Florida Network for Youth and Family Services
Compliance Monitoring Report for

Safe Children Coalition
1106 South Briggs Avenue, Sarasota, FL 34237

February 22-23, 2023

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) with Florida Network of Youth and Family Services (FNYFS) monitoring visit for the Safe Children Coalition (SCC) for the FY 2022-2023 at its program office located at 1106 South Briggs Avenue, Sarasota, Florida. 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. Safe Children Coalition 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 Alexis Sapp, Department of Juvenile Justice Peer Reviewer. Agency representatives from Safe Children Coalition present for the entrance interview were Stacey Schaeffer, Senior Director of Prevention and Diversion Services; Jill Steiner, Senior Director of Out of Home Care; April Ranceful, Vice President of Youth Services; Charles Harris, Director of Residential Programs; Jennifer Warwick, Clinical Supervisor; Alan Abernathy, Residential Manager; and Aaron Bellamy, Youth and Family Advocate Manager. The last QI visit was conducted March 23-24, 2022.

In general, the Reviewer found that Safe Children Coalition is in compliance with specific contract requirements. Safe Children Coalition **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 02-22-2022-2023

Agency Name: Safe Children Coalition	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 1106 South Briggs Ave. Sarasota FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): February 22-23, 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**		
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**	☐	☐	☐	☒	☐	General Liability through Alliance of Nonprofits for Insurance for limits of coverage $1,000,000 each $3,000,000 aggregate, and $20,000 medical expense, effective 7/1/22-7/1/23 Workers Comp insurance through Zenith Insurance Company of America for limits of coverage $500,000 each accident, effective 1/1/2023–1/1/2024. Automobile insurance through Alliance of Nonprofits for Insurance for combined limits of liability/property damage for $1,000,000 each and aggregate. Policy effective for 07/01/2022-07/01/2023. Professional Liability Claims insurance through Alliance of Nonprofits for Insurance for limits of coverage $1,000,000 each/$3,000,000	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						aggregate effective 07/01/2022-07/01/2023. Umbrella Liability through Alliance of Nonprofits for Insurance for limits of coverage $6,000,000 each/aggregate and Sexual Abuse Limit of $2,000,000, effective 07/01/2022-07/01/2023. Florida Network is listed on the Certificate of Insurance as certificate holder.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in the Financial Services Policy and Procedures Manual. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. All policies have a revision date of March 2, 2020.	**No recommendation or Corrective Action.**
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: No change in practice was reported for the agency since the last site program review. The agency has a policy that oversees Petty Cash Funds. It maintains a petty cash system that is secured in a locked box and managed by the Youth and Family Advocate	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						Manager. The petty cash fund $450.00. The funds are disbursed and reconciliations are verified by the designee in the finance department before reimbursement is made. Agency uses an agency reconciliation form to capture beginning cash balance, ending cash balance and to list all receipts. Total amount on hand and counted and reconciled by shelter program staff was $450.00	
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**	☐	☐	☒	☐	☐	Documentation: Agency maintains an inventory in accordance with a written policy and FNYFS contractual requirements. The document that was presented for the contract management review shows that 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 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	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2022 was completed by Kerkering, Barberio and Company Certified Public Accountants and dated December 13, 2022. Per the audit report, a separate Management Letter requiring a Corrective Action Plan is	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**						not required and was not issued by the auditor. A copy of the audit was submitted to the FNYFS.	

CONCLUSION

Safe Children Coalition has met the requirements for the CINS/FINS contract as a result of full compliance with all five indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. Consequently, **the overall compliance rate for this contract monitoring visit is 100% percentage.** 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, all of 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 Safe Children Coalition - Sarasota
Residential Program

February 22-23, 2023

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of Indicators rated Satisfactory: 66.67 %
Percent of Indicators rated Limited: 33.33 %
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: 87.5 %
Percent of indicators rated Limited: 12.5 %
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
Alexis Sapp – Regional Monitor, Department of Juvenile Justice

Methodology

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

Persons Interviewed

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

Documents Reviewed

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

Observations During Review

	Intake	X	Posting of Abuse Hotline	X	Staff Supervision of Youth
	Program Activities	X	Tool Inventory and Storage	X	Facility and Grounds
	Recreation	X	Toxic Item 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

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

Safe Children Coalition (SCC) Inc. is a multi-facetted and multi-funded non-profit community-based care provider that focuses on education, prevention, diversion, and child welfare services, serving Sarasota, Manatee, and Desoto counties in Florida. The corporate headquarters office is located at 1500 Independence Blvd., Suite #210, Sarasota, Florida. Program offices include the shelter which is located at 1106 S. Briggs Ave., Sarasota, and the Youth Prevention Services (YPS) community counseling program is located at 5284 Paylor Lane, Lakewood Ranch, Florida. The major program areas of SCC include foster care/child welfare, youth and family services, and educational outreach services. Funding received through the statewide CINS/FINS program allows the agency to serve both male and female youth up to seventeen years old who are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. SCC is currently licensed through the Department of Children and Families for 20 beds, effective through May 31, 2023 and is also accredited by the Council on Accreditation through June 2025.

During the annual review, the agency provided the review team information regarding programmatic updates pertaining to the following areas of operation.

Staffing

Safe Children Coalition has created two new Vice President (VP) of Community Based Care (CBC) Operation positions which will assume the responsibilities of the current VP of CBC Operations, who will be retiring later this calendar year. After over 4 years in this role, it was determined there was a need to have two positions with a focus on different areas of our organization. Due to the departure of the Director of Human Resources (HR), the HR department has transitioned to be under the direction of the Chief Financial Officer. The agency is currently exploring the benefits of filling the Director of HR position or creating a different HR type of position.

Due to funding reasons related to residential services, community counseling (YPS) opted to dissolve two full-time counselor positions. As of August 2022, YPS was down two full-time counselors until October 2022 when two staff were hired. The program is now fully staffed. YPS counselors moved from a 12-month schedule to an 11-month schedule, leaving two full-time staff at 12-month status. At the time of the review, the residential director reported four full-time direct-care vacancies.

Program

Per Florida Network changes, YPS stopped using the PAT assessment tool and instead trained and implemented the NIRVANA tools. The two new YPS staff were fully trained to utilize the NIRVANA assessment. Beginning February 2023, the Network changed from Netmis2 to Netmis3 requiring additional trainings and operational changes for all staff.

During the annual review, the shelter had a census of nine youth in the program. The shelter director reported an increase in admissions for homeless youth. This trend is due to families being displaced from their rental properties because of increases in the cost of rent. The length of stay is relatively longer for these youth as they await a safe and stable family living arrangement.

Facility

The Youth Shelter will be moving to a new location in March 2023 because the current Briggs Avenue location's lease is expiring. This will be a temporary move, for approximately 2-3 years while the agency builds a new youth shelter facility. The SCC Foundation purchased a former Assisted Living Facility for this move and the agency is currently in the licensing process. The address for the new shelter is 2841 6th Street, Sarasota, FL 34237 and will house 12 youth at this location.

Funding/Finance

Effective July 2022, the CINS/FINS contract with the Florida Network was amended to increase the number of Community Counseling Units from 266 to 321. Also, the agency is currently in the silent phase of its youth shelter capital campaign. This campaign is focused on raising funds to build the new youth shelter facility. The property where this facility will be built has already been purchased.

Governance/Community

SCC programs participated in a Sequential Intercept Mapping (SIM) Workshop with the University of South Florida. This SIM Workshop was focused on how the various local systems of care intersect and how the community can work together more collaboratively and cohesively to better serve the at-risk youth in our community.

External Corrective Action Plans

The program did not report any current corrective action plans with funding sources as of the date of the annual QI review.

Major Challenges

Staffing continues to be a challenge for the residential program and has contributed to its ongoing vacancies.

Narrative Summary

SCC is under the leadership of a Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Vice President of Youth Services, Senior Director of Prevention and Diversion Services, a Senior Director of Out-of-Home Care, Director of Residential Programs, and a Clinical Supervisor. The Senior Director of Prevention and Diversion oversees the community counseling program and the Senior Director of Out-Of-Home Care oversees the residential programs. In addition to the Residential Director, the residential program staffing consists of a Residential Manager, a Youth and Family Advocate Manager, a master's level Residential Counselor, three fulltime Behavior Coaches, and 13 part time (PRN) Behavior Coaches. The community counseling program is housed off-site and is approximately a 30 minute drive away from the shelter location, in a business park office that serves the full spectrum of community-based services provided by the agency, including CINS/FINS. The community counseling program consists of a Program Coordinator, one master's level counselor/case managers, four bachelor's level, counselors/case managers, and an Administrative Assistant.

The overall findings for the modified QI Review for Safe Children Coalition are summarized as follows:

A total of eight indicators were reviewed during the modified QI visit.

Standard 1:

Three indicators were reviewed for this standard: 1.01 Background Screening of Employees/Volunteers, 1.04 Training Requirements, and 1.06 Client Transportation. Indicators 1.01 and 1.06 were rated Satisfactory but indicator 1.06 was found to have an exception because four of 49 single transports conducted were not approved by the supervisor prior to transport. Indicator 1.04 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. Both indicators were rated Satisfactory with exceptions. The exception for 3.01 was due to lack of perpetual and inaccurate chemical counts. Indicator 3.06 exceptions were due to only one instead of two staff being scheduled on two separate dates, and a missing bed check.

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 but indicator 4.03 was found to have an exception because one medication was labeled on the perpetual inventory form as Pepto Bismol and there was none present; the program had switched to antacid tablets.

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

Standard 1:

Indicator 1.04 - Limited

1) The DOJ Civil Rights and Federal Funds training completed on 1/10/2023, was 10 months late for one staff who was hired 2/2/2022.

2) Two of the four training records reviewed were missing and/or were late in completing one or more mandatory trainings due within the first 90-days of hire. One of the staff was missing medication distribution training and the other staff completed the following trainings late: DJJ Civil Rights, cultural humility, youth development, CPR/First Aid, Universal Precaution, MAB, FN Suicide Prevention, CINS/FINS Core, Fire Safety, Medication Distribution, and DJJ SkillPro Child Abuse, Information Security, PREA, Suicide Prevention, and Human Trafficking.

3) Two in-service staff did not complete all mandatory annual trainings as follows: one staff missed DJJ SkillPro Suicide Awareness training (last completed 8/24/2020) and the other staff's annual Child Abuse, and Information Security Awareness trainings, were last completed 8/27/21; and Trauma Informed Care is overdue since 12/28/22 (last completed 12/28/20).

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator.		**Review Based Upon Document Source** *For example: Interview/Surveys, Observation, and/or Type of Documentation*	**Notes** Explain any items that have any deficiencies, exceptions or are not applicable.
Standard One – Management Accountability			
1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: The agency has the required policy and procedure 1.01 that was approved by the Chief Executive Officer September 16, 2022.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.	**Compliance**	The agency uses their own Safe Children Coalition Candidate Evaluation preassessment tool with a passing score of 80% or higher. All three new hire staff had a documented pre-employment suitability assessment that was completed prior to hire using the tool. Each staff exceeded the passing score.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors	**Compliance**	Three new staff were hired since the last onsite Quality Improvement review. All three staff were background screened with eligible ratings received prior to their hire date. The program did not use any applicable volunteers or interns during the review period.	
Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.	**No eligible items for review**	The agency has not rehired any staff during the review period.	
Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	There were three eligible staff during this review period. DJJ five-year re-screening documentation demonstrated timely re-screenings for all three staff members.	

Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The agency submitted an Affidavit of Annual Compliance with Level 2 Screening Standards to the Department of Juvenile Justice Background Screening Unit via fax on January 13, 2023, before the January 31, 2023 deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of employment authorization from the Department of Homeland Security was obtained through E-verify and maintained on file for all three 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)			**Limited**
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 by the Chief Executive Officer September 16, 2022.	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	A review of four pre-service staff training records was conducted. Three of the four staff were currently within their first year of hire and were hired after September 1, 2022, the effective date of this requirement. As of the date of the QI visit, the three staff completed all pre-service training requirements.	
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**	Three of the four staff completed the United States Department of Justice Civil Rights and Federal Funds training within the required thirty days of hire.	The DOJ Civil Rights and Federal Funds training completed on 1/10/2023, was 10 months late, for one staff hired 2/2/2022.
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 pre-service staff completed an excess of 80 training hours ranging from 80 -151.8 hours as of the date of the QI visit.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Two of four pre-service training records reviewed has evidence of staff completing all mandatory training due within the first 90 days of employment.	Two of the four training records reviewed were missing and/or were late in completing one or more mandatory trainings due within the first 90-days of hire. One of the staff was missing medication distribution training and the other staff completed the following trainings late: DJJ Civil Rights, cultural humility, youth development, CPR/First Aid, Universal Precaution, MAB, FN Suicide Prevention, CINS/FINS Core, Fire Safety, Medication Distribution, and DJJ SkillPro Child Abuse, Information Security, PREA, Suicide Prevention, and Human Trafficking.
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			

Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	Two applicable community counseling staff completed the NIRVANA training required. There were no applicable new staff who are responsible for JJIS data entry.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	The program did not hire any non-licensed mental health clinical shelter staff during the review period.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	Three in-service direct care training records were reviewed. All three training records had an excess of 40 hours of training and one of the three demonstrated staff completed all mandatory annual Florida Network, Skill Pro and job related and/or refresher training.	Two in-service staff did not complete all mandatory annual trainings as follows: one staff missed DJJ SkillPro Suicide Awareness training (last completed 8/24/2020) and the other annual staff was missing the following trainings: Child Abuse and Information Security Awareness, which were last completed 8/27/21; and Trauma Informed Care is overdue since 12/28/22 (last completed 12/28/20).
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 Residential and Community Counseling program directors are responsible for managing their employees' individual training files and conducting periodic reviews to monitor and maintain the training records.	
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 seven training records reviewed contained individual training plans for each staff including an annual training tracking form indicating the name of the training, date completed, and the number of training hours received. The files also contained sign-in sheets, certificates and/or agendas of the training received.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency has the required policy and procedure 1.06 that was approved by the Chief Executive Officer September 16, 2022.	

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency's policy and procedure states all staff employed must have a valid driver's license and pass an agency driver training which automatically qualifies them to be covered by the agency's vehicle insurance. This policy was also validated per interview with the residential director.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Agency staff who meet the above mentioned criteria are covered under the insurance policy. The agency furnished a copy of its auto insurance policy that is effective through July 1, 2023.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency's policy was reviewed which addresses one-on-one staff-to-client transport and the exception that can be made if a 3rd party is not available. The Note Active tablet/logbook provides documentation of authorization given by a supervisor/manager for single client transports.	
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 of a single transport of youth, per the transportation policy, approval is required by the program manager or designee who considers the client's history, evaluation, and recent behavior. These individuals were observed as providing single transport approvals on the transport logs.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency transport vehicles include three minivans: a 2022 Honda Odyssey, a 2020 Toyota Sienna, and a 2014 Kia Sedona. Transportation logs were reviewed for the period September 2022 through the review date. With the exception of single transports, third party present in vehicles were typically 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**	Single transport is documented on the transportation log as well as in the Note Active logbook. During the review period, a total of 49 single transports were reviewed. Supervisory approval was documented for 45 of the 49 single transports.	Four of the 49 single transports recorded on the transportation log did not have evidence of 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.	**Compliance**	The agency's transportation log documents names/initials of all staff and youth in the vehicles, number of passengers, date and time of transport, mileage, and destination/purpose of the trip.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory**
	YES		

Provider has a written policy and procedure that meets the requirement for Indicator 2.03		If NO, explain here: The agency has the required policy and procedure 2.03 that was approved by the Chief Executive Officer September 16, 2022.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	Ten youth records were reviewed. Five records were reviewed from residential, and five from community counseling. Of the records selected from residential, three were closed files and two were open. Of the community counseling files selected, three were closed and two were open. All ten records contained documentation reflecting case/service plans being developed based upon information gathered during the initial screening, intake, suicide screening, and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Ten youth records were reviewed for case/ service plans being developed within seven days of the NIRVANA. All ten were developed within the required timeframe.	
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**	Ten youth case/service plans were reviewed. All ten plans were individualized based upon the needs of the youth, as identified by the NIRVANA. All plans included the service type, frequency, and location, as well as the persons responsible, the target dates for completion, and the actual dates of completion for each goal. All of the residential service plans were signed by the youth, parent, counselor, and supervisor. All of the community counseling records indicated parental consent was given via telephone in place of a parental signature. The plans did contain a signature from the youth, counselor, and supervisor. The residential plans did not specifically state initiation date; however, the plans did contain the admission date, which was the same as the case plan initiation date signed by the youth and counselor. All of the community counseling plans contained the initiation date.	
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 youth records were reviewed for case/service plans being reviewed for progress or revised by the counselor, youth, and parent every thirty days for the first three months, and every six months after. All of the case plans for both residential and community counseling were reviewed timely as required based upon how long the youth has been in service.	
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Exception**
		NO	

Provider has a written policy and procedure that meets the requirement for Indicator 3.01		If NO, explain here: Policy 3.01 does not address chemical storage/inventory and postings of egress plans, DCF license. It also does not include requirements of the fire/safety section of indicator 3.01.	
		The agency has a policy and procedure 3.01 that was approved by the Chief Executive Officer September 16, 2022.	
Facility Inspection	**Exception**	A full tour of the facility's interior and exterior areas and transportation vehicles was conducted. The program is in the process of moving to another facility within two weeks and has suspended major repairs/maintenance; however, the facility was observed to be clean and the furnishings throughout were found in fair condition. The facility has monthly pest control services and did not have any visible signs of insect or rodent infestation in both the interior and exterior areas. The exterior grounds was void of landscaping and there was no observed hazard or debris. All bathrooms and shower areas were found to be clean. The girls and boys dorm sleeping rooms contained adequate and clean bedding with individual pillows for each youth. Youth are provided individual secured bins for safe keeping of valuable items requiring lock-up in the shelter. The lighting throughout the building including the dorm areas was operational and provided adequate illumination. A large trash receptacle is located on the premises and is kept covered. Vehicles parked on the premises were secure and locked when checked during the visit. The program uses three minivans to transport youth. Each van is equipped with a first aid kit, flashlight, fire extinguisher, glass breaker, and seat belt cutter. The facility is equipped with two washers and two dryers. All were observed to be in good condition, were clean, and dryers were free of lint.	Chemical count reflected for the week of 2/20-2/26/23 was not accurate with actual counts of chemicals in the storage closet inside the boy's bathroom as follows: bleach shows 1, 0 observed; Clorox wipes show 2, 0 found; Lysol shows 1, 2 found; Dial hand soap shows 1, 0 found; Fabuloso shows 2, 1 found; Sanitect hand sanitizer shows 9, 3 found. Three chemicals in the closet were not on the inventory list: Great Value wipes, Member's Mark wipes, and Gel Rite hand sanitizer.
Additional Facility Inspection Narrative (if applicable)	The program has six sets of keys distributed to staff and four sets distributed to management. Staff sign keys in/out when reporting for work. Egress plans are located in the lobby, hallways, bathroom, bedrooms, offices, and common areas. Abuse hotline number is also visibly posted throughout the facility. Grievance box and forms are accessible to youth in the dayroom. SOGIE signage was observed posted throughout the facility. DCF license is posted in the lobby and is effective through 5/31/2023. No contraband was observed. Chemicals are stored in a locked closet inside the boy's bathroom. Inventories are conducted weekly but not perpetually and was found to be inaccurate during the review. MSDS were available for all chemicals used.		

Fire and Safety Health Hazards	**Compliance**	All fire and safety inspections were found to be current during the review. An annual fire inspection was conducted by Sarasota County Fire Department on 4/13/22 with some violations found which were corrected and resulted in a successful re-inspection on 6/14/2022. Fire extinguishers in the facility and three vans had valid inspections conducted by Cintas, effective through January 2024. Cintas also conducted the semi-annual kitchen suppression inspection on 10/10/22. Alliance Fire and Safety conducted annual sprinkler inspection on 7/18/22. Piper Fire Protection conducted the annual alarm inspection on 1/17/23 and no deficiencies were found. Monthly fire drills were conducted on each shift, with evacuation time less than two minutes each, between August 2022 and January 2023. During the same period, the program conducted mock emergency drills quarterly on each shift.	
Additional Fire and Safety Health Hazards Narrative (if applicable)	Department of Health completed a satisfactory combined Group Care and Food inspection on 8/12/22. A eight week cycle menu approved 2/17/23 by a registered dietician was posted in the kitchen. All food was found to be properly stored during the tour. Two refrigerator temperatures were observed to be 38 degrees Fahrenheit, and the temperature for one freezer was minus 3 degree Fahrenheit.		
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. Grievance forms are accessible and are available next to the grievance box which is mounted on a wall in the dayroom.	
There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook. All grievances are resolved within 72 hours and documented by program director.	**Compliance**	The residential director and managers have possession of the keys to the grievance box. The grievance box was checked during the review and was found to be empty. One grievance was submitted since the last onsite review and was resolved by management within 24 hours.	

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 and posted around the facility. Youth in the program are provided at least one hour of physical activity daily and they are also provided the opportunity to participate in a variety of faith-based activities or provided alternatives for those that choose not to participate in these activities. Youth are also provided opportunities to complete homework and have access to computers, a variety of age-appropriate and program-approved books for reading and are allowed quiet time to do so. The schedule is publicly posted and accessible to youth and staff, which could be found in the common areas.	
Additional Comments: **There are no additional comments for this indicator.**			
3.06 - Staffing and Youth Supervision			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency has the required policy and procedure 3.06 that was approved by the Chief Executive Officer September 16, 2022.	
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**	The staff schedule, log entries, and youth census for the program were reviewed for meeting the minimum staff-to-youth ratios required by contract and Florida administrative code for the following dates: 2/6/23-2/12/23; 1/9/23- 1/15/23; 1/23/23-1/29/23; 12/19/22-12/25/22; 12/5/22-12/11/22; 11/14/22-11/20/22; 10/31/22-11/6/22; 10/17/22-10/23/22; 10/10/22-10/16/22; 9/26/22-10/2/22; 9/12/22-9/18/22; 8/22/22-8/28/22; and 8/8/22-8/14/22. Documentation for all dates reviewed reflect the required ratio was met during both awake and sleeping hours with no exceptions.	

All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Exception**	The staff schedule, log entries, and youth census for the program were reviewed for the presence of a minimum of two direct care staff that have met the minimum training requirements. The program has struggled with maintaining full staffing capacity and reported having four residential youth care vacancies during the onsite review. There were two days (Christmas Eve and Christmas day) observed where the program reduced it's staffing because the youth were on home visits. This reduction in staffing resulted in there being less than two staff on duty as required.	On 12/24/22, there were no youth present in the facility at the time due to the youth having home visits for the holiday and only one staff was present. On 12/25/22, no youth were present due the youth being on home visit for the holidays and no staff was present at the facility during waking hours, but was available via telephone for the duration of the youth's absence.
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**	Staffing schedules for the past six months (listed above) were reviewed to ensure staff included in the staff-to-youth ratio were background screened and properly trained youth care workers, supervision staff, and treatment staff. All new staff were background screened and current prints were maintained in the clearing house for in-service staff. Training files reviewed confirmed all residential program staff received the appropriate training prior to working independently with youth.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	Staff schedule was viewed during the facility tour. Schedule is posted on the wall in the staff control room. This is visible and accessible to all staff. A record of the schedule is maintained in a binder labeled "Staff Authorized to Distribute Medications & Staff Schedules".	
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**	Staff holdover or overtime rotation roster was observed during the facility tour. The roster is posted on the wall in the staff control room. This is visible and accessible to all staff.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	Reviewed staff log entries for bed checks for the following dates and times: September 14th, 12am-2am October 21st, 2am-4am November 17th, 4am-6am December 24th, 1am-3am January 15th, 3am-5am	Staff log entries were checked for bed checks being conducted at least every fifteen minutes while in the sleeping room. Staff log entries from October 21, 2022 between 2:00am and 4:00am, document one bed check was missed. A bed check was conducted at 3:31am, and the next check was not conducted until 3:53am, which is seven minutes after when the next bed check should have been conducted.
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets		**YES** If NO, explain here:	

the requirement for Indicator 4.02		The agency has the required policy and procedure 4.02 that was approved by the Chief Executive Officer September 16, 2022.	
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 total of six youth records were reviewed. Three records were residential records, and three records were community counseling records. All of the reviewed suicide risk screenings were completed during the initial intake process and reviewed by a supervisor. This review was documented with a signature.	
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 was initially approved by the Florida Network of Youth and family Services and has not been changed since approval.	
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**	Three residential youth records were reviewed for level of supervision based on results of the suicide risk assessment. All three records documented youth were placed on the appropriate supervision level after the suicide assessment was completed.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	Three youth residential records were reviewed for monitoring youth's behavior at intervals of 30 minutes or less. Precautionary logs documented that when on precautionary observation the youth's behavior was documented at intervals of thirty minutes or less.	
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**	Precautionary logs were reviewed for the three residential files. All of the records documented supervision levels were maintained until further assessment was completed by the appropriate parties.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**Compliance**	Three community counseling youth records were reviewed for two closed and one open record. In all three records, youth identified as a suicide risk during intake were immediately assessed by either a licensed professional, or a qualified non-licensed professional under the direct supervision of a licensed professional.	

During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**Not Applicable**	None of the files reviewed were applicable because the suicide risk assessment was completed during the initial intake by either a licensed professional, or a qualified professional under direct supervision of a licensed 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.	**Compliance**	All records included documentation to show the parent was provided with contact information for community resources. Referrals were sent home with the youth to provide to the parent, and the parent was notified via telephone that the youth would have the referral.	

If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	All three records had documentation of multiple attempts to contact the youth's parent when the parent was not available. These attempts were documented in the progress notes.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	None of the three community youth screenings were conducted on school property.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency has the required policy and procedure 4.03 that was approved by the Chief Executive Officer September 16, 2022.	
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.	**No eligible items for review**	The employee roster and schedule were reviewed. The program does not currently have an RN or LPN on staff. This position has been vacant for over a year despite the agency's effort to recruit a nurse.	
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	**Compliance**	The facility's Pyxis machine was observed. All prescription medication was kept in the Pyxis machine. The Pyxis machine is located in the back area of the office, where youth are not typically located unaccompanied. The machine is stored in accordance with guidelines. Oral medications are kept separate from other forms of medication. EpiPens are kept in a separate locked drawer from any oral medication. The program has a medication fridge that is only used for medication. At the time of review, there were no refrigerated medications, and the refrigerator was at zero degrees. This is slightly lower than the acceptable limit, however, there were no medications present and it is likely that the refrigerator has not been opened for an extended period of time. The medication fridge is locked, and is kept in a locked room. At the time of review the facility had one controlled substance on site, and the medication was kept in the Pyxis machine. There is a spare set of keys for use in the instance the Pyxis malfunctions, and the keys are labeled appropriately. These keys are accessible to staff.	

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 facility was toured and the program director interviewed to determine the medication distribution compliance. The agency has three site specific system managers for the Pyxis machine, per the program director. Only staff with user permissions have access to controlled medications. A medication distribution log is utilized for the distribution of medication by non-licensed staff. The program does not currently have a licensed nurse due to having a vacant nurse position. Per an interview with the program director, medication is verified via a phone call with the pharmacy, which is one of the methods listed in the FNYFS policies and procedures manual. The medication delivery process is consistent with the FNYFS medication management and distribution policy. Non-licensed staff were trained in the use of epi-pens, and this training was provided by a 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	**Exception**	Youth medication logs were reviewed for perpetual inventory of controlled medications, and shift to shift counts. There is a process in place for a perpetual inventory with running balances, as well as a shift-to-shift count to be conducted and documented on the medication distribution log. A perpetual count is completed as a youth is given medication and there is a spot to document shift-to-shift counts at the bottom of the form. Over the counter medications are inventoried weekly. The agency also utilizes a perpetual inventory where they document anytime a dose is given. The agency does not have any syringes. Sharps counts are conducted daily, on each shift.	One medication was mislabeled on the perpetual inventory form. Inventory reflects four Pepto Bismol. However, when inventory was compared to medication in the cabinet, there were four antacid tablets.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The program director was interviewed regarding reports pulled from the Pyxis machine. The program director reported pulling discrepancy reports weekly and maintains a file of these reports as well as user interaction reports.	
Medication discrepancies are cleared after each shift.	**Compliance**	The program director was interviewed regarding discrepancy reports. It was reported discrepancies are cleared on each shift. Discrepancy reports were observed.	
Additional Comments: **There are no additional comments for this indicator.**			