Florida Network for Youth and Family Services
Compliance Monitoring Report

for

Youth and Family Alternatives, Inc.
George W. Harris Shelter
1060 US Hwy 17 South
Bartow, FL 33830

Date: February 1-2, 2023

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Youth and Family Alternatives, Inc. (YFA) George W. Harris for the FY 2022-2023 at its program office located at 1060 US Hwy 17 South, Bartow, Florida 33830. Forefront LLC (Forefront) is an independent compliance monitoring firm contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. YFA George W. Harris is contracted with FNYFS to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 1, 2022 through June 30, 2023.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewer, Gustavo Mazzora, DJJ Regional Monitor. Agency representatives from YFA George W. Harris present for the entrance interview were Roderick Jefferson, Program Director; Jovia Dukes, Residential Supervisor; Kelley Scott, Community Counseling Program Director (by phone); and Michelle Almand, Senior Office Specialist. The last QI program review was conducted April 18-19, 2022.

The Reviewer found YFA George W. Harris is in compliance with specific contract requirements. **YFA George W. Harris received an overall compliance rating of 100% for achieving full compliance** with all four applicable indicators of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit.

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 02-01-2022-2023

Agency Name: YFA George W. Harris	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1060 US Hwy 17 South, Bartow, FL 33830**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): February 1-2, 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**	☐	☐	☐	☒	☐	Documentation on file: General Liability through Alliance of Nonprofits for Insurance, for limits of coverage $1,000,000 each $3,000,000 aggregate, and $20,000 medical expenses, effective 7/01/22-7/01/23. Automobile insurance through Alliance of Nonprofits for Insurance for combined limits of liability/property damage for $1,000,000. Policy effective for 7/01/22-7/01/23. Abuse/Molestation coverage through Alliance of Nonprofits for Insurance for limits of coverage of $1,000,000 each $2,000,000 aggregate effective 7/01/22-7/01/23. Professional Liability through Alliance of Nonprofits for insurance for limits of coverage of $1,000,000 each	**No recommendation or Corrective Action.**

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	Explain Rating						
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						$3,000,000 aggregate effective 7/01/22-7/01/23. Workers Compensation through American Liberty Insurance Co for limits of coverage of $1,000,000 each accident effective 12/20/22-7/1/23. Umbrella Liability Insurance through Alliance of Nonprofit for insurance for limits of coverage of $3,000,000 each/aggregate effective 7/1/22-7/1/23. Florida Network is listed on the Worker's Compensation certificate 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 under "Financial Management" in the agency's policy and procedure manual. The policies are divided into 43 sections labeled FM400-FM499. The fiscal procedures reviewed appear to be consistent with generally accepted accounting principles (GAAP) and provide for sound internal controls. Procedures	**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		
						are included for general ledger, bank reconciliations, purchasing, invoicing, payroll, petty cash, computer backup, and other relevant financial processes. Policies last revised and approved February 2019 and are updated as needed.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: Reviewed petty cash Policy and Procedures FM482. The Petty Cash fund does not exceed the established minimum total amount of $500 and is used for purchases of $25 or less. Petty cash is stored by the Residential Supervisor in a secure locked location in the building. Petty cash is reconciled on a consistent basis (monthly) by the Supervisor. Disbursements and invoices are approved by the Program Director and Residential Supervisor. Petty cash was reviewed	**No recommendation or Corrective Action.**
e. 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 – Per letter dated1/19/2023 from the agency's controller Nicole Greene, YFA does not utilize FNYFS funds for asset purchases and has not purchased any property with FNYFS funds in fiscal year 2022-2023.	**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)
h. 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 was completed by Reeder & Associates, PA December 7, 2022. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor. A copy of the audit is on file with the FNYFS.	**No recommendation or Corrective Action.**

CONCLUSION

YFA George W. Harris 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. A fifth indicator was not applicable because the provider does not have any current inventory purchased with Florida Network funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing Satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the 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 Youth and Family Alternatives, Inc. - George W. Harris Residential Program

February 1-2, 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
Gustavo Mazzora - Regional Monitor, Department of Juvenile Justice

Methodology

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

Persons Interviewed

	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer	1	# Other (listed by title): Vice President of QI & Sr Admin A
	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
	CCC Reports	X	Grievance Process/Records		# Health Records
X	Logbooks		Key Control Log	6	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	8	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	8	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	6	# 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		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		Meals
	Social Skill Modeling by Staff		Youth Movement and Counts	X	Signage that all youth welcome
	Medication Administration		Staff Interactions with Youth	X	Census Board

Surveys

3	# of Youth	6	# 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

Youth and Family Alternatives (YFA) Inc. operates three crisis shelters in the State of Florida that are contracted with the Florida Network of Youth & Family Services, Inc. The George W. Harris youth shelter is located in Bartow, Florida. The shelter is licensed for 24 beds and offers 24-hour availability, youth supervision, food and clothing, life skills education, crisis counseling, individual and family counseling, recreation and leisure activities, and case management services. The YFA Children in Need of Services/ Families in Need of Services (CINS/FINS) Community Counseling team serves youth and families in the aforementioned counties and coordinates the delivery of community services to families and children in care in these areas. CINS/FINS provides the ability to serve both male and female youth, ages from six to seventeen years old, for community counseling services and ten to seventeen years old for residential services for youth locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The agency also provides specialized services to youth who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, Family/Youth Respite Aftercare Services (FYRAC), Stop Now and Plan (SNAP), and Intensive Case Management (ICM). The youth census during the QI visit was sixteen youth, ten of whom were CINS/FINS residents. YFA is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through October 31, 2024.

The agency provided the following programmatic updates:

Staffing

During the current review period, the executive management structure for YFA Bartow remains intact with no change in key leadership positions for the residential and community counseling program directors and the residential supervisor; however, the former nurse resigned with no notice in September 2022 but the position was recently filled 1/19/2023. The new nurse is a fulltime position with a schedule of Sunday-Wednesday, 6am-4pm. As of the date of the annual review, the program had eleven vacancies for a residential supervisor, eight youth development staff, one cook, and a community counseling staff.

Program Updates

YFA is accredited with the Council on Accreditation effective through October 31, 2024. The program currently serves communities located in Circuit 10, particularly Polk, highlands, Hardee, Citrus, Hernando, Pasco and Sumter counties. During the past year, the agency switched to electronic youth records using the Celerity online platform. Services to residential youth include groups which are provided five times per week via interactions with counselors, staff and volunteer groups. Youth are supported through life skills enhancements with laundry, dishes and daily chores.

Facility

A few facility updates are planned for the near future. These include a barn that will be installed this summer and placed over the basketball court. In addition, a fence will be placed around the facility. The building will also receive new flooring and painting. The council has provided some comfort items such as rugs and wall art to make dorm rooms more homey. A staff-member took the initiative to create a chalk wall in the main hallway and has been updating it periodically to reflect current events at the shelter. The program received a new basketball backboard/hoop which is scheduled to be installed shortly. Some of the old recreational equipment had to be discarded as they no longer met safety requirements; consequently, the agency is working to replace these items.

Funding/Finance

The Leadership Council has become more active in soliciting donations through fundraising events and direct contacts again. They receive funding for a commercial stove which was ordered months ago and recently took delivery.

Governance and Community

1) The program added a new mental health agreement with Peace River counseling services.
2) Recent Board of Directors changes include the promotion of the former Secretary to Board Chair, July 2022.

Major Challenges

The shelter sustained substantial damage from Hurricane Ian in late September, which cost $2000 for cleanup. At least three trees were taken out, as well as piles of debris from the damage. The building did not sustain any damage.

The electronic data system, Celerity, continues to bring challenges. It is not as user friendly as expected and staff are still trying to learn the different nuances to entering data correctly. Administration has determined that a different path may be more viable when the current contract runs out mid-year 2023.

Narrative Summary

The YFA George W. Harris CINS/FINS program is under the leadership of a management team that consists of a Chief Executive Officer, Chief Operations Officer, Vice President of Prevention and Residential Shelter and is staffed by a Program Director, a Residential Supervisor, Office Specialist, Counselor, and fulltime Registered Nurse. The George W. Harris program is currently staffed with five Youth Development Specialist (YDS) Shift Leads, and three full-time YDS. There are eight full time YDS Team Lead, YDS Cook positions, and residential supervisor position vacant at time of the annual review. The program has not reported any critical incidents, administrative review, or current external investigation.

The overall findings for the QI Review for YFA George W. Harris are summarized as follows

Standard 1:
Three indicators were reviewed for this Standard 1: 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 with exceptions. Indicator 1.01 had an exception for five staff, two counseling/case management staff and three SNAP Facilitators, not receiving the suitability pre-screening prior to hire as required by the indicator. Indicator 1.06 was found to have an exception because nine of 38 single transports were conducted and documented in the logbook but were not approved prior to transport or documented on the single transport log. 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 exceptions due to lack of documentation of completion dates for three youth records reviewed, one record was missing a 30-day service plan review, the development of the case plan was beyond the seven days required for one record, two youth case plans were missing signatures of the parent/guardian, and one case plan was missing a supervisor's signature.

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 graffiti observed on bed frames in multiple bedrooms, inaccurate chemical counts, and missing Material Safety Data Sheets for chemicals in use. Indicator 3.06 exceptions were due to three late bed counts.

Standard 4:
There are 2 indicators that were reviewed for Standard 4: Indicators 4.02 Suicide Prevention and 4.03 Medications. Both indicators were Satisfactory with no exceptions.

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

Standard 1:
Indicator 1.04 - Limited
1) Two of the three first year training records reviewed were missing one or more mandatory trainings due within the first 90-days of hire timeframe. Two of the staff did not complete medication distribution training and one staff also did not complete CPR/First aid during the first 90 days.
2) One in-service staff missed the annual Florida Network Suicide Prevention training during the last completed training year 11/2021-11/2022. Another in-service community counseling staff did not complete any of the eight required (annual/biannual) DJJ SkillPro trainings by the end of their training period in September 2022.
3) One community counseling staff training record was missing a training log that shows the list of completed training topics and cumulative hours.
4) Community counseling staff maintain their own individual training records and do not have a designated staff member completing reviews to ensure compliance.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator.		Review Based Upon Document Source *For example: Interview/Surveys, Observation, and/or Type of Documentation*	Notes Explain any items that have any deficiencies, exceptions or are not applicable.
Standard One – Management Accountability			
1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: The agency has the required policy and procedure RGC 1.01 that was approved by the Chief Executive Officer (CEO) on 10/27/2021.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.	**Exception**	The agency uses the Criteria Basic Skills Test (CBST) pre-employment assessment with a passing score of 30. The tool was administered prior to hiring two applicable new youth care staff. One of the two staff did not obtain a passing score but documentation in the file supported three interviews were conducted and valid reason to hire.	Five additional new hires, two of whom are counseling/case management staff and three SNAP Facilitators, did not complete the suitability assessment per the agency's policy, however, this does not meet the requirements that all staff will be prescreened per the FN requirement.
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors	**Compliance**	A total of seven staff were hired since the last onsite Quality Improvement (QI) visit. No interns were utilized by the program during the review period. All seven background screenings were initiated prior to hire dates with eligibility documented on the Clearinghouse results. There were no exemptions required.	
Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.	**No eligible items for review**	None of the new hires were prior employees with the agency.	

Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	The program had one eligible five year re-screening since the last QI visit. The five year re-screening was conducted timely and valid prints are on file with the Clearinghouse.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The program emailed its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit on January 23, 2023 prior to the January 31st 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 seven 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		**NO**	
		Policy and Procedure, RGC 1.04, was not updated after 8/1/22 to reflect required timeframes for specific topics to be completed prior to staff working independently with youth per recent revisions to QI Indicator 1.04.	
		The agency has a policy and procedure RGC 1.04 that was approved by the CEO on 8/1/2022.	
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 three pre-service staff training records were reviewed. All three staff were currently within the first year of hire. One of the three staff was hired after September 1, 2022, the effective date of this requirement. As of the date of the QI visit, the staff completed all new hire 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)*	**Compliance**	A review of three pre-service training records verified each staff completed the United States Department of Justice Civil Rights and Federal Funds training within the required thirty days of hire.	

All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	All three pre-service staff completed an excess of 80 training hours ranging from 97.5 - 131.5 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**	One of the three pre-service training records reviewed has evidence of staff completing all mandatory training due within the first 90 days of employment.	Two of the three first year training records reviewed were missing one or more mandatory trainings due within the first 90-days of hire timeframe. Two of the staff did not complete medication distribution training and one staff also did not complete CPR/First aid during the first 90 days.
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 residential counselor completed the NIRVANA and JJIS training required.	
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).	**Compliance**	One applicable residential counselor completed the required Assessment of Suicide Risk training with supporting documentation confirmed by the licensed clinical supervisor.	
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. Two of the three training records, for residential staff, had an excess of 40 hours of Florida Network, Skill Pro and job related mandatory/refresher training. One community counseling staff training record was missing a training log that shows completed hours.	One in-service staff missed the annual Florida Network Suicide Prevention training during the last completed training year 11/2021-11/2022. Another in-service community counseling staff did not complete any of the eight required (annual/biannual) DJJ SkillPro trainings by the end of their training in September 2022.

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.	**Exception**	The senior office specialist is responsible for managing all residential employees' individual training files and conducts periodic reviews to monitor and maintain the training records.	Community counseling staff maintain their own individual training records and do not have a designated staff member completing reviews to ensure compliance.
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Exception**	Five of the six training records reviewed contained individual training records for each staff including an annual training tracking form indicating the name of the training, date completed, and the number of training hours received. Further review of the files contained sign-in sheets, certificates and agendas of the training received.	One community counseling staff training record was missing a training log that shows a list of completed training topics and cumulative hours.
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 RGC 1.06 that was approved by the CEO on 2/11/2022.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	Per agency's policy RGC 1.06, all staff are approved to transport youth through Human Resources (HR) and insurance agent based on having a valid Florida driver's license and satisfactory driving record. The agency provided a MVR Report dated March 2022 documenting agency-wide YFA approved driver list.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The insurance agent maintains a list of agency staff who meet the above mentioned criteria who are covered under the insurance policy. The list is updated annually at renewal of the insurance policy. The agency's auto insurance policy reviewed 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 transportation policy prohibits transporting a client without maintaining at least one other passenger in the vehicle during the trip and includes exceptions when a third party cannot be present.	

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 two 2022 Chrysler Voyager minivans. Transportation logs were reviewed for the two agency vans for the review period August 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**	During the review period, a total of 38 single transports were identified from the review of transportation logs for the two agency vans. Single transport is documented on the agency's Single Party Transportation Log. Supervisory approval was documented for 29 of the 38 single transports.	Nine single transports were conducted and documented in the logbook and vehicle transportation log but were not approved prior to transport or documented on the Single Party Transportation Log.
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**	A review of the agency's transportation and Single Party Transportation Log for the review period indicated these documents list date, client name, transporter's signature, reason for trip/destination, time of departure from shelter, time of arrival to destination, time of arrival back to shelter and mileage at start and end of stop.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has the required policy and procedure RGC 2.03 that was approved by the CEO on 2/8/2022.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	A total of ten youth records were reviewed (five residential, consisting of three closed and two open records, and five community, consisting of three closed and two open records). All ten records contained a case plan which was developed based on information contained during the intake screening, suicide screening, and NIRVANA.	

Case/Service plan is developed within 7 working days of NIRVANA	**Exception**	Nine of the ten youth case/service plans were developed within seven working days of NIRVANA	One youth case/service plan was developed eighteen working days after NIRVANA, which exceeded the seven working day requirement.
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	**Exception**	All ten youth records contained individualized and prioritized needs and goals identified by the NIRVANA, the service type, frequency, and location, the person responsible, the date the plan was initiated, and the target date for completion. Seven of the ten records contained actual completion dates for the goals. Six of the ten case plans contained the signature of the youth, parent/guardian, counselor, and supervisor. Two youth case plans were not signed by the youth or parent/guardian, but had notes in each plan indicating youth and parent /guardian approved plan by phone).	1) Completion dates for goals were not documented for three youth; one residential youth was discharged within 30 days, and the two other youth had goals with expired target dates and no indication of whether or not those goals were completed. 2) Two youth plans were not signed by parent/guardian and one of these was also not signed by the supervisor.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Exception**	Nine of the ten youth case/service plans were reviewed for progress/revision by a counselor and parent/guardian every thirty days.	One youth case was not reviewed/revised every thirty-days. The first thirty-day review date was due 1/9/23 and had not been reviewed.
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency has the required policy and procedure RGC 2.03 that was approved by the CEO on 2/8/2022.	

Facility Inspection	**Exception**	A full tour of the facility's interior and exterior areas and transportation vehicles was conducted. The facility is clean and the furnishings throughout were found in good condition. The facility did not have any visible signs of insect or rodent infestation in both the interior and exterior areas. The exterior grounds and landscaping were cut and well maintained with 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 not allowed to have valuable items requiring separate lock-up in the shelter. The facility was well-lit throughout the building including the dorm areas. A large dumpster is located on the premises and secured behind a concrete and fenced-in construction. Vehicles parked on the premises were secure and locked when checked during the visit. The program uses two 2022 Chrysler Voyager vans to transport youth. Each van is equipped with a first aid kit, flashlight, fire extinguisher, glass breaker, and seat belt cutter. A camera is also mounted on the dash of each vehicle that is activated when in use. The shelter is equipped with three washers and three dryers. All were observed to be in great condition and were clean and free of lint.	1) Graffiti was observed on the bed frames in bedrooms 4, 5, 6, 7, 9, 10 and 11 2) Some chemicals stored in the chemical closet were not included on the inventory (hand sanitizers, Spectracide wasp spray, and bug spray). No MSDS sheets were on file for these chemicals.
Additional Facility Inspection Narrative (if applicable)	The program has six sets of keys distributed to management (2 keys), nurse, administrative assistant, counselor, and shift lead staff who rotates the keys through each shift for access to all rooms. Egress plans are located in the lobby, common areas, and in each youth's bedroom. The abuse hotline and program rules are posted on a wall in the dayroom and each dorm. A grievance box and the grievance forms are accessible to youth in the dayroom. The SOGIE signage was observed to be posted throughout the facility. The DCF license is posted in the lobby and is effective through 12/18/2023. No contraband was observed. Chemicals are stored in a locked hallway room opposite the dayroom. Inventories are conducted weekly, but not perpetually, and was found to be inaccurate during the review. MSDS were missing for a few chemicals.		Inventories are not conducted perpetually and was found to be inaccurate during the review.

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 Bartow Fire Inspection on 10/10/2022. Fire extinguishers in the facility had valid inspections conducted by Piper Fire, effective through June 2023. Piper Fire also conducted the semi-annual sprinkler and alarm inspection on 2/4/22, and kitchen suppression inspection on 6/10/22. 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 food inspection on 11/18/22 and group care inspection on 11/4/22. All food was found to be properly stored during the tour. Refrigerator temperatures were observed to be 39 and 40 degrees Fahrenheit for two refrigerators, and the temperature for three freezers were between -10 to 5 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 supervisor have possession of the keys to the grievance box. The grievance box was checked during the review and was found to be empty. The two grievances submitted during the annual review were resolved by management within 72 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 agency's program schedule includes a broad range of activities that are provided to residents on a daily basis. The agency's approach to providing structured activities to participants is intended to build responsibility, accountability, reflection, care, trustworthiness, relatability, teaching and responsibility characteristics. The specific activities include wake up, personal hygiene, breakfast, chores, school or related activities, physical exercise and record rush recreation and leisure time, group life skills and/or individual counseling, personal time, homework, reading, youth development meetings, hygiene, quiet time, spirit of time, reading, and bedtime. The agency also provides religious or faith-based activities as an option for residents. The agency provides a minimum of one hour for physical activity to all residents in the program every day during their residential stay. The agency's program daily schedule is posted in the dayroom on a bulletin board of the youth shelter along with other important program-related documents. The agency has a covered recreation area adjacent to the day room for group meetings, free time, reading, or games	
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 RGC 3.06 that was approved by the CEO on 2/8/2022.	
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**	Six randomly selected, two-week time periods of staffing schedules for the past six months were reviewed. The following dates were selected: 7/9/22-7/22/22, 8/13/22-8/26/22, 9/10/22-9/23/22. 10/15/22-10/28/22, 11/5/22-11/18/22, 12/10/22-12/23/22, 1/14/23-1/27/23. Although the program's bed capacity is twenty-four, due to staffing challenges they currently cap their daytime census at twelve, in order to maintain the daytime ratio of one staff to six youth. The number twelve mentioned here is a facility daytime cap placed by the program and is different from the census. The program also serves homeless youth who are not counted in the daytime ratio because they are at work during those hours; however, when they return to the facility in the evenings they are included in the ratio during sleep period. The program maintained the required ratio of one staff to six youth during awake hours, and community activities, and one staff to 12 youth during the sleep period for the schedules and time periods reviewed.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Six, two-week time periods of staffing schedules for the past six months (listed above) were reviewed to ensure a minimum of two direct care staff present on each shift met the minimum training requirements. Reviewed schedules show a minimum of two staff are scheduled on each shift. Training was reviewed and verified by the lead reviewer, which confirmed new direct care staff met the minimum training requirements prior to working on 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**	Six, two-week increments of 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.	

The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	A copy of the program staff schedule is posted in the staff copy room. In addition, all staff receive a copy of the weekly schedule electronically.	
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**	The holdover overtime rotation roster is kept on the shift lead's clipboard, and contains a listing of all staff and their home telephone numbers in the event additional coverage is needed.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	Youth are housed in a two-person dormitory, which has a solid wall dividing the male and female youth. Toilets and showers are also in each section of the dormitory. Each side of the dormitory has a total of six rooms, which allows for a total of twenty-four youth (twelve male and twelve female) at full capacity. There is a central station for the assigned youth care worker which allows for supervision of both sides of the dormitory simultaneously. Logbooks were reviewed for the following listed dates and times to confirm staff observed youth at least every fifteen minutes while the youth were in their sleeping rooms: August 7th, 12am-2am; September 14th, 2am-4am; October 21st, 4am-6am; November 17th, 1am-3am; and December 24th, 3am-5am.	A review of housing unit logbooks on the referenced dates and times, revealed the following three late bed checks: 1) On September 14, 2022, a fifteen-minute check was conducted at 2:43am, and the following check was conducted at 3:00am, two-minutes late. 2) On October 21, 2022, a fifteen-minute check was conducted at 4:00am, and the following check was conducted at 4:16am, one-minute late. 3) On October 21, 2022, a fifteen-minute check was conducted at 5:46am, and the following check was conducted at 6:03am, two-minutes late.
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has the required policy and procedure RGC 4.02 that was approved by the CEO on 2/8/2022.	
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 applicable youth records were reviewed (three residential, of which two were closed and one was open, and three community, of which two were closed and one was open. All six youth records contained suicide risk screenings which were completed during the initial intake and screening process. The results were reviewed and signed by the supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services for the fiscal year.	

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 applicable residential youth records were reviewed (two closed and one open). All three contained documentation which verified each youth was placed on the appropriate level of supervision based on the results of the assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	The three applicable residential youth records reviewed contained documentation confirming each youth was constantly monitored and checks were logged every fifteen minutes.	
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**	Reviewed documentation confirm supervision level was not changed/reduced until the program's licensed clinical supervisor completed a further assessment.	
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 applicable community youth records were reviewed (two closed and one open). All three contained documentation which confirmed the youth were immediately assessed by a licensed professional or non-licensed professional under the direct supervision of a licensed mental health professional. In all three instances, the parents and supervisor were both notified of the results.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**Not Applicable**	The intake case management staff who are under the direct supervision of a licensed mental health professional were present to conduct the initial suicide risk screening for each of the three records reviewed.	

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**	In all three community youth records reviewed, documentation confirmed information on community resources for further assessments was provided to each youth's parent/guardian.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Not Applicable**	Parent/guardian for the three community youth records reviewed were present and/or contacted.	
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			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency has the required policy and procedure RGC 4.03 that was approved by the CEO on 2/8/2022.	
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 has a registered nurse (RN) who has an active and clear license, with an expiration date of April 30, 2023.	

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**	The program has a Pyxis ES medication cabinet, which is stored in a locked room, inaccessible to youth, in accordance with guidelines and policy. This room also serves as the area where youth go for medication pass. The room has a half-door, which is opened, keeping the bottom half--locked, which serves as a counter for youth to go for their medication. The room also has a board which contains the names of youth who currently take medication, their medication history, and any allergies. This board is not visible from outside of the room. All oral medications including narcotics, controlled and over the counter medications are stored in the Pyxis cabinet and stored separately from topical medication. Medications requiring refrigeration are stored in a dedicated, locked refrigerator, in the medication room. At the time of the review, the temperature was 44 degrees Fahrenheit, which is within the required temperature range. The program currently does not have any youth taking refrigerated medication. The Pyxis keys were inspected and were all found to be labelled 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**	The program has four site-specific staff who are designated as System Managers for the Pyxis ES machine. In addition, the program has a list of staff who are trained and approved to administer medication. The program keeps a medication distribution log to account for the distribution of medication by staff. When youth arrive with medication, the program staff verifies the medication by reviewing and signing the Prescription Medication Verification Sheet, reviewing the prescription with the parent/guardian and having them sign the verification sheet, and contacting the pharmacy to verify the prescription and number of refills before accepting the medication and giving any medication to youth. This method is one of the three approved methods for medication verification methods listed in the Florida Network of Youth and Family Services (FNYFS) Operations Manual. The program recently hired a full-time nurse who was attending orientation during the annual review, but will be the person to administer medication when on-duty. The method for medication delivery is in accordance with the FNYFS Medication Management and Distribution Policy. The program does not accept youth who are prescribed injectable medication, with the exception of those using an epi-pen. A review of training records confirmed all three new non-licensed shelter staff have received training in the use of epi-pens 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	**Compliance**	At the time of the review, the program did not have any youth taking controlled substances, however, the program maintains a perpetual inventory of all medications, to include over-the-counter medications. The program also conducts a shift-to-shift count for the purposes of accountability. A perpetual inventory of prescription medication is maintained on the Medication Distribution Log, which is maintained for each youth taking prescription medication. Although the program does not have any youth taking injectable medication, the program maintains a sharps container for youth to discard disposable razors.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Monthly reports generated from the Pyxis machine are currently being conducted by the residential supervisor.	
Medication discrepancies are cleared after each shift.	**Compliance**	Any medication discrepancies are cleared by having the person associated with the discrepancy double check the inventory and count, then have a second staff conduct a count to verify the inventory. The discrepancy is cleared on the shift in which it occurs.	
Additional Comments: **There are no additional comments for this indicator.**			