any one person, effective 6/1/2022-6/1/2023. Workers Compensation through Benchmark Insurance Company with limits of $2,000,000 each and aggregate, effective 6/1/2022-6/1/2023. Automobile insurance through Alliance of Nonprofits for Ins. RRG with combined single limits of $1,000,000, effective 6/1/2022- 6/1/2023. An umbrella policy through Alliance of Nonprofits for Ins. RRG, with limits of $4,000,000 each/aggregate, effective 6/1/2022-6/1/2023.	**No recommendation or Corrective Action.**

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
						Directors and Officers Liability insurance through Alliance of Nonprofits for Ins. RRG with limits of $1 million each/ $2 million aggregate, effective 6/1/2022-6/1/2023. Florida Network is listed on the Certificate of 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: The agency has an employee fiscal manual. The agency's fiscal manual appears to be consistent with Generally Accepted Accounting Principles (GAAP). Specifically, the manual addresses procedures for the agency's budget process, authorization levels, credit cards, donations, capital assets, petty cash, sales tax exemption, required vendor information, journal entries, investment policy, general ledger, cost allocation, internal controls, travel, and purchasing process.	**No recommendation or Corrective Action.**
b. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and	☐	☐	☒	☐	☐	Observation/Documentation:	**No recommendation or Corrective Action.**

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	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**						No change in practice was reported for the agency since the last site program review in March 2022. Reviewed petty cash Policy and Procedure Finance 8.0. The Petty Cash fund does not exceed the established minimum of $150. Petty cash is stored in a secure locked location in the shelter. Petty cash was observed as being reconciled by Shelter Supervisor and which was correct. Disbursements and invoices are approved by the Program Supervisor as required.	
c. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site March 2022	**No recommendation or Corrective Action.**
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: The agency produced Financial Statements, Supplemental Information and Regulatory Reports for Family Resources, Inc. for June 30, 2022 and 2021. The audit is completed by ASSURANCE Dimensions Certified Public Accountants and Associates per letter dated September 22, 2022. Per the audit report, a separate Management Letter requiring a	**No recommendation or Corrective Action.**

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	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)**
						Corrective Action Plan is not required and was not issued by the auditor.	

CONCLUSION

Family Resources Clearwater has met the requirements for the CINS/FINS contract as a result of full compliance with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. One of the five indicators was not applicable because the provider does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is made because 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 responsibility. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.

Florida Network of Youth and Family Services
Quality Improvement Program Report

Review of Family Resources South - Clearwater
Residential Program

April 26-27, 2023

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of Indicators rated Satisfactory: 33.33 %
Percent of Indicators rated Limited: 66.67 %
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: 75 %
Percent of indicators rated Limited: 25 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Marvin Bliss – Regional Monitor, Department of Juvenile Justice

Methodology

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

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records		# Health Records
X	Logbooks		Key Control Log	6	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	8	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	8	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	7	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other:
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

Surveys

2	# of Youth	3	# 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

Family Resources Inc. is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families through the Children In Need of Services/Families In Need of Services (CINS/FINS) program. The central office is located in Pinellas Park, Florida and CINS/FINS SafePlace2B shelters are located in Clearwater, St. Petersburg, and Bradenton, Florida. SafePlace2B Clearwater shelter is located at 1615 Union Street, Clearwater. Family Resources serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The program is also contracted to provide services for Staff Secure Shelter and is a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, domestic minor sex trafficking, and Family/Youth Respite Aftercare Services (FYRAC). The program is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to run away and homeless youth. The agency is currently accredited by the Council of Accreditation (COA) effective through December 31, 2024.

The following programmatic updates were provided by the agency:

Staffing

The previous leadership structure included a director's position that provided oversight of the shelter and the counseling program. Management has reevaluated that previous structure and is replacing the director's position with a community services supervisor who will only oversee the counseling program and the truancy programs on campus while providing clinical support to the shelter team. The previous shelter case manager left the agency last year after completing graduate school and pursuing private practice work. In an effort to recruit and retain staff, the agency raised salaries to $17-$19 for degreed staff during the first year and $15-$17 for non-degreed staff. At the time of the onsite review, the program had six vacant positions for a counseling services supervisor, a residential case manager, one fulltime and three part time youth development specialists (YDS).

Program

The agency is in the process of transitioning to electronic client records through Lauris. The testing phase was recently completed and the shelters will be the first agency program to make this transition. Full transition to Lauris is expected by the next fiscal year.

Intensive case management (ICM) services were fully conducted by the Clearwater program in the past; however, the agency decided to move this service to Manatee County where there's a greater need but will still keep a smaller case load at the Clearwater program location.

Facility

The Clearwater shelter received new dining room tables and chairs, courtesy of a grant from Pinellas County.

Funding/Finance

Clearwater SafePlace2B has not received any new funding. The counseling program remains 100% funded by the Florida Network. The shelter was awarded continued funding this fiscal year through both Juvenile Welfare Board and the Health and Human Services through a Basic Center Program grant. The agency was able to increase salaries with the help of community foundation funds as well as pass through funding.

Governance and Community

The agency's previous Chair, Paul Horowitz, ended his term in 2022 and is now the Vice-Chair. The new Board Chair is Janie Peticca. In September a long-time member, Gary Shephard, resigned from the Board and a new member was voted onto the Board. The agency is actively seeking to recruit new members. The Clearwater shelter does not have any corrective action plans (CAPs) with other funding agencies.

Major Challenges

Recruitment and retention continue to be a post pandemic struggle despite salary increases. There is no influx of staffing for all direct care positions including counseling staff. Staff continues to resign and the background screening process is taking longer, lasting between four to five weeks for DCF screenings.

The shelter program has seen an increase in youth having access to and using vape pens due to the variety of inconspicuous products on the market including ones that look like computer thumb drives. This requires staff to be more educated on the trends and more diligent during searches.

Narrative Summary

Family Resources SafePlace2B Clearwater provides both residential and non-residential CINS/FINS services for youth and their families in Pinellas County and the surrounding areas. The program is under the leadership of a chief executive officer (CEO), a chief operating officer (COO), vice president of impact (VP), a director of client success for community services, a residential supervisor, and a community services supervisor (vacant during the visit). Community counseling program is comprised of a counselor and an ICM case manager. The shelter is staffed by a counselor, a case manager, twelve YDS, and administrative assistant and a part time nurse who works 6-8p.m. in the evenings. The shelter is licensed for 12 beds by the Department of Children and Families effective through December 15, 2023. At the time of the annual QI review, the shelter had a census of eight youth.

The overall findings for the QI Review for **Family Resources SafePlace2B Clearwater** are summarized as follows:

Standard 1:

Three indicators were reviewed for this standard: 1.01 Background Screening of Employees/Volunteers, 1.04 Training Requirements, and 1.06 Client Transportation. Indicator 1.01 was rated Satisfactory with the exception of one staff who scored low on the pre-employment assessment and was hired without documented approval by a manager. Indicators 1.04 and 1.06 received a Limited rating.

Standard 2:

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

Standard 3:

Two indicators were reviewed for standard 3: 3.01 Shelter Environment, and 3.06 Staffing and Youth Supervision. Indicator 3.01 was rated Satisfactory with exceptions. The exceptions for 3.01 are: 1) 1st shift missed monthly fire drills in February 2023 and the 3rd missed monthly fire drills in November 2022, and January and February 2023; and 2) chemicals are stored in three locations (laundry room, first aid closet, and utility closet) without separate inventories for each location. The perpetual inventory chemical count was inaccurate during the review of chemical storage and no MSDS sheets were maintained two chemicals, Drano and Scrubbing Bubbles. Indicator 3.06 was rated as Satisfactory with no exceptions.

Standard 4:

There are 2 indicators that were reviewed for standard 4, indicators 4.02 Suicide Prevention, and 4.03 Medications. Indicator 4.02 was rated Satisfactory with no exceptions. Indicator 4.03 was rated Satisfactory with exceptions because a verified shift-to-shift count for controlled medication was not conducted by staff on April 16, 18, 20, 22, 23, 24 25 and 26.

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

Standard 1:

Indicator 1.04 - Limited

1) One new staff completed the DOJ Civil Rights and Federal Funds training two days after the required 30 day timeframe.
2) Three new staff did not complete all mandatory trainings due within the first 90 days as follows:
One staff is missing behavior management, adolescent and youth development, child abuse reporting, CPR/First Aid, confidentiality, signs and symptoms of mental health and substance abuse, and SkillPro Suicide Awareness training.
A second staff completed medication distribution, SOGIE/LGBTQ, and First Aid training late and is missing behavior management, and child abuse training. The third staff completed CPR/First Aid late, and is missing adolescent and youth development, and child abuse training.
3) Three in-service staff did not complete all mandatory annual training as follows: one staff missed four annual trainings due during the past full training year (fire safety last completed 4/2/20, PREA and sexual harassment last completed 4/1/20, and information security awareness last completed 3/15/21); a second staff missed Florida Network suicide prevention training, last completed 11/1/2021; and, the third staff missed eight annual trainings due during the past full training year including Florida Network suicide prevention, fire safety (12/31/16), PREA (7/5/18), sexual harassment (7/5/18), human trafficking (7/13/18), child abuse (9/7/19), information security awareness (7/12/18), and trauma response care (9/6/19).
4) Florida Network Bridge and DJJ SkillPro training transcripts were not maintained in all of the training records reviewed to support trainings completed. Additionally, two of the six records were missing training log(s) or list of trainings completed.

Indicator 1.06 – Limited

The agency has a current practice in place indicating supervisor's approval for all single transports occurring each day is noted and highlighted in blue in the logbook; however, this notation was not consistently observed and was typically noted after the single transports were completed. Supervisor's prior approval was not evident in eight of the thirteen single transports conducted during the review period. Of the eight single transports missing prior approval, staff established an open phone line during three transports; three transports were noted on the transportation log and logbook as single transports but did not indicate a supervisor was contacted or provided approved; and two were noted as single transports on the transportation log but were not recorded in the logbook.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator.		Review Based Upon Document Source *For example: Interview/Surveys, Observation, and/or Type of Documentation*	Notes Explain any items that have any deficiencies, exceptions or are not applicable.
Standard One – Management Accountability			
1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: The provider has the required policy 1.01 in place that was last reviewed in January 2022 by the Chief Operations Officer (COO).	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.	**Exception**	A total of five new staff were hired since the last onsite QI review. All five staff met the criteria for a pre-screening assessment. The agency uses the Berke Assessment Tool and completed the screening prior to hire for the five staff reviewed. Three of the five staff had a low score on the Berke Assessment. The agency provided documentation via email communication between Human Resources and the COO regarding reasons the staff were hired with the low score, prior to hire for two of the three staff.	One staff scored low on the Berke pre-screening assessment on 10/10/22. The approval to hire email from the COO is on file but dated 4/14/23, four months after the staff was hired on 12/28/22.
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**	All five new staff were background screened prior to hire. There was one intern utilized during the review period and an eligible background screening was obtained prior to the intern's start 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**	Agency has no evidence of any re-hired employees who have had a break in service for less than 90 days.	
Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	The program had two eligible staff who met the criteria for 5-year re-screening. Both staff were re-screened and/or had valid retained prints in the clearinghouse.	

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 had a signed and notarized Annual Affidavit of Compliance with Level 2 Screening Standards that was completed, notarized, and emailed on January 5, 2023 to the Background Screening Unit, prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of E-Verify work authorizations were maintained in the five new hire files.	
Additional Comments: **There are no additional comments for this indicator.**			
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**NO** If NO, explain here: Policy 1.04 was not revised after January 2022 to include the changes to QI Indicator 1.04 that were effective 9/1/2022. The provider's policy 1.04 was last reviewed in January 2022 by the Chief Operations Officer (COO).	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	Training records for three new hires were reviewed. Two of the three staff (one residential and one community counseling) have not completed all pre-service training requirements; however, the residential staff has not worked independently on any shift.	
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**	There were a total of three staff files that were reviewed. Two of the three staff completed the DOJ Civil Rights and Federal Funds training completed within 30 days of hire.	One new staff completed the DOJ Civil Rights and Federal Funds training two days after the required 30 day 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**	Two of the three new staff completed an excess of 80 training hours during the first year. The third staff, date of hire 11/28/2022, has completed 36 hours with time remaining to complete 80 hours.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	While staff completed some training, all three training records reviewed did not demonstrate staff completed all mandatory training within the required 90 days.	Three new staff did not complete all mandatory trainings due within the first 90 days as follows: 1) One staff is missing behavior management, adolescent and youth development, child abuse reporting, CPR/First Aid, confidentiality, signs and symptoms of mental health and substance abuse, and SkillPro Suicide Awareness training. 2) Second staff completed medication distribution, SOGIE, and First Aid training late and is missing behavior management, and child abuse training. 3) Third staff completed CPR/First Aid late, and is missing adolescent and youth development, and child abuse training.

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.	**Compliance**	One applicable community counseling staff completed the required NIRVANA training. There were no applicable new staff who are responsible for JJIS data entry.	
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 program did not hire any non-licensed mental health clinical shelter staff during the review period.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	Three in-service staff training records were reviewed for this training requirement. None of the training records demonstrated staff completed all annual required trainings. Two of the three exceeded the 40 hours required.	Three in-service staff did not complete all mandatory annual training as follows: 1) One staff missed four annual trainings due during the past full training year (fire safety last completed 4/2/20, PREA and sexual harassment last completed 4/1/20, and information security awareness last completed 3/15/21) 2) A second staff missed Florida Network suicide prevention training, last completed 11/1/2021. 3) The third staff missed eight annual trainings due during the past full training year including Florida Network suicide prevention, fire safety (12/31/16), PREA (7/5/18), sexual harassment (7/5/18), human trafficking (7/13/18), child abuse (9/7/19), information security awareness (7/12/18), and trauma response care (9/6/19).
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**	Per the agency's policy 1.04, supervisors will maintain an individual training file for each employee to include documentation of training, including certifications, re-certifications, examinations, practicum, and test results. Supervisors will review the training requirements with each employee and work with the employee to schedule time to meet these requirements. Employees are expected to take an active role in their staff development and training process by identifying training needs and interests and communicating these during individual supervision, staff meetings, and through the annual need's assessment survey.	

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.	**Exception**	Five of the six training records reviewed were maintained in a training binder/file that contained a log of training topics, dates, and hours completed. The training files also included some documentation such as training certificates, sign-in sheets, and training worksheets; however, some of the records were missing the Florida Network Bridge and/or DJJ SkillPro transcript as supporting documentation for trainings completed. Consequently, assistance was required to retrieve those transcripts from the Network and DJJ Peer. One training record was viewed electronically because the agency is in the process of transitioning to electronic training records.	Florida Network Bridge and DJJ SkillPro training transcripts were not maintained in all of the training records reviewed to support trainings completed. Additionally, two of the six records were missing training log(s) or list of trainings completed.
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**NO** If NO, explain here: Policy 1.10 does not address the requirement that states approved agency drivers must have a valid Florida driver's license and are covered under company insurance policy. The provider has a policy 1.10 in place that was last reviewed in September 2021 by the COO.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The program maintains a list of staff who have a valid driver's license and clear motor vehicle check and are approved by Human Resources (HR) to transport youth in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Per interview with the COO, approved drivers as confirmed by HR are covered under the agency's insurance policy. The agency maintains a valid automobile insurance policy with Alliance of Nonprofits for Insurance RRG, effective through June 1, 2023.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency's policy prohibits transporting a youth without another passenger in the vehicle. There are provisions in place in case a 3rd party is not present in the vehicle. The policy notes they can have an open call system, when 1:1 transport is conducted, and the driver will call the on-site staff and leave the phone open for the duration of the journey.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The agency's policy states in the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel considers the clients' history, evaluation and recent behavior when approving single youth transport.	

The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency has a 2017 Ford Transit 12 passenger van used to transport youth. Transportation logs for the agency's van were reviewed for the period November 2022 - April 2023. All non-single transports reviewed had a staff or youth listed as 3rd party.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	Review of transportation logs for the period November 2022 - April 2023 showed a total of thirteen single transports were conducted. Supervisor's approval is documented in the logbook and prior approval was evidenced for five of the thirteen single transports conducted.	Per interview with the Residential Manager, a statement indicating supervisor's approval for all single transports occurring each day is noted and highlighted in blue in the logbook; however, this notation was not consistently observed and was typically noted after the single transports were completed. Supervisor's prior approval was not evident in eight of the thirteen single transports conducted during the review period. Of the eight single transports missing prior approval, staff established an open phone line during three transports; three transports were noted on the transportation log and logbook as single transports but did not indicate a supervisor was contacted or provided approved; and two were noted as single transports on the transportation log but were not recorded in the logbook.
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	The program maintains a vehicle transportation log that documents the date, time, name of the driver and initials of staff passengers, location and purpose of travel, number of passengers, initials of passengers, mileage out/in, and return time. Each page of the log is also reviewed and signed by the supervisor.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has the required policy 2.03 that was last reviewed in September 2021 by the COO.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	Ten youth records were reviewed for five residential (three closed, two open) and five community youth (three closed, two open). All ten case plans reviewed were developed using information gathered during the initial screening, intake, suicide screening and NIRVANA.	

Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All ten records reviewed revealed the case plans were developed within seven working days of 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	**Compliance**	All ten completed service plans included individualized and prioritized needs and goals identified by the NIRVANA, service type, frequency, and location, person(s) responsible, target dates for completion and actual completion dates, signature of youth, counselor, and supervisor, and the date the plan was initiated.	
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**	Eight of the ten youth service plans were reviewed for progress timely, every 30 days. Two of the plans did not meet the criteria for thirty-day reviews because one was a recent admission and the second record was closed prior to 30 days.	
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 has the required policy 3.01 that was last reviewed in January 2022 by the COO.	
Facility Inspection	**Exception**	An on-site tour of the facility confirmed that furnishings, fixtures, and fittings were in good repair as well as the program being free of insect infestation. The grounds were adequately landscaped and maintained. All exterior areas were free of debris and the grounds were free of hazards. The dumpster was secured and observed to be covered. All bathrooms were noted to be clean and functional. There was no graffiti observed throughout the facility. Lighting was adequate in the common areas, bedrooms, and bathrooms. Doors are secure with key access required. Egress plans were posted in several locations as well as the client rules, abuse hotline information, and DJJ incident reporting information is posted in the staff area/youth group room. Blank grievance forms are available on the wall of the youth group room underneath the locked grievance mailbox. The program has one twelve-person passenger van which is equipped with all the major safety equipment as required. The keyring has a seat belt cutter and a window punch which also serves as an airbag deflator. Interior areas did not contain contraband and were free of hazardous items.	Chemicals are stored in three locations (laundry room, first aid closet, and utility closet) without separate inventories for each location to ensure accurate counts. The perpetual inventory chemical count was inaccurate during the review of chemical storage and no MSDS sheets were observed to be maintained for two chemicals, Drano and Scrubbing Bubbles.

Additional Facility Inspection Narrative (if applicable)	Chemicals were stored behind locks in three different locations; however, a separate inventory for each location is not kept. Inventories and MSDS were not adequately maintained. The washers and dryers were operational and clean of lint. Each youth has their own individual bed with clean covered mattress, pillow, and sufficient linens as well as a dresser and/or closet for storage of clothing. The program has lockers in a closet that can be locked and serve as a safe place for youth to keep their personal belongings. Current DCF license for 12 beds expires December 15, 2023 and accreditation certificate expires 12/31/2024. Both are displayed in the facility.		
Fire and Safety Health Hazards	**Exception**	The annual fire inspection was completed by Clearwater Fire and Rescue Division of Fire Prevention Services on September 13, 2022, with one violation due to the fire sprinkler being Red tagged 8/25/2022. A reinspection is usually booked (or may be unannounced) by the Fire Department and was still pending as of the QI visit. Fire extinguisher inspections were completed on April, 22, 2022 by Piper Fire Protection, Inc. and valid for one year. Piper also conducted a satisfactory fire suppression inspection on November 9, 2022. The annual sprinkler inspection by Piper on 8/25/22 noted corrosion and disrepair of the flow switch not triggering an alarm. A work order shows the repairs were completed on 10/4/22.	First shift missed monthly fire drills in February 2023 and the third shift missed monthly fire drills in November 2022, and January and February 2023.
Additional Fire and Safety Health Hazards Narrative (if applicable)	At least one fire drill was completed monthly on the second shift since October 2022 with evacuations completed under two minutes. Mock emergency drills were completed at least quarterly on each shift for the same period. Satisfactory combined Group and Food inspection was conducted by the Department of Health on 4/18/23. Five week cycle menus were posted and signed by an approved and licensed dietician, these menus were last reviewed on 7/1/22. Cold food is properly stored, marked, and labeled and dry storage/pantry areas are clean. The facility's refrigerator and freezer are clean and appropriate temperatures are maintained at 40 and zero degrees Fahrenheit, respectively.		
Grievance			
There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	The agency has a formal grievance process that is reviewed with youth during orientation and is also posted. A grievance box is mounted in the youth group room and grievance forms are accessible below the grievance box.	
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**	The residential manager reported 33 grievances that were filed by a group of siblings complaining against each other during the four month period while they were in the shelter. A review of the grievances show the program responded to and addressed each complaint within 72 hours. The grievance box is checked daily by the shelter manager who documents checking the box and indicates the number of grievances present in the 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 program has an activity schedule for weekdays and weekends. Each weekday youth are engaged in activity from 5:40 a.m. to 10:00 p.m. and from 8:30 am to 11:00 p.m. on weekends. The schedule indicates one hour of recreation/physical activity is provided daily and non-punitive activities are available if youth do not want to participate in a faith-based activity. The schedule includes over an hour of time for youth to complete homework or read approved books. The daily schedule is posted in the program's main group/living area.	
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 has the required policy 3.06 that was last reviewed in September 2021 by the COO.	
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**	Dates of Staff Schedule reviewed between October 2022- April 2023 were as follows: 10/1/2022, 10/6/2022 , 10/26/2022; 11/25/2022, 11/28/2022, 11/30/2022; 12/7/2022, 12/22/2022, 12/25/2022; 1/17/2023, 1/25/2023 , 1/29/2023; 2/6/2023, 2/20/2023, 2/27/2023; and 3/1/2023 , 3/21/2023, and 3/31/2023. A review of the logbooks and schedules found staffing ratios were maintained for awake and sleeping hours.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	A review of the log book indicated there were two staff assigned to a shift as indicated by them signing into the log book on the selected dates noted above.	

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**	Program staff included in the staff-to-youth ratio included staff who were background screened. Although training records for two new direct care staff indicated some pre-service required trainings are not yet completed, those staff have been under the supervision of trained staff and have not been scheduled to work independently with youth.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule is posted and is located behind the staff desk on the white board in the youth shelter.	
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 list of staff and contact numbers to reach if additional coverage is needed is located behind the staff desk on the white board.	
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**	Bed check logs were reviewed for five randomly selected days during the past six months: November 4th, 12am-2am; December 15th, 2am-4am; January 14th, 4am-6am; February 26th, 1am-3am; and March 22nd, 3am-5am. A review of the logs indicate staff observed youth at least every fifteen minutes while they were in their sleeping rooms.	
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 has the required policies, 4.02A and 4.02B, for Comprehensive Master Plan for Suicide Prevention and Response- Pinellas. The policies were last reviewed in October 2021 by the COO.	
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 youth records were reviewed for three residential (two closed, one open) and three community counseling (one closed, two open) youth. All six records show a suicide risk screening completed upon the initial intake. All were signed by the supervisor and documented in the youth record.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program continues to use the suicide risk assessment that was 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**	Each residential youth was placed on sight and sound and monitored by staff every fifteen minutes.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	Monitoring was documented on a Sight and Sound Observation Log. There is a place on the observation logs which indicates if any additional behavior observations or warning signs are observed they will be documented in shift notes.	
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**	Three youth were placed on sight and sound until assessed by a licensed mental health staff. All three youth had the assessment by a licensed staff the same day as the intake. All three youth had fifteen minute checks completed until assessed by the licensed clinical staff.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**Compliance**	Three community counseling youth records were reviewed for youth identified as having suicidal behaviors by the staff at intake. An assessment of suicide risk was completed by a licensed professional or non-licensed professional under direct supervision of a licensed professional	
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**	Each youth was assessed by the provider's licensed professional or non-licensed professional under direct supervision of a licensed professional after being identified for suicide risk during the intake process and did not have to be referred to an outside provider.	

Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**Compliance**	All three youth had a referral made and the youth's file contained evidence that the parent was given the information.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	For each of the three applicable records, the parent/guardian(s) were contacted and notified of the suicide risk findings.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	None of the reviewed screenings were conducted on school property.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency has the required medication distribution, storage, and management policies 4.03, 4.03A, and 4.03B in place that were last reviewed in September 2021 by the COO.	
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 has a registered nurse who has been with the program since August 2021. The nurse's license is valid through 4/30/2025.	

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**	Observations during the review revealed all medications are stored in a Pyxis Med-Station kept in the medical room behind a locked door, in accordance to the required policy and guidelines, which is inaccessible to youth. Narcotics and controlled medications are stored in the Med-Station. Only one youth with narcotics was served the entire annual compliance review year. Oral medications are stored separately from injectables. The program has not had any injectables during the annual compliance review year but injectable epi-pen will be kept separately from oral medication if there is any injectable epi-pen. The program maintains keys to access the medication if there is a malfunction with the Med-Station. The program has a locked refrigerator which was empty during the review week and at a temperature of 42-degree Fahrenheit.	

Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	**Compliance**	The agency currently has three system managers for the med-station. Only staff trained in medication administration assistance have access to the secured medications in the med-station. A Medication Distribution Log is utilized for the distribution of all medications and documents the staff who provided the medication and the youth's initials. Medication verification follows the three methods listed as required. When the nurse is on duty, she conducts medication distribution call. The delivery process of medications in consistent with the FNYFS Medication Management and Distribution policy. The agency indicated they do not accept youth currently prescribed injectable medications. The agency indicated non-licensed staff received training in the use of epi-pens during their first-aid training.	

Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Exception**	The agency indicated they utilize their Medication Distribution Log as a perpetual inventory and to keep their weekly count. There is also a spot to document a shift-to-shift count with a spot for staff and a witness to initial. Per the nurse, there are no over-the-counter medications maintained at the facility and parents must bring it in when needed. The agency does not current have any syringes. They keep their sharps in a locked box inside a locked cabinet in the shelter. An inventory is conducted of the sharps each shift.	The shift to shift count was missing for a youth on a controlled substance. The dates were April 16, 18, 20, 22, 23, 24, 25 and 26. This was the only time controlled substances have been in the facility.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The nurse was interviewed about monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports and confirmed monthly medications counts and pyxis reports are conducted.	
Medication discrepancies are cleared after each shift.	**Compliance**	The agency reported all discrepancies are cleared out at the end of shift. A binder was provided including discrepancy reports which have been printed out.	
Additional Comments: **There are no additional comments for this indicator.**			