Florida Network for Youth and Family Services
Compliance Monitoring Report for

LUTHERAN SERVICES FLORIDA – MIAMI BRIDGE HOMESTEAD
326 NW 3rd Ave.,
Homestead, FL 33030

May 31-June 1, 2023

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Lutheran Services Florida Miami Bridge (LSF Miami Bridge) for the FY 2022-2023 at its program office located at 326 NW 3rd Avenue, Homestead. 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. LSF Miami Bridge 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 Department of Juvenile Justice Peer Reviewer, Ebony Evans. Agency representatives from LSF Miami Bridge present for the entrance interview were Jose Fontanez, Program Director; Cari Still, Assistant Vice President QA; Ashley Wooten, Clinical Director; Samantha Roberts, Shelter Manager; C.J. Fernandez, QA Management Specialist; Tracy Scott, Registered Nurse; and Lashonda Chavis, Intake Coordinator. The last QI visit was conducted on December 8, 2022.

In general, the Reviewer found that LSF Miami Bridge is in compliance with specific contract requirements. LSF Miami Bridge **received an overall compliance rating of 100 % for achieving full compliance** with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. There were no corrective actions as a result of the monitoring visit and no recommendation was made.

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

2022-2023 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 05-31-2022-2023

Agency Name: Lutheran Services Florida Miami Bridge	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 326 NW 3rd Ave., Homestead, FL 33030**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 31 – June 1, 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 – LSF Certificate of Insurance. General Liability through Markel Global Reinsurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, and medical expense for $10,000, effective 6/01/2022 – 6/01/2023. Automobile insurance through Florida Insurance Trust for combined single limits for $1,000,000 each accident, effective 6/01/2022 – 6/01/2023. Workers Compensation through Accident Fund Insurance Company of America with limits of $1,000,000 each/aggregate, effective 6/01/2022 – 6/01/2023.	**No recommendation or Corrective Action.**

Agency Name: Lutheran Services Florida Miami Bridge	Monitor Name: Marcia Tavares, Lead Reviewer
Contract Type: CINS/FINS	Region/Office: 326 NW 3rd Ave., Homestead, FL 33030
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): May 31 – June 1, 2023

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		
						Umbrella liability through Century Surety Company with limits of $1,000,000 each/aggregate, effective 6/01/2022 – 6/01/2023. Professional Liability/Abuse Molestation through Markel Global Reinsurance Company for $1,000,000 each and $3,000,000 aggregate, effective 6/01/2022 – 6/01/2023. Florida Network is listed as certificate holder.	
Fiscal Practice b. 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: Agency maintains an Accounting Procedures Manual that is consistent with GAAP and provides for limited internal controls. The fiscal manual is updated as necessary with revised policies showing a revision/approval date. The most current approval date is October 5,2022. Policies are approved by the Chief Financial Officer.	**No recommendation or Corrective Action.**

Agency Name: Lutheran Services Florida Miami Bridge	Monitor Name: Marcia Tavares, Lead Reviewer
Contract Type: CINS/FINS	Region/Office: 326 NW 3rd Ave., Homestead, FL 33030
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): May 31 – June 1, 2023

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. 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: Reviewed petty cash Policy and Procedure 4.32 included in section 4 of the Fiscal Manual that was last approved October 5, 2022. The program has a petty cash fund that is used for the shelter. The shelter manager is the custodian of the petty cash which is maintained in a locked box in the manager's office. The petty cash fund was reviewed with the shelter manager to reconcile onsite and documentation support accurate reconciliation	**No recommendation or Corrective Action.**
d. 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.	**No recommendation or Corrective Action.**
e. 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	☐	☐	☒	☐	☐	Documentation: Miami Bridge submitted a copy of the Financial audit completed by Verdeja, De Armas, and Trujillo CPA, as of	**No recommendation or Corrective Action.**

Agency Name: Lutheran Services Florida Miami Bridge	Monitor Name: Marcia Tavares, Lead Reviewer
Contract Type: CINS/FINS	Region/Office: 326 NW 3rd Ave., Homestead, FL 33030
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): May 31 – June 1, 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)
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**						June 30, 2022 per letter dated December 28, 2022. The audit did not note any findings and/or questioned costs. A Management Letter was not issued as there were no matters of non-compliance or findings of deficiencies in internal control reported by the audit.	

CONCLUSION

Lutherans Services Florida Miami Bridge 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 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 as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

If required, the provider must submit a corrective action plan to address corrective actions cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Lutheran Services Florida Miami Bridge - Homestead Residential Program

May 31 - June 1, 2023

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	**Limited**
1.04 Training Requirements	**Satisfactory**
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	**Limited**
3.06 Staffing and Youth Supervision	**Satisfactory**

Percent of Indicators rated Satisfactory: 50 %
Percent of Indicators rated Limited: 50 %
Percent of Indicators rated Failed: 0 %

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	**Satisfactory**
4.03 Medications	**Satisfactory**

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 62.5 %
Percent of indicators rated Limited: 37.5 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Ebony Evans – 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
	Chief Operating Officer		Advocate		# Case Managers
X	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
X	Program Coordinator		Intern	1	# Maintenance Personnel
X	Clinical Director		Volunteer	1	# Other (listed Intake Coordinator
	Counselor Licensed		Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan		Youth Handbook
X	CCC Reports	X	Grievance Process/Records		# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	11	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	7	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	9	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	6	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

8	# of Youth	9	# 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

On July 2, 2022, Lutheran Services Florida (LSF) entered into a management service agreement with Miami Bridge Youth and Family Services. Lutheran Services Florida Miami Bridge Youth and Family Services (LSF Miami Bridge) contracts with the Florida Network to operate the Children in Need of Services and Family in Need of Services (CINS/FINS) program in two locations, LSF Miami Bridge Central Shelter located in Miami and a south shelter located in Homestead, Florida (MB Homestead). Funding through CINS/FINS allows the agency to serve both male and female youth up to the age of seventeen years old who are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). Miami Bridge is currently accredited by the Council of Accreditation (COA) and was successfully re-accredited by COA in 2021.

The following programmatic updates were provided by LSF Miami Bridge:

Staffing

During the current review period, under the leadership of our Program Director, Jose Fontanez, the CINS/FINS operations have remained steady while incorporating additional staff to support an effective programmatic structure. Providing additional mental health guidance, Mr. Fontanez is currently a registered mental health counselor in the state of Florida.

Ashley Wooten, a licensed clinical social worker maintains the role as Clinical Director. Her experience and expertise are an integral part of ensuring the therapeutic aspect of the programs (residential and community counseling programs) are sustained to quality standards. Her diligence and leadership supports several key functions of program operations.

Lashonda Chavis leads the program's intake admissions department for our residential and non-residential components. Her organizational skills and commitment to serving youth and families has been instrumental to Miami Bridge's sustainability and growth. Samantha Roberts, previously employed by another LSF residential program in Sarasota, Florida, transferred to Miami Bridge in January 2023 to become the Homestead Shelter Manager. She provides steady and transformational leadership that enhances the workplace and quality of services for all those served in shelter.

Citizen Jane Fernandez, was promoted to the role of Quality Management Specialist. Prior to this new role, Ms. Fernandez was the shelter manager of the Homestead location. This position provides oversight for the development and maintenance of quality programs, systems, processes and procedures that ensure compliance with policies and that the performance and quality of services conform to established internal and external standards and guidelines. Tracy Scott, hired on July 2, 2022, as the in-house registered nurse provides superior medical support to the population served and provides medical training to staff. His primary role is to treat and care for the youth in this program as well as providing information about any treatment procedures or any aspect of their care. In addition, he oversees and directs all youth care staff to ensure adequate monitoring and the delivery of safe and efficient quality medical care. He currently works out of the Homestead location due to the Central location not being operational. When Central opens, he will spend 20 hours per week at each site. Rosie Soroka, the newest residential counselor, joined the team in February 2023. Rosie's experience in working with youth and dedication to making a positive impact in their lives has served the program well. She focuses on mental health services, providing therapeutic care to the youth and families served within the residential program. Also, Rosie leads many of the group counseling sessions.

Program

The program offices have not changed since the last QI visit. The administrative office is located at 2810 NW South River Drive, Miami, Fl. 33125.

Miami Bridge serves Miami Dade County through two sites located at: 1) 2810 NW South River Drive, Miami, Fl. 33125, and 2) 326 NW 3 Ave., Homestead, Fl. 33030. Both sites are licensed to serve twenty (20) residential youth and the licenses was renewed by the Department of Children and Families (DCF) on April 1, 2023 (Homestead) and June 1, 2023 (Central). The residential program serves youth between the ages of 10-17 while our community counseling program serves ages 6-17.

Miami Bridge is recognized by the Council on Accreditation (COA) and accreditation is effective until August 31, 2025. Once the acquisition between LSF and Miami Bridge is finalized, Miami Bridge will be integrated into LSF's re-accreditation timeline of February 28, 2026. The agency's service practice model is diverse in that its services are based on the need of the individual or family. For the residential program, services are offered in-person and when necessary, family sessions can be offered virtually. The community counseling program offers in-person, virtual, and home-visits. All files are stored electronically. The program is are gearing up to implement the Journey to Success Behavior Management System that was developed in-house. Staff attended the six hours foundations and implementation training in May 2023.

Facility

The Central facility has completed its' kitchen renovation and has been approved to open. It is also in the planning stages of converting its dorms to semi-private rooms. Target date for dorm completion is summer/fall 2023. The agency is currently working with the City of Miami, Miami-Dade County, and the city of Homestead to transfer all property leases to Lutheran Services of Florida from Miami Bridge.

Funding/Finance

The agency received award confirmation from The Children's Trust of Miami-Dade County to fund an agriculture/culinary summer program for both residential and non-residential clients. A capital campaign is ongoing. No new assets have been acquired by the agency. Current funding sources include the United Way, Florida Network Youth and Family Services, Department of Children and Families, and private donations. All contracts have been retained and are in full effect. Recently, the agency received a $10,000 donation from Home Goods as LSF Miami Bridge has been selected as their local community partner for the city of Homestead.

Governance and Community

LSF Miami Bridge engaged two new community agencies to increase youth empowerment, youth development and enrichment opportunities. The two agencies are Trinity Church and Recover restart Refreshed, Inc. Until the official merger of Miami Bridge with Lutheran Services of Florida, board structure will remain the same. Community engagements have included over 40 events during current contract year.

External Corrective Action Plans

The corrective action plan per Department of Children and Families has been completed and closed.

Major Challenges

During the current review period, the program has experienced some challenges in successfully recruiting residential counselors and youth care specialists; however, it continues its efforts to interview applicants for both positions.

Narrative Summary

Miami Bridge Homestead is under the leadership of a Regional Director, a Program Director, a Clinical Director, and a Residential Manager. The program operations is supported by an Intake Coordinator, a Quality Management Specialist, a Registered Nurse, and a maintenance staff. There are currently have 23 Youth Care Specialist considered as direct-care staff. In preparation for the Central location opening, the program is seeking to increase this position with approximately 8-10 people so it may serve at the highest capacity possible at both locations. For the residential counseling component, the goal is to hire three additional master's level clinicians. Under the guidance of the Clinical Director, the community counseling services currently consists of five counselors, three bachelors' level and two master's level counselors. There is one vacancy within the community counseling team and the program is actively recruiting to fill that position.

The overall findings for the QI Review for **LSF Miami Bridge** are summarized as follows:

Standard 1:
Three indicators were reviewed Standard 1: 1.01 Background Screening of Employees/Volunteers, 1.04 Training Requirements, and 1.06 Client Transportation. Indicator 1.04 was rated Satisfactory with exceptions due to one community counseling new staff not completing the DJJ Civil Rights training within the 30 days required and the same staff missing five mandatory trainings and was late completing an additional nine trainings all due within the first 90 days of hire. The community counselor was also assigned cases prior to completing all mandatory pre-service training. A second new hire direct care staff was late completing one training and had not yet completed medication distribution training. Indicators 1.01 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 received a Limited rating and indicator 3.06 was rated 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. Both indicators were rated Satisfactory with no exceptions.

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

Standard 1:
Indicator 1.01 - Limited
1) None of the five staff hired during the annual review period completed the required pre-employment assessment.
2) The annual affidavit of compliance with level two screenings was submitted to DJJ BSU on 5/31/23, 4 months after the 1/31/23 deadline.

Indicator 1.06 - Limited
1) Five of the 14 single youth transports did not document approval by the supervisor.
2) Nine of the 14 single youth transportation entries did not include all required information such as mileage, purpose, and/or location.

Standard 3:
Indicator 3.01- Limited
1) Chemical inventory count was inaccurate upon review as follows: Victoria Bowl Cleaner shows two on the inventory but 21 was counted on the shelf; Mr. Clean floor cleaner shows zero, but more than one gallon was on the shelf; and Comet shows zero but more than two bottles were on the shelf. The storage closet also had three cans of stainless steel cleaner, one bottle Scrubbing Bubbles, one bottle Dawn hand soap, and two jars of Odoban but these were not included on the inventory list.
2) Perpetual inventory was not conducted nor were weekly inventories consistently done during the past six months.
3) Fire drills were not completed on the overnight shift in the months of March and April. Evacuation times were not noted for two fire drills.
4) Evidence of checking grievance box and documenting in the logbook was not observed during the past 6 months. One of the fourteen grievances reviewed did not have evidence of resolution, and two grievances were resolved four days after the grievance was submitted. Date received and person receiving grievance was not consistently noted on the grievance forms.

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			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: The agency has the required policy and procedure 1.01 that was approved May 1, 2023 by the program director.	
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**	Per interview with the regional director, the Berke Assessment is the pre-employment suitability assessment used by the program. Applicants who receive a pass rate of medium to high is considered for hire. This practice was not observed in the personnel records for five staff who were hired after the last QI review.	None of the five staff hired during the annual review period completed the required pre-employment assessment.
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors	**Compliance**	A total of eight background screening files were reviewed for five new staff and three interns utilized during the annual review period. All eight background screenings were completed prior to each staff's hire date and 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**	None of the five new hires were prior agency employees.	
Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	The program had three applicable 5-year rescreening during the review period. All three staff had been rescreened with evidence of 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?	**Exception**	Documentation reviewed indicate the provider emailed the Annual Affidavit of Compliance with Level 2 Screening form to DJJ BSU on 5/31/2023.	The annual affidavit of compliance with level two screenings was submitted to DJJ BSU on 5/31/23, 4 months after the 1/31/23 deadline.
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	E-verify and proof of employment authorization from the Department of Homeland Security was documented for all five new hires.	
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 has the required policy and procedure 1.04 that was approved May 1, 2023 by the program director.	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	Training records were reviewed for four first year direct care staff (three youth care and one residential counselor) who had exceeded the first 90 days of hire. Three of the four staff completed new hire pre-service training requirements prior to working independently with youth.	One community counseling staff hired did not complete all pre-service training requirements prior to assignment of their first case in April 2023. There was no evidence of training for three of the six training topics (adolescent and youth development, child abuse, confidentiality) and three topics were completed in May 2023.
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**	Training records were reviewed for four first year direct care staff who had exceeded the first 90 days of hire. Three of the four staff completed the DOJ Civil Rights training within 30 days of hire.	One staff, date of hire (DOH) 2/2/2023, completed the DOJ Civil Rights training on 3/25/2023, exceeding the 30 days 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**	All four new hires are within their first year of hire. Three of the four exceeded the required 80 hours. The fourth staff has completed 66 of the 80 hours and has 8 months remaining in their training year.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Training records for two of four staff reviewed demonstrated staff completed all mandatory training during the first 90 days of employment.	Two of four first year staff did not complete all required trainings due during the first 90 days. One staff (DOH 1/10/23) was late completing adolescent development training (5/30/23), and had not yet completed medication distribution training. There was no evidence the other staff (DOH 2/2/23) completed five required trainings (adolescent development, child abuse, confidentiality, medication distribution, and SOGIE, and staff was late completing cultural diversity, universal precaution, Florida Network and SkillPro suicide prevention, CINS/FINS Core, Nirvana, behavior management, MAB, and fire safety.
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.	**Exception**	The program hired one applicable residential counselor who is responsible for completing and entering NIRVANA data. However, the staff did not complete the required training prior to administering the NIRVANA assessment and entering data. There were no eligible staff responsible for entering JJIS data.	Documentation reviewed for one eligible community counseling staff shows staff was assigned their first case in April 2023 training record shows the required NIRVANA training was not completed until 5/23/2023.
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 hired a non-licensed clinical staff in February 2023. To date, there is no documentation of Assessment of Suicide Risk training but the staff has time to complete the required 20 hours.	
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**	Three in-service staff training records reviewed show staff exceeded the minimum 40 hours required annually and completed the mandatory Florida Network and SkillPro refresher training.	
Required Training Documentation			
The agency has a designated staff member responsible for managing all employee's individual training files and completes routine reviews of staff files to ensure compliance.	**Compliance**	The agency's Quality Management Specialist (QMS) is the designated staff who is responsible for training compliance. The QMS assists in the onboarding of new employees by: creating their training plan and training file; conducting some of the onboarding training; monitoring individual training files and overall compliance; and informing supervisors and employees of upcoming required trainings via the Mandatory Tracking System.	

The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The program maintains individual training records for each staff that contains training transcripts, certificates, sign-in sheets, and other supporting documents.. Each staff's training is documented on a training log that lists the dates, topics, and hours completed for mandatory and in-service training.	
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		**YES** If NO, explain here: The agency has the required policy and procedure 1.06 that was approved May 1, 2023 by the program director.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	Driving records are checked upon hire and also by the insurance company if the staff is identified by the program as a driver. Driving records are also checked by the agency via the Florida Department of Highway Safety and Motor Vehicles (FLHSMV) yearly for all authorized drivers.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Staff approved by the agency's insurance company are included under the automobile insurance policy and listed as authorized drivers. The program provided a list of 27 agency staff approved by administration to drive clients in agency or approved private vehicles. The current automobile insurance is provided by Philadelphia Indemnity Insurance Company and is effective through 12/27/2023.	
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**	Per the agency's transportation policy, when youth are transported, a third party is utilized. If a third party is not available, authorization is given by administration for the youth to be transported with one staff.	
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**	In the event a 3rd party is not present in the vehicle while transporting, the policy states a program director or supervisor will consider the client's history, evaluation, and recent behavior prior to approval of single transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	Transportation records for November 2022-May 2023 were reviewed. Third party present for all non-single transports reviewed were agency 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**	The program documents transportation activities in the electronic logbook as well as the Rastrack App due to being a participant in the Florida Department of Transportation 5310 program. A total of 14 single youth transport events were identified from logbook entries for the period November 2022-May 2023. Nine of the single transports documented prior approval by a supervisor.	Five of the 14 single youth transports did not document approval by the supervisor.
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.	**Exception**	Staff makes a log entry in the electronic logbook whenever the agency vehicle is used. There is no consolidated template or log that lists the required information and staff does not consistently document all required information in their notes or in the Rastrack App.	Nine of the 14 single youth transportation entries did not include all required information such as mileage, purpose, and/or location.
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 and procedure 2.03 that was approved May 1, 2023 by the program director.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	A total of ten records were reviewed for five residential (two open and three closed) and five community counseling (two open and three closed) youth. Case plans were developed based on information gathered during the initial screening, which included an intake, suicide screening and NIRVANA, in each of the ten youth case records reviewed	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Each service plan reviewed was developed within seven working days of completion of the NIRVANA.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Compliance**	Each of the ten youth case records reviewed had a date when the plan was initiated, individualized goals, type of services needed, target/actual completion dates, and signatures of the youth, parent/guardian, as well as the counselor and supervisor.	
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 of the ten youth case records were applicable for thirty-days progress reviews. Reviews were conducted timely every thirty days and revised by the counselor as needed. None of the ten youth case records were applicable for 180-day review.	

Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency has the required policy and procedure 3.01 that was approved May 1, 2023 by the program director.	
Facility Inspection	**Exception**	During the facility walk through, all furnishings were observed to be in good repair. The interior of the facility was free of insect infestation and the exterior of the building which is surrounding by large trees is maintained well. Both the parking lot and basketball court was free of hazard. A large dumpster is located near the exit of gate of the campus and was observed to be covered during the visit. All doors to staff and agency vehicles were locked and secure when checked. The program uses two minivans to transport youth. Both vehicles are equipped with first aid kits, fire extinguishers, glass breaker, flashlights, and seat belt cutter. The program has dormitory style rooming and both the boys and girls dorm rooms were well maintained, did not contain contraband, and were free from graffiti. Youth are assigned individual beds and lockers that are kept locked, to keep personal belongings. All beds had a pillow and were covered with bed sheets and a comforter. Youth have access to a bathrooms in each dorm equipped with three showers, dressing rooms, and three toilet stalls, vanity area with sinks. Doors are secure with key access required. There are three sets of keys per shift for staff to use in addition to a set kept by the program director, nurse, and counseling staff. Program has postings located in the counseling hallway and in each dorm that includes abuse and CCC hotline information, rights and responsibilities, and program rules. SOGIE signage and egress plans was observed throughout the facility. The program schedules are posted on an office window adjacent to the youth lounge.	

Additional Facility Inspection Narrative (if applicable)	The facility has a laundry room furnished with two washers and two dryers. No excessive lint was observed in the dryers during the tour. Chemicals are stored in a locked closet adjacent to the kitchen. Inventory is documented on a form but was not done perpetually and weekly during the past six months as required. The provided implemented a new chemical dispensation system that is mounted in the chemical closet and condenses use of chemicals to only three different chemicals. However, the chemicals that were previously being used were still in the closet and were not being counted which resulted in an inaccurate reflection and count of the facility's chemical inventory. DCF license is issued by Department of Children and Families for 20 beds effective through March 31, 2024 and a copy is on file with reviewer.		1) Chemical inventory count was inaccurate upon review as follows: Victoria Bowl Cleaner shows two on the inventory but 21 was counted on the shelf; Mr. Clean floor cleaner shows zero, but more than one gallon was on the shelf; and Comet shows zero but more than two bottles were on the shelf. The storage closet also had three cans of stainless steel cleaner, one bottle Scrubbing Bubbles, one bottle Dawn hand soap, and two jars of Odoban but these were not included on the inventory list. 2) Perpetual inventory was not conducted nor were weekly inventories consistently done during the past six months.
Fire and Safety Health Hazards	**Exception**	The annual facility fire inspection conducted by Miami Dade Fire Rescue Department on 3/28/23 resulted in a violation for not having its emergency action plan reviewed by the fire department annually. A satisfactory reinspection was completed 5/18/23 and the facility is in compliance with local fire safety guidelines. Fire and emergency drill records were reviewed for the past six months. Fire drills were completed monthly on the first and second shifts and quarterly emergency drills were conducted by all shifts. Annual Fire extinguisher inspection was completed on 12/7/2022 by City Fire Inc. for 14 facility and two vehicle fire extinguishers. City Fire also conducted the annual fire suppression system inspection on 3/23/2023 and emergency/exit light inspection on 5/2/2023.	3) Fire drills were not completed on the overnight shift in the months of March and April. Evacuation times were not noted for two fire drills.
Additional Fire and Safety Health Hazards Narrative (if applicable)	The kitchen is equipped with two commercial refrigerators and one freezer; refrigerator temperatures were optimal at 42 - 43 degrees Fahrenheit and the freezer's temperature was zero degrees Fahrenheit. A satisfactory combined Department of Health (DOH) Group Care and Food inspection was completed 3/28/2023 with no violations noted. The facility has a valid Sanitation Certificate issued by DOH, effective through 9/30/2023		
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 on the wall next to the youth lounge. Grievance forms are accessible and are available next to 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.	**Exception**	Fourteen grievances were reported during the past six months. Eleven of the 14 grievances reviewed were resolved within 72 hours.	4) Evidence of checking grievance box and documenting in the logbook was not observed during the past 6 months. One of the fourteen grievances reviewed did not have evidence of resolution, and two grievances were resolved four days after the grievance was submitted. Date received and person receiving grievance was not consistently noted on the grievance forms.
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 youth are engaged in meaningful, structured activities seven days a week during awake hours and idle time is minimal as evidenced by the daily schedule of activities provided. The program has a weekday and weekend schedule with structured activities each day. Physical activity is scheduled for at least 1 hour daily. Youth are provided an opportunity to attend religious/faith based activities and alternate activities are planned for youth who do not choose to participate in faith-based activities. Youth are given the time and opportunity to do homework and read daily. The program schedule is posted in the dayroom and is accessible to both youth and staff.	
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 and procedure 3.06 that was approved May 1, 2023 by the program director.	

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 staff schedules indicated for the past six months of year 2023, the program staff maintained a minimum of 1:6 during the hours the youth were awake and 1:12 during the hours the youth were sleeping.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	The program schedules from January 2023-May 2023 show a minimum of two direct care staff on each shift (A-C) who met the requirements for training.	
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**	Reviewed trainings indicated staff-to-youth ratio included staff who were background screened and properly trained youth care workers. Staff in training were not scheduled to work independently.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	All staff schedules are posted within the staff office and visible to staff at all times.	
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**	Documentation supports there is a holdover or overtime rotation roster, with staff telephone numbers for additional coverage if needed.	
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 random selection of the following five dates were reviewed for staff observation of youth during sleep period: December 21st, 2am-4am; January 19th, 4am-6am; February 5th, 1am-3am; March 29th, 3am-5am; and May12th, 12am-2am. The review indicated staff observed youth every fifteen minutes while youth are sleeping at bedtime.	
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 policy and procedure 4.02 that was approved May 1, 2023 by the program director.	

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**	Five youth case records were reviewed for four residential and one applicable community counseling youth. The review indicated suicide risk screenings occurred during the initial intake and screening process. All screenings were signed by a supervisor and documented in the youth case records.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment has been 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 four residential youth case records indicated each youth was placed on appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	The four residential case records indicated staff was assigned to monitor the youth and the youth's behavior every thirty minutes or less intervals.	
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**	Each of the four case records reviewed indicated a supervision level was not changed/reduced until a licensed professional or non-licensed mental health professional under the supervision of licensed professional completed a further assessment or Baker Act by local law enforcement.	
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**	One applicable community case record reviewed indicated the youth was assessed by a licensed professional after being identified for suicide risk during intake process and the parents and supervisor were both notified of the results.	

During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**Compliance**	During intake the youth identified for suicide risk was immediately referred by the provider and parent/guardian is notified of suicide risk findings disclosed and advised an Assessment of Suicide Risk (ASAR) was needed and completed by a professional.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**Not Applicable**	Parent/guardian was present during the screening and was notified of the suicide screening results.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Not Applicable**	Parent/guardian was present.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	Screening was not completed on school property.	
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 has the required policy and procedure 4.03 that was approved May 1, 2023 by the program director.	
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 agency has a fulltime Registered Nurse (RN) and credentials have been verified to be effective 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**	Pyxis ES Medication Cabinet is inaccessible to all youth. All medication is stored in accordance with guidelines in FS 499.0121. Oral medication is stored separately from injectable epi-pens and topical medications. At the time of the annual review there were no medications that needed to be refrigerated; however, the refrigerator temperature was observed to be ranging from 2-8 degrees C or 36-46 degrees F. All Narcotics and controlled medications are stored in the Pyxis ES Station. Pyxis keys with labels indicated are accessible to staff in the event they need access.	

Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	**Compliance**	The agency maintains a minimum of two site-specific system managers for the Pyxis ES Station, which are only designated staff delineated in user permissions have access. All medication distribution log shall be used for distribution of medication by non-licensed and licensed staff. Verification of medication using one of three methods listed in the FNYFS Policies & Procedures Manual. When the nurse is on duty, medication processes are conducted by the nurse. Documentation indicated the delivery of medication is consistent with FNYFS medication management and distribution policy. The agency does not accept youth currently on prescribed injectable medication, except epi-pens and non-licensed staff has received training on the use of epi-pens provided by the registered nurse.	
Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	Documentation indicated a perpetual inventory of controlled substances with running balances is maintained as well as a shift-to-shift counts verified by a witness and is documented. Over-the counter-medications are accessed regularly are inventoried weekly by maintaining a perpetual inventory. Sharps are secured, and counted and documented weekly. The agency does not utilize any syringes.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Documentation indicated the nurse runs monthly reports using the Pyxis machine to monitor the medication management practice. Copies of the reports are maintained by the nurse.	
Medication discrepancies are cleared after each shift.	**Compliance**	Documentation indicated medication discrepancies are cleared after each shift.	
Additional Comments: **There are no additional comments for this indicator.**			