# Florida Network for Youth and Family Services
# Compliance Monitoring Report for

**Lutheran Services Florida Southwest - Oasis**

**3642 Central Avenue**
**Fort Myers, Florida 33901**

**Date: May 31st - June 1st, 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 Southwest for the FY 2022-2023 at its program office located at 3642 Central Avenue Fort Myers, Florida 33901. 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. Lutheran Services Florida Southwest 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 Baldwin Davis Consultant for Forefront LLC, and Department of Juvenile Justice Peer Reviewer, Rondarrell George. Agency representatives from Lutheran Services Florida Southwest – Oasis present for the entrance interview were Shelia Dixon, Regional Director; Samuel Laguerre, Shelter Manager; and Erick Scott, Shelter Supervisor and Nicole Lewis CINS/FINS Program Manager, Heidrun Braeuer-Smith, Senior Administrative Assistant. The last QI visit was conducted May 11th – 12th, 2022.

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

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

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

| | |
|---|---|
| **Agency Name: Lutheran Services Florida Southwest** | **Monitor Name: Baldwin Davis, Lead Reviewer** |
| **Contract Type: CINS/FINS** | **Region/Office: 3642 Central Avenue Fort Myers, Florida 33901** |
| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): May 31st – June 1st 2023** |
| | |

| Major Programmatic Requirements | Explain Rating | | | | | Ratings Based Upon: | Notes |
|---|---|---|---|---|---|---|---|
| | Unacceptable | Conditionally Unacceptable | Fully Met | Exceeded | Not Applicable | I = Interview<br>O = Observation<br>D = Documentation<br>PTV = Submitted Prior To Visit<br>(List Who and What) | Explain Unacceptable or Conditionally Acceptable:<br>(Attach Supportive Documentation) |
| **I. Administrative and Fiscal** | | | | | | | |
| **Limits of Coverage**<br>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:<br>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 6/01/2023 – 6/01/2024<br><br>Automobile insurance through Markel Global Reinsurance Company for combined limits of liability/property damage for $1,000,000. Policy effective date 6/01/2023 – 6/01/2024<br><br>Workers Compensation through Accident Fund Insurance Company with limits of $1,000,000 each/aggregate, effective 6/01/2023 – 6/01/2024<br><br>Umbrella liability through Century Surety Company with limits of | **No recommendation or Corrective Action.** |

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| **Major Programmatic Requirements** | **Explain Rating** | | | | | **Ratings Based Upon:** I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What) | **Notes** Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation) |
| | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | | |
| | | | | | | $4,000,000 each/aggregate, effective 6/01/2023 – 6/01/2024<br><br>Professional Liability/Abuse Molestation through Markel Global Reinsurance Company for $1,000,000 each and $3,000,000 aggregate, effective through 6/01/2023 – 6/01/2024<br><br>Florida Network is listed as certificate holder. | |
| **Fiscal Practice**<br>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:<br>Fiscal Policies and Procedures of specific sections pertaining to the CINS/FINS contract were reviewed. Agency maintains an Accounting Procedures Manual that is consistent with GAAP and provide for limited internal controls. The fiscal manual is currently being revised by the Chief Financial Officer and is updated as necessary with revised policies showing a revision/approval date. | **No recommendation or Corrective Action.** |

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|---|---|---|---|---|---|---|---|
| | Explain Rating | | | | | | |
| b. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Observation/Documentation: Reviewed petty cash Policy and Procedure 4.32 included in Finance Section 4 of the Fiscal Manual. The admissions administrative assistant is the custodian of the petty cash fund. Petty cash is stored in a locked box in her office at the main administrative building across from the shelter. All receipts are submitted for accounting and requesting reimbursement as needed and the funds are reconciled and sent to the head office for replenishment of funds. Petty cash was reconciled onsite with the staff. Cash and receipts totaled $1000.00 | **No recommendation or Corrective Action.** |
| c. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Observation: The agency maintains an inventory that was reviewed, the agency has not purchased any items with FNYFS monies since the last time on-site. | **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 | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: The provider submitted a copy of the financial audit conducted for year ending June 30, 2022 and 2021 for the | **No recommendation or Corrective Action.** |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| 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** | | | | | | review. The audit was completed December 22nd 2022 by RSM US, LLP as well as letter from the auditor was dated December 22nd, 2022. Per the audit, a final corrective action plan report was completed, recorded and submitted by LSF for two items cited from previous audit: 1) evaluation and monitoring risk assessment for 72 subrecipients, and 2) federal funding accountability and transparency for 4 LSF subcontracts in its Head Start Program. Corrective actions were implemented in February and March 2022, respectively. | |

Explain Rating

## CONCLUSION

Lutheran Services Florida Southwest has met the requirements for the CINS/FINS contract as a result of full compliance with all five applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. 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 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/Southwest – Oasis
CINS/FINS Program

DATE: May 31 - June 1, 2023

**Compliance Monitoring Services Provided by**

# CINS/FINS Rating Profile

Standard 1: Management Accountability

| | |
|---|---|
| **1.01 Background Screening** | **Satisfactory** |
| **1.04 Training Requirements** | **Satisfactory** |
| **1.06 Client Transportation** | **Satisfactory** |

**Percent of indicators rated Satisfactory: 100 %**
**Percent of indicators rated Limited: 0 %**
**Percent of indicators rated Failed: 0 %**

Standard 2: Intervention and Case Management

| | |
|---|---|
| **2.03 Case/Service Plan** | **Satisfactory** |

**Percent of indicators rated Satisfactory: 100 %**
**Percent of indicators rated Limited: 0 %**
**Percent of indicators rated Failed: 0 %**

Standard 3: Shelter Care & Special Populations

| | |
|---|---|
| **3.01 Shelter Environment** | **Satisfactory** |
| **3.06 Staffing and Youth Supervision** | **Satisfactory** |

**Percent of indicators rated Satisfactory: 100 %**
**Percent of indicators rated Limited: 0 %**
**Percent of indicators rated Failed: 0 %**

Standard 4: Mental Health/Health Services

| | |
|---|---|
| **4.02 Suicide Prevention** | **Satisfactory** |
| **4.03 Medications** | **Satisfactory** |

**Percent of indicators rated Satisfactory: 100 %**
**Percent of indicators rated Limited: 0 %**
**Percent of indicators rated Failed: 0 %**

**Overall Rating Summary**
**Percent of indicators rated Satisfactory: 100 %**
**Percent of indicators rated Limited: 0 %**
**Percent of indicators rated Failed: 0 %**

## Rating Definitions

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

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

## Reviewers

Members

Baldwin Davis - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Rondarrell George– 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 | X | Case Manager | | Nurse – Full time |
| | Chief Financial Officer | | Counselor Non-Licensed | X | Nurse – Part time |
| | Chief Operating Officer | | Advocate | | # Case Managers |
| X | Executive Director | X | Direct – Care Full time | 2 | # Program Supervisors |
| | Program Director | | Direct – Part time | 1 | # Food Service Personnel |
| X | Program Manager | | Direct – Care On-Call | 1 | # Healthcare Staff |
| | Program Coordinator | | Intern | | # Maintenance Personnel |
| X | Clinical Director | | Volunteer | | # Other (listed by title): ___ |
| | Counselor Licensed | X | Human Resources | | |

## Documents Reviewed

| | | | | | |
|---|---|---|---|---|---|
| X | Accreditation Reports | | Table of Organization | | Visitation Logs |
| X | Affidavit of Good Moral Character | | Fire Prevention Plan | | Youth Handbook |
| X | CCC Reports | X | Grievance Process/Records | | # Health Records |
| X | Logbooks | | Key Control Log | | # MH/SA Records |
| | Continuity of Operation Plan | X | Fire Drill Log | | # Personnel /Volunteer Records |
| | Contract Monitoring Reports | X | Medical and Mental Health Alerts | 8 | # Training Records |
| | Contract Scope of Services | | Precautionary Observation Logs | 7 | # Youth Records (Closed) |
| X | Egress Plans | X | Program Schedules | 3 | # Youth Records (Open) |
| X | Fire Inspection Report | | 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 | | Tool Inventory and Storage | | Facility and Grounds |
| X | Recreation | X | Toxic Item Inventory & Storage | X | First Aid Kit(s) |
| | Searches | | 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

| | | | | | | |
|---|---|---|---|---|---|---|
| 6 | # of Youth | 4 | # 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**

Lutheran Services Florida Southwest (LSF SW), Inc. contracts with the Florida Network to operate the Child in Need of Services and Family in Need of Services (CINS/FINS) program in Fort Myers, Florida. CINS/FINS funding allows the agency to provide residential, community counseling, and case management services over five counties in Circuit 20; Collier, Hendry, Glades, Charlotte, and Lee. Oasis Youth Shelter is licensed to serve twenty-two (22) youth and the program's license was renewed by the Department of Children and Families (DCF) on February 1, 2023 and is valid until January 31, 2024. The agency also provides specialized services to youth 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). The agency continues to be contracted to provide Intensive Case Management (ICM) and Stop Now And Plan (SNAP) services. During the current review period, the executive management structure for LSF-SW remained intact and stable. The agency is accredited by COA through February 2026.
The Oasis shelter was awarded a CDBG grant in December of 2022 as well as for renovations to the former community counseling building. The funding with this grant will afford the opportunity to provide the youth served at Oasis Youth Shelter a better living environment. The program received close to $900,000 in funding to support the renovations at Oasis. The funds must be exhausted by August of 2023 and renovations at the facility are currently underway. The program does not anticipate any disruption in services. However, the agency reports there may be times throughout the renovation process in which the residential census is reduced.

**The following programmatic updates were provided by the agency:**

Under the leadership of Regional Director, the agency's operations have remained stable. With local administrative and Human Resources (HR) support by a Senior Administrative Assistant. The program's Residential Services Manager has been in place since June 2019 and continues to provide steady and hands-on leadership with the shelter program. One of the program's longest tenured direct care staff (11 years in total) is the Youth Care Specialist III (YCS III), being in that position for the past 3 years. During the last review period, the Oasis Youth Shelter experienced staff turnover and vacancies on an ongoing basis despite diligent recruitment efforts. They currently have vacancies of two full time and six part time direct care staff. The Registered Nurse is part time and works 20 hours per week and leads the program's efforts in managing the risk associated with medication management. She has been with the program for the entire review period and has provided stability for the program. In June of 2022, a former residential counselor was promoted to a CINS/FINS Program Manager role to assist in providing supervision and oversight of the Intensive Case Management, residential and community counseling programs. Additionally, she facilitates the Case Staffing committee in parts of Circuit 20.
The agency reported that the community counseling team had some turnover since the last review period resulting in the Master level family counselor position being vacant since January of 2023; however, they are in the process of hiring an intern who recently graduated with her MSW. In February of 2023, one of their community counselors transitioned to the Court Case Manager position; however, is still serving cases in the Charlotte County area until a replacement is found. The rest of the community counseling team has been in place since the last review period. The Intensive Case Management team remains fully staffed with two full-time staff. In July of 2022 the agency filled their Outreach and Mentoring specialist position as they strive to increase outreach efforts in all programs and have created a culture in which all staff have embraced outreach as part of their role.

The Stop Now and Plan (SNAP) program continues to be fully implemented in Circuit 20, a five-county area. They report that their contract goals for last year were met and some areas over performed. They hired a new Case Manager in September of 2022 after the previous case manager resigned. They have expanded their SNAP capacity to serve in Charlotte County as that service continues to grow, so does the capacity for SNAP in Schools. The agency now has an office in the Charlotte County's Family Services Center which is essentially a one stop shop for human services resources for families in Charlotte County. A strong partnership with Charlotte County Boys and Girls Club continues with plans to do groups with the youth over the summer. In May of 2023, Oasis Youth Shelter began implementation of a new Behavior Management System called Journey to Success which was developed through cross-collaborative efforts across all levels of staff in their residential programs at LSF. They considered it imperative that the behavior management system be rooted in theory and philosophical foundations that would serve to support the work of direct care staff to assist youth to make meaningful change in behaviors and look to the future for successful young adulthood. Oasis staff are still adjusting to implementing this new system and continue to be supported by leadership and clinical staff. At the end of 2022, community counseling staff were trained in Moral Recognition Therapy (MRT) hoping to provide MRT groups to both youth and parents in the community as well as court involved families. They have recently built a partnership with Lee County Boys and Girls Club and will provide summer groups to at risk youth involved in those groups. The files reviewed are manual charts as the agency does not use an electronic management record system. They are providing all services to youth and families face to face and/or in-person.

The community counseling/administrative program office has changed locations as the previous building is undergoing renovations to become a teen drop-in center. The new community counseling location has moved across the street where the current Regional Administrative office is located at 3615 Central Avenue Suite 4, Fort Myers, FL 33901. The agency recently hosted a toy drive to provide presents to community counseling and shelter youth in addition to hosting an On the Table event in which community members came together to discuss topics that are impacting the community and to introduce other community members to the programs. They have recently re-established a Local Advisory Committee that was initially recommended by United Way and is comprised of local community members from their school district, law enforcement, police athletic league, human services, and a local child welfare agency that serves to assist them in assessing community needs, addressing how they can both expand services, as well as gaining feedback on improving/enhancing service delivery within their communities. They continue to work collaboratively with all community groups and resources, such a mental health providers and other stakeholders with whom they have memorandum of agreements. The shelter has a capacity for twenty two youth, fourteen youth were on census at the time of the review.

In September of 2022, the community was significantly impacted by Hurricane Ian. Shelter Manager and one of our direct care staff evacuated Oasis with four youth to Lippman Youth Shelter after evacuation orders were given by DJJ. The Oasis shelter withstood the hurricane with minor damage which was quickly repaired; however, the shelter remained closed until power and water were restored. While the shelter was closed staff and leadership worked together to clean up the shelter and participated in many community distribution efforts to help staff and clients with food, water and other essentials. Shelter staff took turns cooking meals for each other from the shelter kitchen as well as the shelter was opened for staff to shower, charge electronics and so on, the shelter was temporarily powered by a generator. Several staff also reported significant damage to their homes. The shelter was closed from September 27, 2022-October 11, 2022. Although there was much devastation from the storm in the community, the agency reports feeling that this experience brought staff closer together and afforded unique outreach and community engagement opportunities. The program has not received any corrective action since the last review period.

**Narrative Summary**

Lutheran Services Florida Southwest (LSF SW), Inc. contracts with the Florida Network to operate the Child in Need of Services and Family in Need of Services (CINS/FINS) program in Fort Myers, Florida. The agency provides services for Circuit 20 across 5 counties including: Collier, Hendry, Glades, Charlotte, and Lee. The agency is accredited by COA through February 2026. The LSF SW Oasis Youth Shelter is licensed to serve twenty-two youth and the program's child caring license by the Department of children and Families (DCF) is valid until January 31, 2024.

The overall findings for the QI Review for **LSF SW Oasis** are summarized as follows:

**Standard 1**: Three indicators were reviewed for this standard. Indicators 1.01 and 1.04 were rated Satisfactory with exceptions; Indicator 1.01 noted exceptions due to five staff missing the suitability assessments prior to hire date and Indicator 1.04 noted exceptions for three late or missing trainings for new hire and in-service staff. Indicator 1.06 was rated Satisfactory with no exceptions noted.

**Standard 2**: One indicator was reviewed for standard 2. Indicator 2.03 was rated Satisfactory with no exceptions.

**Standard 3**: Two indicators were reviewed for standard 3, indicators 3.01 and 3.06. Indicators 3.01 was rated Satisfactory with exceptions for Material Safety Data Sheets (MSDS) were inacurate for chemical items, Lysol Toilet and Brighton Handsoap. The agency uses a chemical inventory but does not have one that meets the requirement of a perpetual inventory process and Indicator 3.06 was rated Satisfactory with no exceptions noted.

**Standard 4**: There were 2 indicators reviewed for standard 4, indicators 4.02 and 4.03. Both indicators were rated Satisfactory.

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

There were no indicators resulting in Limited or Failed at the time of this review.

## 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**<br><br>The agency has the required Policy and Procedure 1.01. Titled: Background Screening of Employees, Interns and Volunteers. Policy was last reviewed on February 7, 2022 by the Executive and Clinical Directors and Residential Services Manager. | |
| 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** | The agency uses the Predictive Index tool with established passing score greater than five. | Five direct care counseling staff did not complete the Predictive Index Assessment tool prior to date of hire. |
| 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 fourteen new staff were hired and were utilized since the last QI review. All fourteen had eligible background screenings completed prior to hire/start dates. | |
| 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 fourteen new staff hired were previously employed with the agency. | |

| | | | |
|---|---|---|---|
| Five-year re-screening completed every 5 years from initial date of hire | **Compliance** | The program had three applicable five-year rescreen staff since the last QI review. All three staff had evidence of DJJ Clearinghouse screening completion and evidence of valid retained prints from initial date of hire. | |
| Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st? | **Compliance** | Provider emailed the Annual Affidavit of Compliance with Level 2 Screening form to DJJ BSU on 1/03/2023, prior to the January 31st deadline. Email receipt evidence was provided to the agency from BSU on 1/4/2023. | |
| 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 verified for all fourteen 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**<br><br>The agency has the required Policy and Procedure 1.01. Titled: Training Requirements. Policy was last reviewed on August 1, 2022 by the Executive and Clinical Directors and Residential Services Manager. | |
| **First Year Direct Care Staff** | | | |
| All direct care staff have completed new hire pre-service training requirements for safety and supervision as required. | **Compliance** | Reviewed documentation and confirmed all direct care staff have completed new hire pre-service training requirements for safety and supervision as required. | |
| 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,* | **Compliance** | A review of three pre-service direct care staff training records were reviewed. All three staff completed the DOJ Civil Rights training within 30 days of hire. | |
| All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment. | **Compliance** | Each direct care CINS/FINS staff complete a minimum of 80 hours of training or more for the first full year of employment. | |
| All staff receives all mandatory training during the first 90 days of employment from date of hire. | **Exception** | Review of training documentation confirmed two pre-service direct care staff completed all mandatory training as required. | One staff missed completing the fire safety training on time, staff stated this was due to program hurricane disruption that necessitated shelter evacuation at the time. |

| Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS) | | | |
|---|---|---|---|
| Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings. | **No eligible items for review** | There is no applicable file to review for designated staff that is responsible for entering NIRVANA or JJIS. | |
| **Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)** | | | |
| Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor). | **No eligible items for review** | There is no applicable non-licensed mental health clinical staff person's training files to review for 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** | A review of five in-service direct care staff training files were reviewed and each file had completed the required annual training in excess of 40 hours. Three staff completed all of the required trainings within the timeframes specified. | Two in service staff files reviewed were missing the annually required Course #168 Child Abuse and Course #45 Information Security Awareness. |
| **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** | Interview with the residential shelter manager and the community shelter supervisor confirm the agency has a designated staff members responsible for managing all employee's individual training files and confirmed that routine reviews of staff files to ensure compliance are completed. | |
| 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** | All training files reviewed included a spreadsheet with all trainings, date completed, and hours. The training files included training certificates and training worksheets. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 1.06: Client Transportation | | | Satisfactory |
|---|---|---|---|
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.06** | | **YES**<br>The agency has the required Policy and Procedure 1.06. Titled: Client Transportation. Policy was last reviewed on August 1, 2022 by the Executive and Clinical Directors and Residential Services Manager. | |
| Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle | **Compliance** | The program maintains an approved list of agency staff to transport youth in agency vehicles. The list also includes staff who are non-drivers. | |
| Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy | **Compliance** | All approved agency drivers have current driver's licenses and are covered under the agency's insurance policy. The agency's auto insurance policy is current and was also provided for review. | |
| 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 outlines the importance of avoiding single youth transports. In the event of a single transport of youth, per the policy, approval is first required by the Residential Supervisor. | |
| 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 that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior. The program has three vans to transport youth, a 2018 Ford Transit 350, a 2010 Honda Odyssey (out of commission at the time of the review), and a 2014 Ford E350. | |
| The 3rd party is an approved volunteer, intern, agency staff, or other youth | **Compliance** | The transportation logs for the review period showed third party present in vehicles was an agency staff or other youth. | |

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| The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports. | **Compliance** | The agency demonstrated evidence via logbook and verification that supervisor approval was obtained prior to all single youth transports. A total of 112 single transports were accounted for in total for both useable vans, for the last six months. Further sample review was done of cell phone log and Note Active logbook for four dates of single transports that revealed compliance with the practice. These were on 11/30/2022 (x 3 single transports); 12/20/2022 (x 2 single transports); 01/23/2023 (x 2 single transports) and 03/07/2023 (x 4 single transports). The agency transports all youth to multiple school sites, hence the higher number of single transports. | |
| 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** | Program staff conducts regular vehicle inspections and maintains documentation of vehicle use on the mileage log. Transportation logs include the date, driver's name, number of passengers, beginning and ending odometer, time out/in, and activity/location. Activity and location is used to indicate purpose of travel and 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**<br><br>The agency has the required Policy and Procedure 2.03. Case Service Plans. Policy was last reviewed on August 1, 2022 by the Executive and Clinical Directors and Residential Services Manager. | |
| The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA. | **Compliance** | Reviewed documentation confirmed the case plan is developed based on information gathered during the initial screening intake suicide screening and NIRVANA. | |
| Case/Service plan is developed within 7 working days of NIRVANA | **Compliance** | A review of ten case management records were reviewed to include three open and two closed residential records and five closed community counseling record. All ten files contained a case service plan completed with 7 days of the needs assessment or Network Inventory of Risks, Victories, and Needs Assessment (NIRVANA). | |

| Indicator | Rating | Findings | |
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| **Case plan/service plan includes:**<br>1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA<br>2. Service type, frequency, location<br>3. Person(s) responsible<br>4. Target date(s) for completion and Actual completion date(s)<br>5. Signature of youth, parent/ guardian, counselor, and supervisor<br>6. Date the plan was initiated | **Compliance** | A review of all ten youth records found each of the ten records contained a case plan which was individualized, identified the service type, frequency and location of services, and the person responsible. Signatures were documented for all required parties. | |
| 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** | Six of the ten youth case management records were applicable for thirty day reviews. All six records were revised by the parent and counselor when applicable and reviews were conducted timely. | |

***Additional Comments:*** **There are no additional comments for this indicator.**

| 3.01 - Shelter Environment | | | Exception |
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| Provider has a written policy and procedure that meets the requirement for Indicator 3.01 | | YES<br><br>The agency has the required Policy and Procedure 3.01. Titled: Shelter Environment. Policy was last reviewed on August 1, 2022 by the Executive and Clinical Directors and Residential Services Manager. | |
| Facility Inspection | Exception | A tour of the facility was conducted with the Residential Services Manager and Supervisor. The furnishings were observed to be in reasonably good condition with no visible damage. All beds appeared sturdy and functional. The shelter was clean and while it needs some updating, no graffiti, insect droppings or infestation were noticeable. The exterior areas by the shelter facility is maintained and landscaped with fresh mulch and flowers. There is a major renovation underway at the building situated at the front of the premises and the dumpster was overfilled and the site is accessible to anyone, potentially posing a safety risk for youth, staff and visitors. The facility has a large backyard with adequate recreational and garden space which requires some pruning. There is a dumpster in front of building which is behind an enclosed gate and is kept locked. The facility has a male and a female bathroom; each is equipped with 2 shower stalls, sinks, and 2 toilets. Each bedroom is equipped with 2 bunkbeds, bookshelf/shoe shelf, four lockers and a posted board with attached schedule, grievance policy, behavior management system, emergency procedures, and chore schedule. The facility is adequately lit throughout. The program uses three vans to transport youth, one van is out of commission and not currently being used, the Honda Odessey, per the program staff. The vans are equipped with a first aid kit, flashlights, fire extinguishers (which are not labeled to show their purpose), flashlight, glass breaker, and seat belt cutter. The Residential Services Manager and team lead has a full set of keys and each staff has keys for entry doors. Doors are kept locked throughout the residential areas and is only key accessible. | Material Safety Data Sheets (MSDS) were inaccurate for chemical items, Lysol Toilet and Brighton Hand Soap. The agency uses a chemical inventory but does not have one that meets the requirement of a perpetual inventory process. This was also observed and noted as a finding on the last review.<br><br>The dumpster is currently overfilled but this is due to an ongoing renovation. The gate leading to the rear of the building is broken and is laid onto a fence. |

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| **Additional Facility Inspection Narrative (if applicable)** | The facility egress plans are located in hallways, common areas and in the kitchen. The abuse hotline number is posted in each bedroom and on the wall in youth common room/lounge. The grievance box and forms are accessible to youth in the dayroom, adjacent to the kitchen. SOGIE signage was seen posted throughout the facility. Youth has a locker for personal clothing and no contraband was observed. Chemicals are stored in the laundry room and closet in the medication room. An inventory is conducted daily but not maintained on a perpetual basis to accurately reflect reduction in count due to removal from the stock. There is a laundry room that is equipped with 2 washers and 2 dryers, they were checked observed to be in good condition and clean and free of lint. All beds had a pillow and was covered with bed sheets and a comforter. DCF license is posted in the lobby and is effective through January 31,2024. | | |
| **Fire and Safety Health Hazards** | **Compliance** | Fort Myers Fire Department, completed annual inspection for shelter facility and nonresidential offices on 3/16/2023 and reinspection on 4/20/2023 and 4/24/2023. The shelter failed the initial inspection on ten areas of violation relating to fire hood, sprinkler system, multiple areas of storage clutter impeding pull station and sprinkler, inappropriate wall height extinguisher installation and backflow valve issues. The clearance inspection report was received 4/24/23 and this review did not identify any of these fire inspection issues. All of the fire extinguishers had valid inspection tags with expiration dates of May 2023. An annual sprinkler system inspection and backflow certification was conducted by Wayne Automatic Fire Sprinklers Inc. on 12/12/22 . Fire extinguishers were inspected by Advance Fire Systems Inc. on 05/19/23. Alarm testing and inspection was completed by Fyr-Fyter Inc on 8/30/22. A review of fire drills indicated the program conducted on average three fire drills per month, one on each shift within the prescribed time. The program also completed mock emergency drills, including at a minimum, one per shift per quarter. Satisfactory combined food and group care inspection was conducted by the DOH on 01/23/23. Four week cycle menus as well as a 7 day emergency menu were posted and signed by a licensed dietician effective until 8/5/23. The registered dietician's license is valid through 5/31/2025. Cold food was properly stored, marked and labeled and dry storage areas were clean. Refrigerators and freezers were clean and optimal temperatures were maintained on each appliance. | |
| **Additional Fire and Safety Health Hazards Narrative (if applicable)** | | | |

| Grievance | | | |
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| 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** | There is a formal procedure and grievance forms, and a locked box which are easily accessible to youth in a common area. | |
| 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** | There is evidence that grievance boxes are checked by the Shelter supervisor at least daily as evidenced in the program logbook. All grievances are resolved within 72 hours and documented by program director. | |
| **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.<br>b. At least one hour of physical activity is provided daily.<br>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.<br>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.<br>e. Daily programming schedule is publicly posted and accessible to both staff and youth. | **Compliance** | Youth are engaged in meaningful, structured activities seven days a week during wake hours. Some of the activities include but not limited: educational, recreational, life, counseling, and social skill training. Idle time is minimal.<br><br>Daily schedules reflect at least one hour of physical activity is provided daily and notated in the logbook.<br><br>Youth are provided the opportunity weekly to participate in faith-based activities. Non-punitive structured activities such as reading, journaling, tutoring, education, recreational board game and counseling are offered to youth as an alternative to youth who do not choose to participate in faith-based activities.<br><br>Daily programming includes opportunities for youth to complete homework and access books in the facility library that have been approved by the agency. Daily programming schedule is publicly posted in the two areas (living room and provided to the youth) and accessible to both staff and youth. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 3.06 - Staffing and Youth Supervision | | | Satisfactory |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 3.06** | | **YES**<br>If NO, explain here:<br>The agency has the required Policy and Procedure 3.06. Titled: Staff and Youth Supervision. Policy was last reviewed on August 1, 2022 by the Executive and Clinical Directors and Residential Services Manager. | |
| The program maintains minimum staffing ratios as required by Florida Administrative Code and contract.<br>• 1 staff to 6 youth during awake hours and community activities<br>• 1 staff to 12 youth during the sleep period | **Compliance** | A review of staff schedules for the past 6 months revealed that the program maintained the required ratio of 1 staff to 6 youth during awake hours and community activities and 1 staff to 12 youth during the sleep period. | |
| All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements | **Compliance** | A review of log book entries was conducted in relation to the staff schedule and staff schedules verified that at least two staff were present on all shifts during the last six months reviewed. | |
| Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff | **Compliance** | The shelter staff included in the staff-to-youth ratio included only staff are background screened and received adequate training to work with youth. | |
| The staff schedule is provided to staff or posted in a place visible to staff | **Compliance** | The monthly staff schedule is provided to staff and posted in the camera room. | |
| 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** | Staffing availability experienced by the program since the last review continues to impact availability of additional staff to create a holdover roster; however, residential services manager, supervisors, team leads, counselors, and other trained agency staff are utilized to fill any call out gaps. | |

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| 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** | Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times. Random selection of bed checks were reviewed as being logged in Note Active which has real time capability built in for bed checks. | |
| ***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**<br><br>The agency has the required Policy and Procedure 4.02. Titled: Suicide Prevention. Policy was last reviewed on August 1, 2022 by the Executive and Clinical Directors and Residential Services Manager. | |
| **Suicide Risk Screening and Approval (*Residential and Community Counseling*)** | | | |
| Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file. | **Compliance** | A review of five case management records, three open and two closed, was conducted for suicide risk screening. Three of the five records included a suicide risk screening tool completed during the initial intake. Each suicide screening was reviewed and signed by the supervisor and maintained in the record. | |
| The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services | **Compliance** | The agency's suicide risk assessment 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** | Each of the three reviewed youth suicide risk assessment indicated a need for sight and sound supervision. A review of the assessment validated each youth was placed on the appropriate level of supervision based on their suicide risk. | |
| Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals | **Compliance** | Review of the Precautions Observation Log (POL) confirmed staff assigned to monitor youth documented youth's behavior at 30 minute or less intervals. | |

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| 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 youth were removed from sight and sound supervision after a suicide assessment was completed by a licensed professional. | |
| **Youth with Suicide Risk *(Community Counseling Only)*** | | | |
| Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results. | **No eligible items for review** | There were no cases to review for youth identified for suicide risk during intake for community counseling and who was immediately assessed by a licensed professional or non-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** | No files met this criteria for the period of review. | |
| Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone. | **No eligible items for review** | No files met this criteria for the period of review. | |
| If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file. | **No eligible items for review** | No files met this criteria for the period of review. | |
| When the screening was completed during school hours on school property, the appropriate school authorities were notified. | **No eligible items for review** | No files met this criteria for the period of review. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 4.03 - Medications | | | Satisfactory |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 4.03** | | **YES**<br><br>The agency has the required Policy and Procedure 4.03. Titled: Medications. Policy was last reviewed on August 1, 2022 by the Executive and Clinical Directors and Residential Services Manager. | |
| 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 one registered nurse (RN) and all the credentials have been verified. | |
| **Medication Storage** | | | |
| a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff)<br>b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management<br>c. Oral medications are stored separately from injectable epi-pen and topical medications<br>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.)<br>e. Narcotics and controlled medications are stored in the Pyxis ES Station<br>f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT | **Compliance** | The program maintains a written policy and procedure outlining Medication protocols. Observation of the medication room found all medication are stored in a Pyxis Es medication cabinet that is inaccessible to youth.<br><br>The Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy sections in medication management. Oral medications are stored separately from topical medications located in the locked medical cabinet.<br><br>All narcotic and controlled medications are stored in the Pyxis Med-Station 4000 medication cabinet. Observation of the Pyxis keys with appropriate labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction. | |

| Medication Distribution | | | |
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| a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station<br>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)<br>c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff<br>d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual<br>e. When nurse is on duty, medication processes are conducted by the nurse<br>f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy<br>g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens<br>h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse | **Compliance** | An observation of the medication room found the program maintains a list of Super Users and a list of designated staff delineated to have access to secured medication. The program has identified three Super Users for the Med-Station. Reviewed documentation with interview with the RN and Shelter Manager confirms the agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual. When nurse is on duty, medication processes are conducted by the nurse and the delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy. The Agency does not accept youth currently prescribed injectable medications, except for epi-pens and all non-licensed staff have received training in the use of epi-pens provided by a registered nurse. | |

| Medication Inventory | | | |
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| 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<br>b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory<br>c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly | **Compliance** | An observations of the Medication Distribution Log (MDL) found controlled substances are counted shift-to-shift with two staff members present and documented on the youth's MDL.<br><br>A perpetual inventory with running balances is also maintained on the MDL's for all medications.<br><br>Interview with the RN and residential services manager indicated the nurse counts all the medication each day and syringes and sharps are secured and counted as required, weekly. | |
| There are monthly reviews of the Pyxis reports to monitor medication management practice. | **Compliance** | The registered nurse is responsible for reviews and runs weekly and monthly reports via the knowledge portal. | |
| Medication discrepancies are cleared after each shift. | **Compliance** | Interview with the nurse and residential service manager indicated there have been no medial discrepancies and no medical discrepancies were found in any of the documentation reviewed during the annual review. The nurse reported that discrepancies are cleared after each shift. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |