Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth Crisis Center
3015 Parental Home Road
Jacksonville, Florida 32216

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Youth Crisis Center (YCC) for the Fiscal Year (FY) 2022-2023 at its program office located at 3015 Parental Home Road, Jacksonville, Florida 3221. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. The Youth Crisis Center is contracted with the 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 Keith Carr, Consultant for Forefront LLC, and Department of Juvenile Justice Peer Reviewer, Mike Marino. Agency representatives from YCC present for the entrance interview were Stepheny Durham IV, Chief Operations Officer; Logan Farley, CINS/FINS Clinical Director; Tamika Gloston, Residential Director; Lisa Pitts, Quality Improvement and Compliance Manager. The last QI visit was conducted May 25-26, 2022.

In general, the Reviewer found that YCC is in compliance with specific contract requirements. The Youth Crisis Center **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 02-08-09-2022-2023

Agency Name: Youth Crisis Center	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 3015 Parental Home Road Jacksonville, Florida 32216**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): February 8-9, 2023**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: General Liability through Philadelphia Indemnity Insurance Co. for limits of coverage $1,000,000 each/$3,000,000 aggregate, and $20,000 medical expense, effective 7/01/22 – 7/01/23. Workers Comp insurance through Bridgefield Employers Insurance Company for limits of coverage $500,000 each accident, effective 7/1/2022 – 7/1/2023. Automobile insurance through Philadelphia Indemnity Insurance Co. for combined limits of liability/property damage for $1,000,000 each and aggregate. Policy effective for 7/1/2022 – 7/1/2023. Professional Liability Claims through Philadelphia Indemnity Insurance Co.	**No recommendation or Corrective Action.**

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	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						for limits of coverage $1,000,000 each/$3,000,000 aggregate effective 7/1/2022 – 7/1/2023. Florida Network and their official address is listed on Certificate of Liability Insurance as certificate holder.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in the Financial Services Policy and Procedures Manual. The financial manual is divided into forty-three sections. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for general ledger, cost accounting, payroll, petty cash, computer backup, and other relevant financial processes. The agency's annual accounting firm indicates the provider's net assets and cash flows for the year ended are acceptable and are in compliance with US generally accepted accounting principles (GAAP).	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
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 the agency's Petty Cash practice was reported for the agency since the last site program review in May 2022. The Petty Cash policy and procedure is number FS0305. The Petty Cash fund does not exceed the established minimum of $250. Petty Cash is stored in a secure locked location in the building. Petty cash is reconciled on a consistent basis (monthly/quarterly) by designated Assistant Residential Director and audited by the Director of Strategic Partnerships. The last audit was completed on February 6, 2022 and no discrepancies were noted. Disbursements and invoices are approved by the Assistant Director.	**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**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**

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Contract Type: CINS/FINS						Region/Office: 3015 Parental Home Road Jacksonville, Florida 32216	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): February 8-9, 2023	
	Explain Rating					Ratings Based Upon:	Notes
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
d. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2022 and 2021. The combined financial statements as of June 30, 2021, were audited by Masters, Smith and Wisby, P.A. whose report was dated February 21, 2022. The date the report was submitted to the Board of Directors is November 15, 2022. Per the audit report, a separate Management Letter requiring a Corrective Action Plan is not required and was not issued by the auditor.	**No recommendation or Corrective Action.**

CONCLUSION

The Youth Crisis Center has met the requirements for the CINS/FINS contract as a result of full compliance with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. One of the five indicators was not applicable because the provider does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100% 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, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF RECOMMENDATIONS

Recommendation
None.

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

Youth Crisis Center
CINS/FINS Program

February 8-9, 2023

Compliance Monitoring Services Provided by

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CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	**Satisfactory**

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

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	**Satisfactory**
3.06 Staffing and Youth Supervision	**Limited**

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 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

Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Mike Marino – Regional Monitor, Department of Juvenile Justice

Methodology

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

Persons Interviewed

X	Chief Executive Officer	X	Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
X	Chief Operating Officer		Advocate	2	# Case Managers
	Executive Director	X	Direct – Care Full time	2	# Program Supervisors
X	Program Director	X	Direct – Part time	2	# Food Service Personnel
	Program Manager		Direct – Care On-Call	1	# Healthcare Staff
	Program Coordinator		Intern	1	# Maintenance Personnel
X	Clinical Director		Volunteer	2	# Other (listed by title): ___
X	Counselor Licensed	X	Human Resources		QI Coordinator, Administrative Assistant

Documents Reviewed

	Accreditation Reports	X	Table of Organization	X	Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	8	# Health Records
X	Logbooks	X	Key Control Log	8	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	11	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	11	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	7	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	7	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

9	# of Youth	15	# of Direct Staff Res and Non-Res		# 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.

Programmatic Updates:

The agency reports that in the last few months, it has made adjustments to its residential program and the program is returning to a status of some normalcy since the COVID Pandemic. The agency reported its continuing to see an increase in its youth census as staffing improves. The agency has re-instated onsite residential program activities, including yoga and art and offsite recreational activities. The agency reported its Director of Residential Programs, Tamika Gloston, has been working the majority of her work shifts on the third shift due to staff vacancies. The treatment team revised their process for reviewing youth. The agency reported having had two treatment team staffing meetings after changing the structure. The agency's clinical director, residential director, lead residential supervisor, shift supervisor, and therapists all meet to discuss both clinical and programmatic needs of each youth on Wednesdays. The agency reports the feedback has been positive and mentioned the overall results have been more collaborative and productive. Team leads of these staffings are also providing feedback to the youth as to successes and areas for improvement based on the team's feedback.

The agency reports its community counseling program experienced changes in staffing related to therapists in St. Johns County. Despite the staffing challenges, the agency reports clients continued to be served. The agency has ongoing efforts to secure new staff and have made offers for new therapists to begin in St. Johns County. They are awaiting the background screening process. The agency reports its ability to begin providing groups to several charter schools and the Y's afterschool program. The agency has therapists which are now based out of Jacksonville Classical Academy. The agency reports there have been an abundance of referrals originating out of Clay County. As a result of these referrals the agency is moving one St. Johns position from St. Johns to Clay County. The agency continues to receive referrals from Care Connect based out of Flagler Health. Youth who may be in need of medication may attend services through the agency's onsite behavioral health program's Psychiatrist and Psych ARNP.

The agency reports its SNAP program is operating on a reduced number of staff members. However, despite the staff challenges the agency report impressive teamwork and leadership its SNAP team has utilized to continue to have at successful year serving youth and families. Agency staff members cover groups and schools across both locations. The agency reports it has also made offers for two St. Johns SNAP facilitators and are awaiting clearance. The supervisor and lead facilitator positions are filled and ready to serve the county once trained.

The agency reported they have increased partnerships across various schools' bachelors and masters' programs including University of North Florida and Walden University. The agency secured several interns from these programs and has utilized them in their residential, community counseling, and SNAP programs. The agency reports the interns have provided a great deal of assistance with programming, and several have transitioned into YCC employees throughout the year. The agency's clinical director will be sitting on the University of North Florida (UNF) Social Work Community Advisory Committee. This committee will assist in

students gaining knowledge, skills, and experience that employers are looking for in their students. She is also a Motivation Interviewing trainer and attended the Girls Centered practice program through Georgetown University Certificate program.

The agency has two community counseling staff mebers that are currently licensed-- Carissa Brede (licensed mental health counselor) and Logan Farrelly (licensed clinical social worker).

The agency created two part time positions for answering crisis calls. This has now resulted in the agency having two referral line specialists who answer calls during the day shift. This position assists with scheduling appointments with staff and directing calls, as well as handling crises. The agency also provides CPR/First Aid training in-house after several staff received proper training from the community. The agency also reported another member agency, Anchorage Children's Home, out of Panama City provided great assistance in the area of training, human resources, and nursing. Youth Crisis Center report Joel Booth, CEO of Anchorage's team provided training to new hires with YCC.

The agency reported its Intensive Case Management (ICM) case manager has been successful in receiving referrals from judges in St. Johns County. The ICM communicates with the Judges on program updates and has not had a need to staff a case through case staffing due to the clients meeting goals.

The agency also provided a summary on its programs, services, and successes from 07/01/2022-01/30/2023.

SNAP (Stop Now and Plan) Clinical (ages 6-11)
- Served 28 youth

SNAP In Schools (ages 6-11)
- Operated in 3 schools throughout St. Johns County (five classrooms at Southwoods Elem, three classes at Webster Elem, and one classroom at Otis Mason Elem)
- Operated in 2 schools throughout Duval County (three classrooms at Bayview Elem and one class at Rufus E Payne Elem)
- Signed a memorandum of understanding with Clay County and waiting for approval from the school district to begin serving Montclair Elementary

Residential Crisis Care Facility (ages 10-17)
- 192 youth were served
- 33 were admitted under the domestic violence respite program
- 2 youth were considered Special Populations
- 100% of youth were reunited with their family or appropriate party at completion of services
- 100% of youth successfully completed services
- Provided a total of 1,706 care days (as of Dec 31, 2022)

Family Link (Community-based Program, including ICM ages 6-17)
- Served 209 youth
- 99.5% of youth completed counseling services

Narrative Summary

The Youth Crisis Center (YCC) is a sub-contract service provider of Childrens In Need of Services and Families In Need of Services (CINS/FINS) with the Florida Network of Youth and Family Services (FNYFS). The agency is headquartered at 3015 Parental Home Road, Jacksonville, FL 32216 and has a St. Johns County office located at 100 Whetstone Place, Suite 303, St Augustine, FL 32086. The agency provides services to Judicial Circuit 4, Baker, and St. Johns Counties. The agency reported its Department of Children and Families license is active until April 2023 for 34 beds. The agency reported it continues to maintain their Council on Accreditation which became effective in October 2022.

The overall findings for the QI Review for Youth Crisis Center are summarized as follows:

Standard 1: Three indicators were reviewed for standard 1: 1.01 Background Screening of Employees/Volunteers, 1.04 Training Requirements and 1.06 Client Transportation. Indicator 1.01 was rated Satisfactory with no exceptions. Indicators 1.04 and 1.06 were rated Satisfactory with exceptions.

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

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

Standard 4: There are two indicators that were reviewed for standard 4, Indicators 4.02 Suicide Prevention and 4.03 Medications. Indicator 4.02 was rated Satisfactory with no exceptions. Indicator 4.03 was rated Satisfactory with exceptions.

Summary of Deficiencies resulting in Limited or Failed Rating:

Standard 3: Indicator 3.06 – Review of the aforementioned bed check practice found multiple randomly selected 15 minute bed checks documented in the electronic logbook and were not supported by video on three different nights. There were nine checks documented in the electronic log that were not supported by video. The director for residential services has the dates, times of checks not supported by video, and staff names reported to the CCC. An official incident report was accepted by the DJJ Central Communications Center on day two of the program review. The CEO and COO also viewed video camera footage and confirmed checks were not supported by video camera footage.

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 policy number is 7.01 and is called Background Screening of Employees and Volunteers. The policy was reviewed and signed by the Chief Executive Officer in February 2023.	
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 program uses the Avitar employee assessment tool. Twenty-one new hires and six volunteers were reviewed. The Avitar was completed on all new hires and volunteers. Each staff member and volunteer received a passing score.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors	**Compliance**	Twenty-one new hires and six volunteers were reviewed. A background screening was completed on each new hire and volunteer prior to their start date.	

Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.	**No eligible items for review**		
Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	One employee required a five-year rescreen. The rescreening request was submitted two months prior to the anniversary of hire date and was completed.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and submitted to the Background Screening Unit on January 10, 2023.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Twenty-one new hires were reviewed. Proof of E-Verify was obtained for each new hire.	
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** The agency policy number is 7.02 and is called Staff Training. The policy was reviewed and signed by the Chief Executive Officer in December 2022.	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	Five staff members were reviewed for pre-service training. All required pre-service training was completed with one exception, but four of the five staff members had some courses completed late and one staff member was missing one required course.	Multiple required trainings completed late and one staff member missing one training.
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*	**Exception**	Five staff members were reviewed for pre-service training. Four of the five staff members completed the United States Department of Justice Civil Rights and Federal Funds training within 30 days of hire.	One staff member completed the training late.

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**	Five staff members were reviewed for pre-service training. Each staff member received over 80 hours of training, with staff receiving between 81 and 90 hours of training during their first year of employment (note: each staff was still within 6 months of hire).	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Five staff were reviewed for pre-service training. Each staff completed mandatory training, but four of the five staff did not complete all the mandatory training within 90 days of hire.	DOJ Civil Rights & Federal Funds (1 late), Cultural Humility (2 late), Behavior Management (1 late, 1 not completed), Understanding Adolescent Development (3 late), CPR/First Aid (1 late), Confidentiality (2 late).
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	One applicable new hire reviewed did complete the required training on time.	
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).	**Exception**	One applicable training record was reviewed and the licensed professional was interviewed. The program has not tracked training on completion of the Assessment of Suicide Risk (ASR). Documentation of ASRs and staff member interviews demonstrated the licensed professional closely supervises and provides input to non-licensed staff when they complete ASRs, but it has not been documented in accordance to requirements. The Department's form for tracking the required training was provided to the licensed professional.	Training for non-licensed staff on the completion of the Assessment of Suicide Risk was not documented in accordance to requirements.
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Compliance**	Five training records were reviewed for in-service training. One of the records documented over 40 hours of training. The remaining four staff still have time to complete training to meet the requirement. All staff were on pace to meet the 40-hour requirement. There were some trainings completed late and two instances of training not being completed.	Florida Network Suicide Prevention (1 not completed), DJJ Suicide Awareness and Prevention in SkillPro (3 late), PREA (1 late), Trauma-Informed Care (1 not completed), Child Abuse (1 not completed) and Information Security Awareness (1 not completed).

Required Training Documentation			
The agency has a designated staff member responsible for managing all employee's individual training files and completes routine reviews of staff files to ensure compliance.	**Compliance**	The agency has appointed the Human Resources Director and HR support staff as primarily responsible for reviewing training hours compliance for all staff members.	
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	Ten training records were reviewed (5 pre-services and 5 in-service). All records contained a tracking form and documentation to confirm training completed.	
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 policy number is 5.05 and is called Transportation of Youth. The policy was reviewed and signed by the Chief Executive Officer in December 2022.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency provided a copy of staff members appointed as drivers approved by the agency to transport youth. The agency provided a current list of 26 residential staff members designated as drivers.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency hires direct care staff members with valid drivers licenses. At the time of this onsite Quality Improvement review, all 26 staff members have valid drivers licenses and are insured under the agency's Commercial automobile insurance coverage with Gallagher Insurance Company.	

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 for Client Transportation policy prohibits transporting a youth alone and includes exceptions in the event a third party is not present in the vehicle. The policy requires the supervisor be notified of the transportation event. The policy requires the transportation event to be approved if a third person cannot be present. There was evidence in the shelter program log and in the transportation log the supervisor approves all transportation events.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The agency's policy includes what the staff must do in the event a third party cannot be obtained for transport. The policy requires the client's history, evaluation, and recent behavior is considered. There was evidence on the log sheet and transportation log that the supervisor considered the client's history, current and overall behavior prior to each transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	A review of the agency's policy currently lists a volunteer, intern, agency staff member or other youth as an approved third party to be used by the agency during transportation events.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	A review of all single transport events completed in the last six months (August 2022 - February 2023) was conducted. The review of this information found a total of 80 single transport events documented which required prior approval from authorized program directors logged in the agency's Transportation Authorization Log. A total of 60 logged transportation events included documentation of single driver and passenger verification of the director or assistant director prior approval.	Evidence of prior approval of a single transport event by a designated supervisor or director is documented on single transport events, however the agency does not have evidence of documenting the director's approval time on the following dates of 9/3/22, 9/18/222, 9/28/22, 1/28/22,11/23/22, 11/4/22,1/6/23, and 2/2/23.

There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Exception**	The agency utilizes the Transportation Authorization Log to document the use of agency transportation vehicles. The Transportation Authorization Log requires the driver to document the outbound transportation event which included date, time, named of staff, name of youth, reason for transport, person authorizing, date and time of prior approval authorization, driver checklist was completed, and notes. The return or in-time is also required to be documented with date and time.	The current vehicle transportation sheet does not include mileage and purpose of travel.
2.03 - Case/Service Plan			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency policy number is 4.04 and is called Case/Service Plans. The policy was reviewed and signed by the Chief Executive Officer in December 2022.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	A random sample of eight open and closed client residential and community counseling records serviced by the agency in the last six months was conducted. All residential and community counseling files reviewed contained a service plan created with information obtained the initial screening, intake, suicide screening and NIRVANA assessment instrument process.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All client files service plans reviewed onsite contained evidence confirming each was developed within seven days of completion of the NIRVANA assessment.	

Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Compliance**	The agency's service plan utilizes a process which collects client information during the screening process. The agency includes all information obtained to create the client's goals and objectives. The service plan for each client case file includes the documentation of multiple goals and objectives, service type, frequency, location, the person responsible, the target date for completion, actual completion date, and the signature of the counselor and supervisor. Eight client records contain documented evidence of service plans that were consistent with the requirement of the indicator. All client cases have assigned goals, objectives, frequency, persons responsible, signatures of required parties and date the plan was initiated. One client case was also closed early due to client only being in shelter less than seven days. However the service plan was initiated and developed with signatures from child, parent through telephone confirmation which is documented in the client file.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	Eight client records contained documentation of file review sessions which include evidence of documentation of goals and objectives tracking the stats at the 30 day interval and all progress made towards completion. These service plan review sessions include the signatures of all required parties. One of the client files did not contain evidence of reviews due to the residential client being discharged early.	
3.01 - Shelter Environment			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency policy number is 8.03 and is called Facility Environment and Safety. The policy was reviewed and signed by the Chief Executive Officer in December 2022.	

Facility Inspection	**Exception**	A tour of the youth shelter was conducted with the agency's assistant residential director. The exterior area of the shelter's front of the building was clear. On day one, the reviewer observed interior deficiencies which were identified and reported. No trash items were found and all garbage was located in trash receptacles. The trash receptacles lids were observed and all lids were closed. On day two of the review, the interior deficiencies had documented evidence provided by the agency as being addressed or in the process of address through official Work Orders. All exterior areas are free from hazards or items which are out of place or not secured. All interior furnishings are in good order. No graffiti was found in either interior furniture or in interior areas. Exterior lighting is operational and all lights are working as required. The agency has two transportation minivans which were both locked and secured. The agency utilizes a keyless entry system to access the shelter. Staff members use a key control system from shift to shift. All keys were accounted for during the two-day onsite program review. The agency has a facility map listing all areas of the facility. The agency has 12 posted egress plans. Locations include residential lobby, youth care staff station, residential break room, level one girls hall, level two girls hall, level one boys hall, level two boys hall, residential therapist hall, residential administration, shelter entry/walkway. The client rules, incident and abuse reporting, and contact numbers are posted on the general bulletin board in the both the boys and girls day rooms. The daily activity schedule is posted and includes	During the onsite tour of the shelter environment, there were observations of peeling of paint in the residential bathrooms in the level 1 male bathroom and female bathroom. Work orders issued 2/8/2022 to paint shower ceiling in male bathroom. Issues found on Day 1: leaking shower, rust on sprinkler and repair vent in restrooms. Issue #2: Strings and cords on blinds found in Residential bedrooms and halls. A Work order was issued on 2/8/2022 to eliminate and remove all strings and cords in bedrooms and halls. Issue #3: battery in smoke detector is sending an audible alert indicating the battery requires replaced in residential girls area. There is evidence of a work order issued on 2/9/2023 to repair the smoke detector. Issue #4: Light coverings for florescent and other bulbs are missing in seven areas in boys and girls common areas and halls. Work orders have been submitted to replace light coverings in halls and five bedrooms.

Additional Facility Inspection Narrative (if applicable)	other client-related rules and expectations in the both the boys and girls day rooms. The shelter has a large commercial kitchen and dining hall. At the time of this onsite program review, the kitchen, pantry, oven, refrigerator and sinks are clean. All aforementioned kitchen items are also operational. Current kitchen built-in refrigerator thermometer is operational. The kitchen is equipped with 2 Freezers and one Refrigerator. Freezer one and two both have temperature readings of zero degrees. The Refrigerator reading is 40 degrees. The Dietitian's menu is posted in the kitchen and the dietician's license is valid. Per the most recent policy update in December 2022, the agency is conducting weekly chemical inventory checks for all chemicals listed and approved for use. Chemicals are stored and locked in the facility's storage closet.		At the time of this onsite program review, the perpetual use of chemicals when used by staff members is not being documented. A draft document to capture the perpetual use of chemicals was presented by the agency prior to the close of day two.
Fire and Safety Health Hazards	**Compliance**	A review of Material Safety Data Sheets (MSDS) was conducted on a sample of seven chemicals stored at the agency. The City of Jacksonville Fire and Rescue Department Inspection was conducted on September 22, 2022. No violations were found and a passing grade was issued. Emergency Disaster Plan was signed by CEO of the agency. Fire safety equipment inspection were performed by Cintas. The Cintas company conducted a fire equipment and extinguisher checks on September 16, 2022. The inspection was conducted on site. The Hood Suppression system was inspected for the kitchen hood by Cintas on September 19, 2022. Life Safety Designs conducted an alarm system inspection September 19, 2022. Sprinkler heads in bathrooms are rusting on both girls and boys shower areas. The shelter alarm system was inspected by Life Safety systems on September 19, 2022. Department of Health Inspection was on conducted March 7, 2022 and Satisfactory with no exceptions was noted. The 2022-2023 Food Menu is posted in the dining hall. The Menus are signed by the dietician.	

Additional Fire and Safety Health Hazards Narrative (if applicable)	A review of fire drill completed in the last six months was conducted. There was documented evidence of the following drills. First Shift: August 18, 2022 at 2:30 and completed within one minute. September 23, 2022 at 7:13am and completed within 20 minutes. October 22, 2022 at 4:45 and completed within 1 minute. December 28, 2022 at 1:30pm and completed within 1 minute. January 15, 2023 at 10:00 and completed within 61 minutes. Second Shift: August 9, 2022 at 6:30PM and completed within 15 minutes. September 28, 2022 at 2:30pm and completed within one minute. November 29, 2022 at 6:26pm and completed within one minute. Third Shift: October 29, 2022 drill is conducted. November 26, 2022 at 12:45pm was completed. December 17, 2022 at 11:54pm and completed within four minutes. The agency reported it officially uses the term alternative drills as opposed to mock drills. The agency provided evidence of conducting drills on the first shift on August 21, 2022 - phone outage at 2pm. An additional drill was conducted on November 20, 2022 at 5:30am - power outage drills. The agency provided evidence of conducting drills on Second Shift on Sept 30, 2022 at 6:41pm - power outage. An additional drill was conducted on November 15, 22 at 6:30pm - hurricane drill. The agency provided evidence of conducting drills on Third Shift on September 28, 2022. An additional drill was conducted on November 4, 2022 at 10:50pm - gas leak.	There was no documented evidence of the First shift drill being completed in November 2022; Second shift drills in October 2022 and January 2023; Third shift drills in August 2022, September 2022, December 2022, January 2023. In addition, on the third shift the October 2022 drill was completed, however the agency did not document time drill was conducted and no lapse evacuation time. The November 26, 2022 drill at 12:45pm was completed and no evacuation time was documented. One of six alternative drills is not completed as required. Additionally, documentation details such as time and shift are missing so the reviewer cannot determine which shift conducted the alternative drill.
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 grievance box is locked and affixed to the wall on each girls and boys day rooms. Blank grievance forms are provided in a document sleeve holder which is directly connected to the metal grievance box for youth to complete and submit as needed.	
There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook. All grievances are resolved within 72 hours and documented by program director.	**Compliance**	The current program logbook was reviewed to determine if the agency is consistently documenting daily checks of the grievance box by management in the logbook. The agency does have evidence of checking the box daily since late October 2022.	

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**	Youth are provided with the opportunity to complete school work and reading materials specific to their age. The clients are provided with information on the daily schedule of activities during orientation and the schedule is posted on the bulletin board in each respective boys and girls day rooms. Additionally, all youth are provided with the opportunity to participate in faith-based activities. Alternative non-punitive structured activities are provided for residents that do not wish to participate in faith-based activities.	
3.06 - Staffing and Youth Supervision			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency policy number is 4.02 and is called Staffing and Youth Supervision. The policy was reviewed and signed by the Chief Executive Officer in October 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**	Staff schedules were reviewed for the past six months (August 2022 to February 2023). Each work shift had enough staff scheduled to ensure ratio.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	It was noted some trainings were completed late, but there were at least two staff who met the minimum training requirements scheduled on each shift.	
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**	All staff were background screened and had received the required training.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule is posted in the staff station.	
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**	Interviews indicated staff are not held over, but rather staff are called in and includes administration. All work shifts were covered and there was evidence to support administration would come in to provide coverage.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	The bed check dates/times selected for review were: February 7, 2023; January 25, 2023; January 23, 2023; and January 20, 2023. The electronic logbook and video were reviewed for four nights, with an hour reviewed each night. Documentation in the electronic logbook did not reflect staff checked on youth every 15 minutes. Some checks documented in the electronic logbook were not supported by video.	Review of the aforementioned randomly selected bed check practice found multiple 15 minute checks documented in the electronic logbook were not supported by video on three different nights. There were nine checks documented in the electronic log that were not supported by video. The director for residential has the dates, times of checks not supported by video, and staff names reported to the CCC. An official incident report was accepted by the DJJ Central Communications Center on day two of the program review. The CEO and COO also viewed video camera footage and confirmed checks were not supported by video camera footage.
4.02 - Suicide Prevention			**Satisfactory**
		YES	
		If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 4.02		The agency policy number is 3.02 and is called Suicide Prevention. The policy was reviewed and signed by the Chief Executive Officer in December 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 randomly selected client files screened positive for suicide risk were assessed to determine their adherence to the requirements of this indicator. Five client files were residential and one client was non-residential client file. Each of the six client files screened were determined to be positive for suicide on one of the suicide risk screening questions during the admission process. The suicide risk form was reviewed, signed and dated by the supervisor as required.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The agency's suicide risk assessment tool was reviewed, and it was reported it had been previously approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Five out of six files are residential client files. All five residential client files contained evidence of documentation of the youth placed on sight and sound observation based on the suicide risk screening question answered by the youth during the initial screening process.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	All five residential client files have the required forms documenting evidence of youth placed on sight and sound observation. Each form captures information observed by staff by work shift. All information reviewed contains evidence of staff members documenting each status including behavior, warning signs, and observer's initials. Each client's observation form recorded the youth's status at the thirty minute requirement.	

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**	All five residential client files contained a completed suicide risk screening and suicide risk assessment. Four of the five client files contain an assessment completed by the CINS/FINS Clinical Director, Licensed Mental Health Counselor (LMHC). The remaining client file was completed by a non-licensed mental health practitioner working under the direct supervision of the LMHC. All five youth were not taken off elevated supervision until each was directed by the LMHC to be stepped down to standard supervision and placed in regular supervision status with the general shelter population.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**Compliance**	One out of six client files were Community Counseling clients. The CINS/FINS Intake and assessment documents were present and properly completed in the client file. The client was properly screened and the client indicated positive for risk question number four. The therapist completed the assessment and consulted with the LMHC regarding the client's suicide risk status via phone. There is evidence of the LMHC reviewing the client file.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**Compliance**	The non-residential client file has evidence of a completed assessment which was reviewed and signed by the LMHC.	

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**	The therapist has documentation of contacting the parent and local mental health resources were provided to the parent for future use if possible. The therapist has documentation of contacting the parent and local mental health resources provided to the parent. There is documented evidence of the therapist administering a Safety Plan with client and family.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	Therapist has documentation of contacting the parent as required in the agency's policy.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**		
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 policy number is 5.04 and is called Medication Management and Distribution. The policy was reviewed and signed by the Chief Executive Officer in December 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.	**Compliance**	The program had two part-time Registered Nurses (RN), with one working in the morning and one in the evening. It was reported one of the RNs resigned during the program review.	
Medication Storage			

a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	Medication storage was observed at the morning medication pass on day two of the program review. All medications were stored in accordance with all requirements. All storage equipment was in place and operational as required.	
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**	A medication pass was observed. Youth were given medication by the nurse. Youth were in the clinic one at a time to receive their medication. The medication was obtained by entering the youth's name in Pyxis, which made only the youth medication available. The nurse and youth initialed the medication distribution log to document the medication being given. There is a list of non-licensed staff who are authorized and trained to give medication to youth when a nurse is not on site.	
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**	Perpetual inventories are maintained for all medications. Sharps are secured and inventoried. Three controlled medication inventories were reviewed. Perpetual inventories were documented for each controlled medication and the inventories were accurate. Shift-to-shift inventories were documented for controlled medications with the exception of two work shifts on February 4 and one work shift on February 7.	Shift-to-shift inventories for controlled medications were not documented for the first and second work shifts on February 4, 2023 or for the second shift on February 7, 2023.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Pyxis reports are generated and reviewed monthly.	
Medication discrepancies are cleared after each shift.	**Compliance**	Medication discrepancies are required to be cleared at the end of each work shift. There were no uncleared discrepancies reflected in the system during the program review.	