Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth and Family Alternatives, Inc.
Runaway Alternatives Project (RAP House)
7522 Plathe Road
New Port Richey, Florida 34653

Date: April 26-27, 2023

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 and Family Alternatives, Inc. (YFA) Runaway Alternatives Project (RAP House) for the FY 2022-2023 at its program office located at 7522 Plathe Road New Port Richey, Florida 34653. 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 Rap House 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 from July 1, 2022 through June 30, 2023.

The review was conducted by Keith Carr, Consultant for Forefront LLC and Peer Reviewer, Bonita Williams, DJJ Regional Monitor. Agency representatives from YFA Rap House present for the entrance interview were Toby Fritz, Chief Operations Officer, Rebecca Kapusta, Vice President of Operations, Amanda Killian, Vice President of Quality Improvement, Ryan Pettit, Program Director, Kelley Scott, Community Counseling Program Director, Alexander Pruett, and Pearl Tillery, Residential Supervisor. The last QI program review was conducted May 4-5, 2022.

The Reviewer found YFA Rap House is in compliance with specific contract requirements. **YFA Rap House 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 04-26-27-2022-2023

Agency Name: YFA Runaway Alternatives Project (RAP House)	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 7522 Plathe Road New Port Richey, Florida 34653**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 26-27, 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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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						$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 Certificate of Insurance as certificate holder.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained 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	**No Recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						sound internal controls. Procedures 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 $225 and is used for purchases of $25 or less. Petty cash is stored by the Program Director in a secure locked location in the building. Petty cash is reconciled on a consistent basis (monthly) by the Residential Supervisor. Disbursements and invoices are approved by the Program Director and Residential Supervisor. Petty cash reconciliations from October 2022 through March 2023 were submitted for review. All were reconciled for $225 each month.	**No Recommendation or Corrective Action.**

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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) has been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The Program Director reported has not used FNYFS funds for any of any property inventory related items with FNYFS funds in fiscal year 2022-2023.	**No Recommendation or Corrective Action.**
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: The agency Financial Audit was 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 Runaway Alternatives Project (RAP House) 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

Youth and Family Alternatives - New Port Richey
CINS/FINS Program

April 26-27, 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	**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	**Limited**

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 37.5 %
Percent of indicators rated Limited: 62.5 %
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
Bonita Williams – Regional Monitor, Department of Juvenile Justice

Methodology

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

Persons Interviewed

	Chief Executive Officer		Case Manager	X	Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed		Nurse – Part time
X	Chief Operating Officer		Advocate	1	# Case Managers
	Executive Director	X	Direct – Care Full time	2	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager	X	Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer	6	# Other (listed Direct Care Staff
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks	X	Key Control Log	5	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	9	# Personnel /Volunteer Records
	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	6	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	4	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts	5	# Other: ___
	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

	Intake	X	Posting of Abuse Hotline	X	Staff Supervision of Youth
X	Program Activities		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		Youth Movement and Counts	X	Signage that all youth welcome
X	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

4	# 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 (FNYFS). The YFA Runaway Alternatives Project (RAP House) youth shelter is located in New Port Richey, Florida and serves judicial circuit 6, which includes Pasco County. The YFA agency as a whole serves additional Counties including Citrus, Hernando, Sumter, Hardee, Highlands and Polk. The RAP House youth shelter is licensed for 26 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. Educational services are provided by the local school district, in the county in which the shelter is located. The YFA Children in Need of Services/ Families in Need of Services (CINS/FINS) Community Counseling team serves youth and families in the aforementioned services 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 year old for community counseling services and ten to seventeen year 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 Domestic Violence, Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). The youth census during the Quality Improvement (QI) visit was seven CINS/FINS residents. The YFA is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through October 31, 2024. Since the last QI visit, the YFA agency has a new leadership team with a new Chief Operations Officer coming on board within the last 30 days. The Vice President of Prevention reports to the Chief of Operations and a New Senior Director position which will report to the Vice President of Prevention. The agency has each Program Director position at each residential youth shelter reporting to the Senior Residential Director. Each of the three service locations will have a Program Director and all have two Residential Supervisors, and residential and non-residential direct care staff members which report to them accordingly.

The following programmatic updates were provided by the agency:

The YFA RAP House location has been providing services as required in the midst of ongoing staffing challenges. The agency as a whole is reporting it is still experiencing staffing issues in the aforementioned areas. The Rap House Youth Shelter Program Director reported significant turnover rate in the counselor positions. At the time of this onsite program review, the agency reported counselor positions being vacant. The last Residential Counselor in the position resigned in January 2023. In addition, the agency reported many candidates not being able to pass background screening eligibility requirements. At the time of this onsite program review, the Program Director and the Residential Supervisor are assigned a caseload and servicing all residents in the youth shelter. The agency is still consistently working to fill counseling vacancies in residential and counseling staffing.

The agency reported receiving Basic Center grant funding this fiscal year. The agency adopted Solarity, an electronic client file records system that manages all major forms in sections which follows the agency's client file format. The Community Counseling staff members utilize the YFA Plathe Road location to conduct community counseling sessions with clients and parent/guardian meetings, supervision, and to complete various housekeeping items. The agency recently cleared all the exterior shrubs and removed several pine trees to clear the area and make it more connected to its administrative offices which are adjacent to the youth shelter. The agency also had a new covered pavilion area that flanks the building and provides shade from the heat coverage from wet weather.

Narrative Summary

The YFA RAP House CINS/FINS program that serves Citrus, Hernando, Lake, Marion, Sumter Counties is under the leadership of a management team that consists of a Chief Executive Officer, Chief Operations Officer, Vice President of Prevention, Senior Residential Director, Program Director, Office Specialist, and eleven Youth Development Specialists. The RAP House program is also staffed with 5 Youth Development Specialist (YDS) Shift Leads, 5 fulltime YDS and YDS Cook. At the time of this onsite program review, there are several vacant positions which include one full time YDS Team Lead, six Full Time YDS, five Part Time YDS, and a Part Time Registered Nurse. The agency has not reported any critical incidents, administrative review, or current external investigation.

A total of eight indicators were reviewed during the modified QI visit. These indicators include: 1.01 - Background Screening, 1.04 – Training, 1.06 – Transportation, 2.03 – Case/Service Plan, 3.01 – Shelter Environment, 3.06 – Staffing and Youth Supervision, 4.02 – Suicide Prevention, and 4.03 – Medication.

The overall findings for the QI Review for **YFA RAP House** 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 Background Screening was rated Satisfactory with no exceptions. Indicator 1.06 Transportation was rated Satisfactory with exceptions. Indicator 1.04 Training received a Limited rating.

Standard 2: One indicator was reviewed for standard 2, Indicator 2.03 Case/Service Plan. Indicator 2.03 was rated Limited.

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 Limited. Indicator 3.06 was rated Limited.

Standard 4: Two indicators are reviewed for Standard 4: 4.02 Suicide Prevention and 4.03 Medications. 4.02 Suicide Prevention was rated Satisfactory with exceptions. Indicator 4.03 Medications was rated Limited.

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

Standard 1:
Indicator 1.04 – Limited
Three of four New Hire staff members had 22 missing required trainings and one late required training. One of four Annual staff members had training records which did not have evidence of completing the minimum of 40 annual training hours and had five missing required trainings.

Standard 2:
Indicator 2.03 – Limited
One residential file does not have a NIRVANA Assessment. Three client files do not have evidence of Treatment/Service Plan service delivery verification information missing includes: Goals, Target dates, Completion dates, Signatures, Plan reviews). No Supervisor signature on NIRVANA Post Assessment completed in Non-Residential client files.

Standard 3:

Indicator 3.01 – Limited

There is no evidence of several Fire and Mock Drills across multiple work shifts. No evidence of Fire drills conducted in the last six months on First shift: October, November, December, January, February, March; Second shift: October and November 2022; Third Shift: October, December, January, and March. Total completion time of drills are documented for exiting building are not being documented correctly. Agency is utilizing an older form which captures total evacuation time. The agency also uses a newer or updated form that captures the total time it takes to evacuate the building. Fire drills are required to be completed in 2 minutes or less). Mock Drills conducted in the last six months: None found in First Shift: October 2022-March 2023 (2 required) and on Third Shift: One found October 2022 through January 2023. The exterior of the shelter has broken rocks, rusted wheel and tire. This debris was cleared on day one of the review. Grievances are only being checked once per week. Grievance boxes are not being checked by management or designated supervisor daily (excluding weekends and holidays) and there is no documented evidence of this in program logbook as required. Garbage bin does not have a lid and is exposed and potential trash overflow. Shelter environment basic needs cleaning. There is no chemical perpetual inventory in the three locations where chemicals are being stored.

Indicator 3.06 – Limited

A review of suicide observation checks on youth placed sight and sound supervision found on April 9, 2023, documentation observed staff not conducting fifteen-minute checks as required. Client status checks were conducted two and five minutes late. On April 25, 2023, staff conducted a check at 5:35am and the next check did not occur until 5:52am. (CCC 2023-01987 Operator Amari number 148).

Standard 4:

Indicator 4.03 - Limited

The program does not currently have a Registered Nurse (RN) and there is no documentation of monthly reviews of medication management practice generated reports by the Pyxis medication cabinet. Medication counts for controlled substances and narcotics is being conducted twice a day. The program could not confirm controlled counts being conducted daily with a witness. Witness verification for these counts is required at the end of each shift. The program could not confirm discrepancies being cleared by staff on a routine basis following each work shift. Review of agency sharps counts of the last six months indicate some agency sharp counts for the last months are not consistent.

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 program policy and procedure policy number is RGC 1.01, and was reviewed and approved by the President/CEO on November 17, 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.	**Compliance**	The program utilizes a pre-employment tool, called Criteria Basic Skills Test (CBST). This suitability test is used by the agency to provide additional information on new hires prior to hire. Each of the four hires had documented evidence of each employee with a score which indicated passing the CBST with a minimum score of 30 per the agency's 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**	Each of the four new hires was found to have an eligible background screening in the Department's Background Screening Unit (BSU) which was completed prior to each staff person's hire 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.	**Not Applicable**	This measure is not applicable.	

Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	The program had two staff members applicable for five-year screening. Each staff member was found to be in compliance and had a completed and eligible background screening in the Background Screening unit (BSU) prior to their five-year anniversary date.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	An Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department on January 18, 2023, meeting the annual requirement.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	There was evidence of documentation of the completed E-Verify form obtained from the Department of Homeland Security in each of the ten reviewed staff records.	
Additional Comments: **There are no additional comments for this indicator.**			
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency policy number is RGC 1.04 and called Training. The policy was reviewed and signed President/CEO February 11, 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**	Three of the four pre-service staff members completed their trainings as required.	One staff member completed two trainings late.
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**	Each of the four staff completed the United States Department (DOJ) Civil Rights & Federal Funds training completed within 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**	Each direct care staff member completed at least eighty hours of training within the first year of their hire.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	One out of four staff member files reviewed had evidence of training records indicating completing all required first year training hours and no missing or late trainings.	Three out of four staff files showed evidence or late and/or missing trainings. The second new hire staff file reviewed had no evidence of six required trainings. No evidence of six trainings for this staff member include: Provider Orientation, Cardiopulmonary Resuscitation (CPR), First Aid, FNYFS Suicide Awareness, Medication Distribution, and Information Security Awareness. The third new hire staff member had no evidence of eight required trainings as follows: Provider Orientation, Child Abuse Reporting, CPR, First Aid, Confidentiality, FNFYS Suicide Prevention, CINS FINS CORE and Information Security Awareness. The fourth new hire staff member had no evidence of 10 required trainings including: Cultural Humility/Diversity, Understanding Youth Development, CPR, First Aid, Confidentiality, FNFYS Suicide Prevention, CINS FINS CORE, Signs and Symptoms of Mental Health, Medication Distribution and SOGIE. Late trainings for this staff member included: Managing Aggressive Behavior.
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**No eligible items for review**	None of the staff members reviewed were staff members required to receive JJIS training.	

Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	The program did not have any staff applicable for this review item.	
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**	The first staff member reviewed had training records with evidence of completing minimum of 40 annual training hours and no missing trainings. The second staff member reviewed had training records with evidence of completing 40 annual training hours and no missing or late trainings. The third staff member reviewed had training records with evidence of completing 40 annual training hours and no missing or late trainings. The fourth staff member reviewed had training records with evidence of completing 40 annual training hours.	The fourth staff member had 5 missing required trainings. No evidence of training for this staff member include: CPR, First Aid, Sexual Harassment, Information Security Awareness and Trauma Informed Care.

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 agency's Human Resource department maintains the formal training file of all completed trainings for each member. The Human Resources department works with each staff member's supervisor to coordinate training hours required to be completed by each staff member.	The agency's current training process does not include a designated person responsible for managing the training topics and hours required to be completed by each staff member that completes routine reviews for ensuring 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.	**Compliance**	Each staff had an individual training record which included SkillPro and Bridge training documentation. The record includes a training plan which documents date, number of hours, and signature of trainee the training was completed. The reviewer verified all training by reviewing training certificates of completion, attendance sheets and associated agendas. In some cases the agency included training topic transcripts which included the staff person's name(s).	
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 policy number is RGC 1.06 and called Client Transportation. The policy was reviewed and signed by the COO on January 24, 2022.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency requires all direct care staff members to be utilized as drivers and be listed as approved to drive all official transportation vehicles. The agency provided documentation from its automobile insurance carrier indicating all staff members with a valid drivers license are permitted to drive all agency vehicles.	

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	A review of a sample of eight staff member personnel files indicated staff members have valid driver's licenses. The agency submitted documented evidence of automobile insurance coverage which includes provisions stipulating employees with valid drivers licenses are covered under its insurance policy.	
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 protocol for single transportation events states in the event a single client needs to be transported, and no staff or youth are available to be the third person, staff members must obtain authorization from the Shelter Supervisor or a manager prior to transport. Documentation of prior approval must be documented in the shelter log book.	
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**	A review of the agency's policy describes a third party participant as a staff member, intern, volunteer, or youth that has been preapproved. The agency assesses the past history and current behavior of clients in order to approve them as eligible for single client transport events.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency has a policy states 3rd parties are an approved volunteer, intern, 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**	A review of logged transportation events completed in the last six months from October 2022 to April 2023 was conducted. Of these events, there were 12 out of the 14 single youth transport events reviewed which had documented evidence of supervisor approval in the program logbook.	Of the documented transportation events, two out of the 14 single youth transport events reviewed did not have documented evidence of supervisor approval prior to the single transportation event.

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**	All areas of the form are listed for employees to document in the agency's monthly trip and mileage log. A review of logged transportation events completed in the last six months from October 2022 to April 2023 was conducted and verified the driver completing the travel log as required.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Limited**
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 RGC 2.03 and called Service Plan Development and Service Monitoring. The policy was reviewed and signed by the COO on February 3, 2022.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Exception**	A random sample of ten (open and closed) client residential and community counseling records which received services in the last six months starting in October 2022 through April 2023 was conducted to assess the agency adherence to the requirements of this indicator. A total of seven out of ten client files reviewed contained a service plan developed from information gathered at the initial general screening, intake, suicide screening and NIRVANA assessment.	A total of three out of ten client files reviewed did not contain evidence of a comprehensive service plan developed from information gathered at the initial screening, intake, suicide screening and with information from the NIRVANA assessment.
Case/Service plan is developed within 7 working days of NIRVANA	**Exception**	Eight out of ten client file case records contained evidence of service plans which were developed within seven days of completion of the NIRVANA assessment.	Two out of eight client file case records (residential files) did not contain evidence of service plans which were 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	**Exception**	At the time of the QI program review, the residential counselor position is vacant. The agency utilizes a service plan form for all client files, which utilizes the observations collected by staff during the screening process. All staff are trained to conduct screenings. Once collected the findings which included presenting problems are used to determine the client's eligibility status. The presenting problems collected by the agency are used to build the number of goals and objectives for each client's service plan. Six of the ten client files contain documentation for each case which includes multiple goals and objectives, service type, frequency, location, the person responsible for completing the goals and objectives, target dates for completion, and actual completion date. Six of the ten client files have evidence of the signature of the youth on the initial plan. Client cases did contain evidence of a signature of the parent/guardian in five cases. Five of the ten client files have evidence of the counselor's signatures. Signatures of supervisors were found in five cases. Six out of ten client files have documented evidence indicating the date the service plan was initiated.	Four of the ten client files did not contain documentation for each case which includes multiple goals and objectives, service type, frequency, location, the person responsible for completing the goals and objectives, target date for completion, and actual completion dates. Four of the ten client files do not have evidence of the signature of the youth. Five Client cases did not contain evidence of a signature of the parent/guardian when plan is initiated. Five of the ten client files do not have evidence of the counselor's signature on service plan reviews. Four out of ten client files have documented evidence indicating the date the service plan was initiated.
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**	Client file records were assessed to determine if the files contain documentation of file review sessions which track goal sand objective progress and completion. The current status of client files captures progress in case notes only. Five community counseling client cases reviewed were applicable for 30, 60 and 90 day case reviews. All cases contained document evidence confirming plan review sessions at the required intervals.	
Additional Comments: **There are no additional comments for this indicator.**			

3.01 - Shelter Environment			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency policy number is RGC 3.01 and called Residential Group Care Environment. The policy was reviewed and signed by the COO on February 3, 2022.	
Facility Inspection	**Exception**	A tour of the youth shelter was conducted by an agency staff member. The facility is a one story landscape dwelling with a stucco fascia and barrel tile roof. The facility has a foyer, multipurpose room, full kitchen with commercial grade appliances and an eat-in dining area with multiple tables and chairs. The facility also includes a large dayroom for numerous functions for daily activities and events. The facility has separate male and female sleeping quarters with two bathrooms on each of the wings of the dorm areas. The facility also includes multiple utility and other purposed rooms for storage, laundry and medication distribution. All furnishings are in good order and no graffiti was found in the interior areas. One agency SUV vehicle was clean. Both transportation vans have van logs, fire extinguishers, seat belt cutters and window punches to break the glass in case of an emergency. The agency utilizes a key control system for all direct staff which requires keys to be passed down from shift to shift. All keys were accounted for during the two-day review.	During day one of the review, potentially hazardous debris which included medium and large sized rocks, a rusted wheel and deflated tire on the grounds were accessible to residents. These items were cleared on day two of the program review. On day one, the trash receptacle bin was found open and did not have visible lids to cover exposed trash. One minivan was not cleaned and requires cleaning inside and out. At the time of this onsite program review, the perpetual use of chemicals, when used by staff members, is not being documented. Prepared food was observed in the refrigerator without date indicating date.

Additional Facility Inspection Narrative (if applicable)	The agency has facility egress plan maps listing all areas of the facility. The facility has a knife-for-life, wire cutters and a metal wand detector. Facility egress plans are located in the entry area, dayroom, kitchen, dorm halls, and program multi-purpose room. The client rules, incident and abuse reporting information, and important contact numbers are posted on the general bulletin board in the dayroom. The daily activity schedule is posted and includes other client-related rules and expectations. At the time of this review, the interior areas were clean as required, including resident bedrooms, bathrooms, dayroom, kitchen, and the eating areas. The reviewer did not observe any leaks, dust, grime, or mildew in each of the bathrooms. At the time of this onsite program review, the shelter kitchen, pantry, oven, refrigerator and sinks are clean. All aforementioned kitchen items are in working order. Current kitchen built-in refrigerator thermometers read 37 and 41 degrees. The kitchen freezer has a temperature of 3 degrees. The dietitian's menu is posted in the kitchen and the dietician's license is valid. The agency is conducting weekly chemical inventory checks for all chemicals listed and approved for use. Chemicals are stored in a locked closet in the facility's chemical closet near the day room. A review of Material Safety Data Sheets (MSDS) was conducted on chemicals stored at the agency. Chemicals observed onsite did contain MSDS sheets.	

Fire and Safety Health Hazards	**Exception**	A facility fire inspection was conducted by the Pasco County Fire Rescue on December 14, 2022. Infractions were cited for electrical box repairs in the kitchen and laundry room. Electrical light for fires was out in boys dorm. Girls side fire exit door alarm is delayed. Closet in laundry room shelving needs to be replaced and needs to be 18" of space between items on shelves and the ceiling. Doors leading to dorms and lobby door should not be locked and or add an unlocking mechanism. Holiday closet needs to be 18" of space between items on shelves and the ceiling. Backflow inspected and revealed a dust accumulation violation. All aforementioned violations were corrected on reinspection. A real alarm was triggered alert and fire came onsite on 12/13/2022. Piper company came onsite following the alarm to reset the alarm. Agency placed on fire watch on 12/13/2022 at 10:30pm and ended 12/14/2022 at 10:30am. Taken off fire watch at 4:30pm on 12/14/2022. Re-inspection was conducted on 2/1/2023. There were minor infractions noted that included an exit near living area shall not require a key or special knowledge to exit. Piper conducted a Panel service for Fire Alarm 12/1/2022. All violations issued by Piper have been corrected.	There is no evidence of several Fire and Mock Drills across all work shifts. There was no evidence of fire drills being conducted in the last six months on the first shift for the following months: October 2022, November 2022, December 2022, January 2023, February 2023, March 2023; second shift: October 2022 and November 2022; third Shift: October, 2022 December 2022, January 2023, and March 2023. The total time drills are being documented for exiting the building is not being documented correctly. The agency is utilizing an older Fire Drill form which captures total evacuation time. The agency also uses a newer or updated form that captures total time it takes to evacuate the building (which indicates they must be completed in 2 minutes or less). No mock drills were found for the first shift for the following months: October 2022-March 2023 and the third shift did not have evidence of one mock drill for the period under review.
Additional Fire and Safety Health Hazards Narrative (if applicable)	The second shift completed two mock drills as required. The third shift completed one mock 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 has grievance forms and boxes which are accessible to all residents. The agency's grievance boxes are located in the day room and in the hall leading to the dorm sleeping rooms. All blank grievance forms are accessible in a slot built into the grievance box. The grievance box is locked and only accessible to the Residential Supervisor and Program Director.	
There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook. All grievances are resolved within 72 hours and documented by program director.	**Exception**	The agency process involves the Residential Supervisor or the Program Director checking the grievance box and resolving the filed grievance form within 24 hours and or less than three days. The agency reported checking the grievance boxes every 2-3 days.	The agency does not have evidence of designated staff members documenting daily checks of the grievance box in the program logbook.
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 has a daily schedule which is posted in the day rooms and is accessible to all residents. All residents are also informed of the daily schedule during their shelter orientation. The reviewer observed youth participating in all activities listed on the program's daily schedule. The residents participated in groups and decision making. The residents were divided into teams to learn to work toward collective decision-making and to foster teamwork. The residents also participated in creative art work. The program followed a structured schedule to transport children to school. The program was also observed providing meals and recreational time on both days. Children also used the basketball court and new covered pavilion area during recreation time. The schedule also provided residents with free time to read and also to make necessary telephone calls. The program does offer youth access to religious and faith-based activities. Youth that wish to not participate are offered other non-faith based options.	
Additional Comments: **There are no additional comments for this indicator.**			

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 has a policy number is 3.06 and the policy is called Staffing and Youth Supervision and policy number is reviewed and approved President/CEO February 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**	During video observation and daily observations it was confirmed staff to youth (1:6 daytime and 1:12 sleeping) ratio was being met.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	The program has three shifts. The program work shifts include First Shift 8am-4pm; Second Shift 4pm-12am; and Third Shift 12am-8am. The program has an additional 'Middle Shift' which is between 2pm-10pm. The scheduled work shifts was reviewed over the past six months. Each work shift had evidence of two direct care staff members consistently supervising the residents.	
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 members who have the responsibility to supervise youth have been background screened. Each staff member had training prior to contact with the youth.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The program has a staff member schedule which is emailed to all employees. The schedule is not posted because it is emailed to all staff members.	
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 program does not have a hold over roster. The programs practice is the staff person who calls out is responsible for finding a replacement and notifying the supervisor. The agency provides all staff with other staff member's contact information.	

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**	Video observations was conducted over five randomly selected overnight shifts. On three of the five dates staff conducted fifteen minute checks as required.	Two dates were observed where staff conducting bed checks were either late or did not complete checks as required. Bed checks were conducted two and five minutes late. One check was documented as completed, but could not be verified as completed. An additional check on one of the remaining two days, the staff was late conducting the checks. On April 9, 2023, it was observed staff not conducting fifteen minute checks as required. On April 25, 2023, staff conducted a check at 5:35a and the next check did not occur until 5:52am. An incident was called in by the Program Director and was accepted by the Central Communications Center for falsification of bed checks during the program review (CCC 2023-01987 Operator Amari 148). The employee resigned on day two of the program review. The camera system does not save the last thirty days; it saved approximately 22 days of footage. In addition, the video is grainy and there is a time lapse between cameras.
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency policy number is RGC 4.02 and called Suicide Prevention. The policy was reviewed and signed by the COO on February 3, 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**	Five randomly selected applicable case records were reviewed to assess the agency's adherence to the requirements of this indicator. All youth were screened for suicide risk during the initial intake process using the CINS/FINS Intake Assessment form. Each of the five client files screened were determined to be positive for suicide on at least 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 program's suicide risk assessment was previously approved by the Florida Network.	

Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	All five applicable files are residential client files. All five files contained evidence of documentation the youth was placed on sight and sound observation based on the suicide risk screening questions 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	**Exception**	All five residential client files have the required forms documenting evidence of each youth being placed on sight and sound observation. Each form captures information observed by staff for the respective 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 or less requirement.	It was observed that there is some inconsistency in completion of the Observation Status forms. Two client files are missing supervisor signatures on Observation Status check forms. The date of one Observation Status form is missing and does not indicate the date the observations were completed.
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. Five of the five client files contain an assessment completed by the residential supervisor under the supervision by the Licensed Mental Health Counselor (LMHC). All five youth were not taken off elevated supervision until each was directed to do so, 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.	**No eligible items for review**	The agency reported no applicable samples for this indicator at the time of this onsite program review.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**	There were no community counseling youth identified with suicide risk for the review period timeframe.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**	There were no community counseling youth identified with suicide risk for the review period timeframe.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	There were no community counseling youth identified with suicide risk for the review period timeframe.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	There were no community counseling youth identified with suicide risk for the review period timeframe.	
Additional Comments: **There are no additional comments for this indicator.**			

4.03 - Medications			Limited
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 RGC 4.03 and called Medication Control and Management. The policy was reviewed and signed by the President/CEO February 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.	**Exception**	The program does not currently have a Registered Nurse (RN) to monitor and oversee medication management. The last RN was on site in October 2022. Daily mediation management practice and training is being entirely conducted by non-licensed staff members.	The program does not currently have a Registered Nurse (RN) to monitor and oversee medication management.
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**	All medications are stored in the Pyxis ES Medication Cabinet which is not accessible to youth. The Pyxis cabinet is located in a locked room only accessible to authorized staff. The program keeps all medications separate (individual case). The program has a refrigerator to store medications located in a locked room. The refrigerator had the correct temperature; however, there were no medications stored in the refrigerator. The program had one controlled substance and it was stored in the Pyxis separate from other medications. The keys to the Pyxis was located next to the cabinet for easy access for staff. The agency houses the emergency access keys to the Pyxis machine in its locked medication room.	

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 had a minimum of two system managers. The program has a list of staff who has permissions to access the secured medications. When non-licensed staff administer medication, they document the distribution in the Medication Distribution Log for the individual youth. The program does not admit youth who are prescribed injectable medications. The agency's policy regarding the verification and distribution process of medications is consistent with the FNYFS Medication Management and Distribution Policy. When a nurse is on staff the Registered Nurse has a multiple duties which include overseeing the agency's medication management process. The program does not accept youth prescribed injectable medications, except epi-pens. The agency utilizes another RN from one ifs other shelter locations to assist in providing live training in the use of Epi-pens.	

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**	The program does not conduct perpetual counts monthly; however, daily counts are conducted twice a day. The counts are documented in both the Pyxis and medication distribution logs. The program did not maintain any syringes or sharps at the time of the review. The agency does not have razors. The agency does have scissors, nail clippers and the traditional kitchen sharps. Sharps are maintained and locked in a locked cage in the dry storage pantry in the kitchen. The medication count documentation is conducted through the Pyxis medication cart and program's medication distribution logs.	Medication counts for controlled substances and narcotics is being conducted twice a day. The program could not confirm controlled counts being conducted daily with a witness. Witness verification for these counts is required at the end of each shift. A review of agency sharp counts of the last six months indicate some agency sharp counts for the last months are not consistent.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Exception**	The program reported they do not have the current ability to review documentation of monthly reviews of the Pyxis reports. At the time of the program review, the program does not have a Registered Nurse at this youth shelter to oversee and monitor medication management practice.	There is no documentation of monthly reviews of the Pyxis to monitor medication management practice.
Medication discrepancies are cleared after each shift.	**Exception**	Observation of three medication distribution sessions confirmed the medication count matched the count documented by the Pyxis; therefore, no discrepancies were reported by the agency. The staff members were able to explain the agency's internal process if there is a discrepancy with the medication count. The agency does not have a RN and the status of monitoring the clearing discrepancies by Supervisors or Managers is completed at the end of each work shift on an inconsistent basis.	The program could not confirm discrepancies being cleared by staff on a routine basis following each work shift.
Additional Comments: **There are no additional comments for this indicator.**			