Florida Network for Youth and Family Services
Compliance Monitoring Report for

Anchorage Children's Home of Bay County

2121 Lisenby Avenue
Panama City, Florida 32405

June 13-14, 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 Anchorage Children's Home of Bay County (Anchorage Children's Home) for the Fiscal Year (FY) 2022-2023 at its program office located at 2121 Lisenby Avenue Panama City, Florida 32405. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to programmatic, service delivery, fiscal and overall contract requirements. Anchorage Children's Home is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 1, 2022 through June 30, 2023.

The review was conducted by Keith Carr Consultant for Forefront LLC, Jessica M. Gibson Operations Regional Monitor North Region Department of Juvenile Justice and Stephanie Solano, Regional Monitor Regional Monitor, Bureau of Monitoring & Quality Improvement. Agency representatives present for the entrance interview were Joel Booth - Executive Director, Rebecca Mos - Program Administrator, Navet Morales – Clinical Director, Krissy Botzong – Quality Improvement Director, and Robert Ashley – Assistant Shelter Ashley. The last QI visit for this agency was conducted on September 22-23, 2021.

In general, the reviewer found that Anchorage Children's Home is in compliance with specific contract requirements. Anchorage Children's Home **received an overall compliance rating of 100% for achieving full compliance** with four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. There were no corrective actions cited as a result of the compliance monitoring visit and no recommendations were made.

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

2022-2023 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 06-13-14-2022-2023

Agency Name: Anchorage Children's Home of Bay County	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2121 Lisenby Avenue, Panama City, FL 32405**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): June 13-14, 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: Commercial General Liability is provided through Florida Insurance Trust for limits of coverage $1,000,000 each occurrence $1,000,000 and General Aggregate $3,000,000, and $20,000 per person for medical expenses. Effective date 6/01/23-6/01/24. Workers Compensation Insurance is provided through Markel-American Insurance Company for limits of coverage $2,000,000 each accident. Effective date 6/01/23-6/01/24. Automobile insurance is provided through Florida Insurance Trust for combined limits of liability/property damage for $1,000,000 each and aggregate. Effective date of 6/01/23-6/01/24.	**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		
						Directors and Officers is provided through Travelers Casualty and Surety Company of America for limits of coverage $2,000,000. Effective dates 12/1/2022-12/1/2023. Umbrella Insurance is provided through Florida Insurance Company for limits of coverage of $1,000,000 for each occurrence and Aggregate of $1,000.000. Effective dates 6/1/2023-6/1/2024. 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 in Section F-Financial Management of the Administrative Standard Operating Manual. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. Procedures are included for general ledger, payroll, petty cash, purchasing process, financial management,	**No Recommendation or Corrective Action.**

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	Explain Rating					Ratings Based Upon:	Notes
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						budget process, capital assets, and other relevant financial processes. Policies were last reviewed 3/5/2021 by the Executive Director.	
b. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: No change in the agency's Petty Cash practice was reported for the agency since the last site program review in September 2021. Reviewed petty cash Policy and Procedure FS0305. The Petty Cash fund does not exceed the established minimum of $200. Petty cash is stored in a secure locked location in the building. Petty cash is reconciled on a consistent basis (monthly) by designated the Assistant Shelter Manager and reviewed by the Supervisor. Agency provided proof of monthly Petty Cash reconciliations from November 2022 through June 2023. Disbursements and invoices are approved by the Financial Director as required.	**No Recommendation or Corrective Action.**
c. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**							
d. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: The agency's financial audit conducted for the year ending June 30, 2022, and 2021 was completed by James Moore, C.P.A. and Consultants and dated March 11, 2023. Per the audit report, a separate Management Letter requiring a Corrective Action Plan is not required and was not issued by the auditor.	**No recommendation or Corrective Action.**

CONCLUSION

Anchorage Children's Home has met the requirements for the CINS/FINS contract as a result of full compliance with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. One of the five indicators was not applicable because the provider does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF RECOMMENDATIONS

Recommendation
None.

If required, the provider must submit a corrective action plan to address corrective actions cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.

Florida Network of Youth and Family Services
Quality Improvement Program Report

Review of Anchorage Children's Home of Bay County
CINS FINS Program

June 13-14, 2023

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	**Satisfactory**

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

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

Rating Definitions

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

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

Reviewers

Members

Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Jessica Gibson, DJJ Operations Regional Monitor, Department of Juvenile Justice
Stephanie Solano, DJJ Operations Coordinator, Regional Monitor, Department of Juvenile Justice

Methodology

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

Persons Interviewed

X	Chief Executive Officer	X	Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
	Chief Operating Officer		Advocate	2	# Case Managers
X	Executive Director	X	Direct – Care Full time		# Program Supervisors
X	Program Director		Direct – Part time	1	# Food Service Personnel
X	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
X	Clinical Director		Volunteer	4	# 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	6	# Health Records
X	Logbooks	X	Key Control Log	6	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	16	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
X	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		List of Supplemental Contracts		# 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	X	Tool Inventory and Storage	X	Facility and Grounds
X	Recreation	X	Toxic Item Inventory & Storage	X	First Aid Kit(s)
X	Searches		Discharge	X	Group
X	Security Video Tapes		Treatment Team Meetings	X	Meals
X	Social Skill Modeling by Staff	X	Youth Movement and Counts	X	Signage that all youth welcome
X	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

3	# of Youth	17	# 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

The agency reports the governing board continues to be an engaged body and the current Chairman has shown great initiative by attending some of the Senior Management meetings and assisting with the development of the agency's strategic plan. The board continues to be instrumental in advancing the agency's positive community image and having continued success in its fundraising efforts.

The agency just completed an unprecedented capital fundraising campaign to construct new Transitional Living housing apartments. The new Transitional Housing apartments were developed and located on the agency's existing main campus adjacent to the youth shelter. The agency's fundraising initiative combined support from state and local governments and a tremendous amount of private donations (several very significant amounts). The agency reports the resident youth in the Transitional Living Programs have been in mobile homes since Hurricane Michael and are thrilled and grateful to have them in a brick and mortar structure in which to live. The newly constructed Transitional Living Programs meet current severe storm and hurricane construction codes. The agency has successfully moved youth in the program into the brand new facility which is completely paid for.

The agency reported its had the entire existing youth shelter and administrative building repainted with support from a private donor. Impact resistant windows have been installed in the administration hallway, kitchen area and great room. The Executive Director reports when the agency has a need for a critical repair, the community is very responsive and committed to helping.

The following programmatic updates were provided by the agency:

Anchorage Children's Home (ACH) operates the Hidle House Youth Shelter. The not-for-profit organization provides a broad range of human services across counties in the panhandle of Florida. The shelter and main community counseling offices are located at 2121 Lisenby Avenue in Panama City, Florida. The agency provides both residential and community counseling services to youth and their families in Bay, Gulf, Calhoun, Holmes, Jackson, and Washington counties.

The agency is led by Mr. Joel Booth, Executive Director. The Executive Director oversees a Program Administrator, who oversees all residential services, and a Clinical Supervisor, who oversees the residential counseling and community counseling programs. The agency has a total of 15 (11 full-time and 4 part-time) Youth Care Specialist (YCS), one Program Director, one SNAP Facilitator, one Shelter Manager, one Assistant Shelter Manager, one part-time Registered Nurse, two Residential Case Managers (a third Case Manager position is pending acceptance of position offer), five community counseling counselors, one Human Resource Director, one Administrative Assistant, one Business Office Manager, one Maintenance Coordinator, one Financial Director, one Fundraising Director, and one Quality Improvement Director. At the time of the review there were no vacant positions.

The agency reported it had been fully staffed for approximately three straight months until some recent resignations. This represents a more stable staffing pattern that has begun to set in comparison to a year ago. The agency reported that their Shelter Residential Case Manager position has been vacant for several months. The agency reports that they have recently made a job offer to a candidate that should allow them to fill all three positions.

The agency reports that their Community Counseling component has been consistently staffed for the last several months. The agency reports that SNAP program has seen recent staffing changes with the previous Program Manager moving to another position within the agency. The Case Manager was promoted into the Program Manager position.

The agency operates a Stop Now and Plan (SNAP) program at this site. The SNAP program is staffed with one SNAP Supervisor and three SNAP Facilitators. The agency reports that it has served youth in Domestic Violence and Probation Respite services in the last year. The program has not had Staff Secure, Domestic Minor Sex Trafficking, or Family and Youth Respite Aftercare Services (FYRAC) referrals within the last year. This agency does not provide Intensive Case Management Services.

The youth shelter operates a total of three work shifts and follows a daily schedule that allows time for school, homework, reading, meals, recreation, and sleeping. The schedule is posted in all common areas throughout the shelter. The shelter is licensed by the Department of Children and Families for twenty beds. At the time of the review the shelter had four CINS/FINS youth.

The Clinical Supervisor oversees the five community counseling counselors and two Residential Case Managers. The Clinical Supervisor has a master's degree in Counseling/Psychology and is also a Licensed Mental Health Counselor (LMHC). All the counselors and case managers have a minimum of a bachelor's degree or higher level Master's degree.

Narrative Summary

Anchorage Children's Home (ACH) operates the Hidle House Youth Shelter. The not-for-profit organization provides a broad range of human services across Bay County in Florida. The shelter and main community counseling offices are located at 2121 Lisenby Avenue in Panama City, Florida. The agency is licensed by the Florida Department of Children and Families. The agency has a child caring agency that's licensed for 20 beds and the license is in effect through November 9, 2023. The agency is accredited by the Council on Accreditation. The agency's accreditation status is in effect through July 31, 2023. The program has not reported any major challenges, critical incidents, administrative review, or current external investigation from any of its funding sources or local authorities.

The overall findings for the QI Review for **Anchorage Children's Home** are summarized as follows:

Standard 1: Three indicators were reviewed for standard 1: 1.01 Background Screening of Employees/Volunteers, 1.04 Training Requirements and 1.06 Client Transportation. Indicator 1.01 was rated Satisfactory with exceptions. Indicator 1.04 was rated Satisfactory with exceptions. Indicator 1.06 was rated Satisfactory with exceptions.

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

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

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

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

None cited at the time of review.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator.		Review Based Upon Document Source *For example: Interview/Surveys, Observation, and/or Type of Documentation*	Notes Explain any items that have any deficiencies, exceptions or are not applicable.
Standard One – Management Accountability			
1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: ACH-ADM-HR-009 is policy number and was approved by the CEO 7/11/2022.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.	**Exception**	The Human Resources Director will ensure employees are screened prior to employment according to Florida Statutes Chapters 409, 985, and 435. As well as Florida Administrative Code 65C-46.011. Before interviewing for a job vacancy, all CINS/FINS direct care applicants (staff who will have direct interaction with youth, as defined by the Florida Network) must complete the Berke Employment Suitability Assessment. The decision to hire or not to hire is made based upon the interviewers' assessment of the applicant's answers to inquiries. Hiring managers will provide a written explanation for a decision to hire staff with a non-passing/low-score on the suitability assessment. The program utilizes the Berke Employment Assessment for individuals who have applied for positions at the program. Sixteen staff records were reviewed. Eleven of the sixteen staff received a passing score on the Berke Employment Assessment.	Four of the sixteen staff members completed the Berke Employment Suitability Assessment after their hire date. Five of the sixteen staff received a low score on the Berke Employment Assessment. Per an interview with the interim human resources staff, the program does not have a system in place to provide an written explanation for staff hired with a non-passing/low score.
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors	**Compliance**	The Human Resources Director will ensure employees are screened prior to employment according to Florida Statutes Chapters 409, 985, and 435. As well as Florida Administrative Code 65C-46.011. Sixteen out of sixteen staff records included documentation the required background screenings were completed prior to the hire/start date.	

Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.	**Not Applicable**	No staff members were applicable for review to determine if there was a break in service of less than 90 days.	
Five-year re-screening completed every 5 years from initial date of hire	**Not Applicable**	No staff were eligible for their five-year re-screenings at the time of the review.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The Annual Affidavit of Compliance was reviewed and was notarized on January 18, 2023 and submitted to the Department of Juvenile Justice Background Screening Unit prior to January 31, 2023.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Exception**	Anchorage completes a screening on student interns that meets statutory and contractual requirements. All student interns having direct contact with children are required to meet the background screening requirements of Chapter 409.175 F.S. and F.A.C. 65C-46.011 in the same manner as employees of the facility. The agency follows the steps outlined for the screening of staff in DJJ and DCF funded programs when completing background screening on student interns. Fifteen out of sixteen staff records reviewed included documentation the E-Verify was obtained from the Department of Homeland Security.	Per a discussion with the interim human resources director, the student intern did not have the E-Verify completed at the time of hire. This was completed during the annual review and documentation was provided for review.
Additional Comments: **There are no additional comments for this indicator.**			
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES**	
		If NO, explain here:	
		ACH-ADM-PQI-019 is policy number and was approved by the CEO 7/11/2022. The agency has a Training Plan that describes the orientation process, training and development requirements to be obtained the first full year of employment and annually thereafter.	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	A total of four pre-service staff member training files were reviewed to assess the requirements of this indicator. Three out the four completed all required safety and supervision training as required.	One of the four staff did not complete the required pre-service training requirements for safety and supervision.

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 total of four pre-service staff members were reviewed to assess the agency's adherence related to this indicator.	
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**	A total of four pre-service staff member training files were reviewed to assess the requirements of this indicator. One of the four staff members hired in March 2022 and completed 93 training hours in their first year. The remaining three staff members were hired September 2022 (completed 121 hours since hire date); November 2022 (completed 74.5 hours since hire date) and March 2023 (completed 65 hours since hire date).	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	A total of four in-service staff member files were reviewed to assess the agency's adherence related to this indicator. Three of the four staff member training files contained evidence verifying completion of required training during the first 90 days.	One of the four staff did not complete the required mandatory training within the first 90-days of employment. The staff completed the first part of the Prison Rape Elimination Act (PREA) within the first ninety days, however the second part of PREA was completed five months late. The same staff completed Cardiopulmonary Resuscitation (CPR) and First Aid in SkillPro within the required ninety-days, but did not complete the in-person training within the required timeframe.
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 staff member training file was reviewed and contained evidence of completed the NIRVANA trainings.	
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**	Two staff were applicable for this indicator. There were no issues regarding training hours.	

In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Compliance**	A total of four in-service staff member files were reviewed to assess the agency's adherence related to this indicator of completing a minimum of 40 annual training hours. Staff member one completed 45.5 training hours; Staff member two completed 53 training hours; Staff member three completed 75.5 training hours; Staff member one completed 54.5 training hours. All four staff member files indicated each completed the minimum number of mandatory hours required for Direct Care staff members.	
Required Training Documentation			
The agency has a designated staff member responsible for managing all employee's individual training files and completes routine reviews of staff files to ensure compliance.	**Compliance**	The agency has a designated staff member responsible for managing all matters related to training. Each employee's training year is defined as annually from their anniversary date of hire. The Training and PQI Director identifies staff training needs and requirements and communicates this information to the appropriate supervisor.	
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**	The agency has a designated staff member responsible for managing all matters related to tracking, monitoring and ensuring each employee has an individual staff member training file. Each staff member training file contains evidence to verify completed training course which include a training log and other documentation such as signing sheets and agendas.	
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:	
		ACH-CS-SD-023, ACH-HH-PM-005 is policy number and was approved by the CEO 7/11/2022.	

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	Transportation Policy ACH-CS-SD-023 states only authorized staff that have completed the agency's defensive driving course will transport or operate Anchorage vehicles, as well as operate personal vehicle on ACH business. Staff must have a valid unrestricted driver's license (DL) and will have driving record annually validated. There was a random sample size of 5 staff files reviewed and all had valid DL. The agency maintains a list of staff who have a valid driver's license and have valid motor vehicle check and are approved by Human Resources (HR) to transport youth in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency has an approved list of drivers which are covered under the agency's insurance policy. The agency maintains a valid automobile insurance policy. Policy ACH-CS-SD-023 states the agency carries liability insurance with a minimum liability policy for $100,000 per person and $300,000 per incident.	
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 policy, ACH-HH-PM-005, states to avoid situations that put the youth or staff in danger of real or perceived harm or allegations of inappropriate conduct be either a staff or youth whenever possible a 3rd party present in the vehicle when transporting youth. A third party is an approved volunteer, intern, agency staff, or other youth.	
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**	Policy ACH-HH-PM-005 states that in situations where it is not possible to have a 3rd party present and an individual staff will be transporting a single CINs/FINs youth; approval needs to be obtained from the Program Supervisor prior to the transport and documented in the consent log. The following criteria will be utilized to determine the approval for single transports; the client's evaluations, history, personality, recent behavior, and length of stay in the program indicating no inappropriate behavior is likely to occur. Additionally, transporting employees work performance, history, length of employment are considered so that no inappropriate behavior is likely to occur.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	In the last six months a 3rd party member was an approved volunteer, intern, or agency staff. All current staff have been approved to meet third party members for transport events.	

The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	A total number of 67 single youth transports events were documented as having occurred in the last six months. The rest had an agency staff, approved volunteer, or intern. The majority of these events have demonstrated evidence documented in the logbook which includes supervisor approvals prior to transport.	A total of 10 single youth transport events reviewed in the last six month period did not consistently document the supervisor approval in the logbooks.
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	The last six months were reviewed in the electronic and paper logbook. All contained initials of driver, date, time, mileage, number of passengers', and purpose of travel and location.	
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: ACH-CS-SD-009 is policy number and was approved by the CEO 7/11/2022	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	A total of nine youth records were reviewed for compliance with this indicator. Five residential and four community youth files (including five closed and four open). All nine case plans reviewed were developed using information gathered during the initial screening, intake, suicide screening and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Exception**	A total of six out of nine total client file records reviewed revealed the case plans were developed within seven working days of NIRVANA.	Three out of five residential client files have the NIRVANA assessments that were not completed within the required timeframe.
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	All five completed case/service plans included individualized and prioritized needs and goals identified by the NIRVANA, service type, frequency, and location, person(s) responsible, target dates for completion and actual completion dates, signature of youth, counselor, and supervisor, and the date the plan was initiated.	A total of four client files did not meet all case/service plan requirements. Two residential files do not have goals identified by NIRVANA. One residential file does not have objectives for goals 1 and 2 documented as required. One file does not have target dates documented as required. Two residential files are missing evidence of signatures of parent/caregivers. One residential files is missing evidence of youth, counselor and 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	**Compliance**	Four of the nine client file records were applicable for a case review for progress. Four of the nine youth service plans were reviewed for progress timely, every 30 days. Every youth record contained 30 day case plan review sessions as required.	
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: ACH-HH-PM-010 Staffing Requirements and Scheduling is the title and policy number and was approved by the CEO 7/11/2022. There are additional policies across several categories associated with this Shelter Environment indicator. All were reviewed and approved by the CEO 7/11/2022.	
Facility Inspection	**Exception**	A tour of the youth facility was conducted with the Assistant Shelter Manager during the onsite QI visit. During the tour, the furnishings were observed to be in good condition with no rips or tears. All bedrooms are furnished with two beds, ensuite bathrooms, and personal closet space for each resident. All beds appeared sturdy and functional. During the tour, all beds had a pillow and were covered with bed sheets and comforters. All bathrooms are clean and no leaks detected and no mold or mildew was observed. No insect droppings or infestation was noticeable. All bathroom facilities were clean and functional. Facility has four bedrooms, two for boys and two for girls. Each bedroom has three beds, dressers, nightstands, and a closet. The bathroom is equipped with a walk-in shower, toilet, and sink. Walls appeared clean and void of soil, stains, or graffiti. The exterior areas are well maintained and landscaped. The side and rear are partitioned off by a highly decorated wood security fence. The facility has an expansive amount of green space and backyard with a basketball court, volleyball area, picnic tables, and shed. A large trash receptacle was observed during the visit. The program has a GMC Savana large passenger van and a Kia Carnival Mini Van used to transport youth.	1) During inspection, the fire extinguisher in the Kia mini van was not inspected and tagged. Item was re-tagged on day two of the program review. 2) Sharps count is currently 23 sharps, but documented count is 22 knives. One pair of shears in the sharps box in the kitchen is not in the total count. New count sheet was developed and updated on day two of the program review. 3) Lint filter in one of the commercial dryer was not clean in the laundry room. Lint filter was cleaned in real-time on day one. 4) First aid box kitchen is not on the inspection and refill schedule on a monthly basis. First aid box was added to the review inventory and replenishment list on day two of the program review. 5) Trash dumpster was observed open on day one and was later observed closed on day two of the program review.

Additional Facility Inspection Narrative (if applicable)	The vehicles are equipped with a fire extinguisher, flashlight, compact device with seatbelt cutter, and mobile first aid kit. The program has three full sets of keys, one for the program manager and two sets that rotates through shifts. There is a spare set of keys. Doors are kept locked throughout the residential areas and accessible only with a key. Egress plans are located throughout the building in all main areas of the youth shelter, general hallways, in common areas and in each youth bedroom. Rights and responsibilities and abuse hotline number is posted in the day room in the youth common area. Grievance box and forms are accessible to youth in the day room area. DJJ CCC number is posted in the day room and common areas. SOGIE signage was observed posted throughout the facility. Each youth has access to an individual storage area in their room and the program can store all valuables. No contraband was observed. There is a primary chemical storage area in the chemical metal closet in the laundry room; however, chemicals were also observed in a kitchen cabinet and in a laundry room cabinet. Inventories are maintained for each storage cabinet location with a clip board. The inventory is done weekly. Program has one laundry room equipped with 2 commercial washers and 2 gas powered commercial dryers. All were observed to be in working condition. DCF license and COA accreditation is posted in the lobby. The facility is licensed by DCF for 20 beds effective through November 9, 2023 and COA accreditation is effective through July 31, 2023.		Perpetual chemicals are not being documented by the agency. Current chemical inventory for daily use of chemicals does not account document perpetual in and out use of specific chemicals. The agency produced a draft form for documenting the perpetual use of chemicals on day two of the program review.
Fire and Safety Health Hazards	**Exception**	Fire Drills were conducted for First Shift on December 2022 (no time documented), January 2023 (not time documented), February 2, 2023 at 12:30pm completed 1 minute and a half. March 1, 12:45pm completed 1:30 secs. April 3, 2023 at 12:45pm completed in 1:30 seconds. May 1, 2023 at 8:47pm completed 1:20 seconds. June 5, 2023 at 12:45pm completed in 1:30 seconds. Fire Drills were conducted for Second Shift December 2022 (no time), January 2023 (not time), February 3, 2023 at 1:30pm completed in 1:30 seconds. March 30, 2023 at 1:17pm completed drill 2 minutes. May 30, 2023 at 9:30pm completed drill in 1:10 seconds. Fire Drills were conducted for Third shift January 22, 2023 at 9:20pm completed drill 1:30 seconds. February 26, 2023 at 9:15pm completed 1:30 seconds. April 23, 2023 at 9:05pm completed in one minute. May 19, 2023 at 8:59pm completed in 1 minute. June 11, 2023 at 10:30pm completed in 1:15seconds.	The following months did not include drills as required: April 2023 on Second shift, December 2022 on the Third shift, and March 2023 on the Third shift.

Additional Fire and Safety Health Hazards Narrative (if applicable)	Mock Drills were conducted for First Shift on December 21, 2022 - Youth Unresponsive 3 staff March 21, 2023 - Bomb Threat 3 staff and May 1, 2023 - Active Shooter Drill 3 staff. Mock Drills were conducted for the Second shift on December 30, 2022 - Disruptive Youth 3 staff and February 15, 2023 - Active Shooter Drill 3 staff (youth participated in shooter drills.) and April 20, 2023 - Tornado Warning 3 staff (real warning issued local weather channel). Mock Drills were conducted for Third shift December 29, 2022 - Bomb Threat 3 staff, March 23, 2023 Tornado Drill 3 staff and May 17, 2023 - Active Shooter 3 staff. The annual fire safety equipment inspection was conducted. The Alarm System was conducted by Advanced Fire Protection Service on April 7, 2023. The Overhead Hood System inspection was conducted on January 4, 2023 and violations found - Microswitch not working and Link Line frayed in box and needs replacement. Reinspection on January 20, 2023. Malfunctions were documented as repaired. The Fire extinguishers were inspected in January 2023. The Florida Department of Health Food Safety Inspection was conducted on October 7, 2022. No Violations noted. The Dietician's menu was reviewed and approved on July 21, 2022 and is effective for one year.	

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 the orientation process and is also posted. A grievance box is mounted in the youth day room and grievance forms are accessible below or near the grievance box.	
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 residential manager checks the grievance box daily. No grievances were reported during the past six months.	At the time of the program review, supervisor daily documentation of Grievance Box checks was not found in the 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 program has an activity schedule for weekdays and weekends. Each weekday youth are engaged in activities from 6:00 a.m. to 9:30 p.m. Residents have access to faith-based activities. Volunteers come to the facility to conduct faith-based activities onsite. Residents have other options if they choose not to engage in these activities. The schedule indicates one hour of recreation/physical activity is provided daily and alternative activities are available if youth do not want to participate in a faith-based activity. The schedule includes 45 minutes of time for youth to complete homework at 6:00 pm and 6:45 pm with additional time to read approved books. The daily schedule is posted in the program's day room/living area. The reviewers observed staff engaged with clients returning from school and the general search process. The client search process is hands off and the reviewer did not observe anything inappropriate regarding this process. The recreation time for clients' was observed and clients' did have opportunity to participate in large muscle activities including basketball, volleyball, and access to open green space. The reviewers observed staff members engaging youth in meal time, study time, free time and groups. At the time of this onsite program review, staff member engagement was observed to be appropriate and attentive. No inappropriate, abusive or threatening behavior was observed.	

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: ACH-HH-PM-010 Staffing Requirements and Scheduling is the title and policy number and was approved by the CEO 7/11/2022.	
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	The agency's Youth Specialists provide awake supervision 24 hours per day, 7 days per week. The staff to youth ratio is maintained at a minimum of 1:6 when the residents are awake, and 1:12 during sleeping hours. There will be at least two staff on duty at all times. Hidle House does not house more than 20 residents at any given time. Furthermore, Hidle House, does not house youth under the age of 10 years of age, unless a waiver is acquired. Five dates were reviewed via video for staff ratio: May 6, 2023, May 16, 2023, May 31, 2023, June 5, 2023, and June 9, 2023 with the assistant facility administrator for the shelter. The staff schedule was also checked for the listed dates above. There were no inconsistencies.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	The staff schedule identifies adequate coverage for all shifts while minimizing overtime and the over-utilization of Youth Specialists. In scheduling, equitability and fairness are required. There is a female and male staff member scheduled on-duty when possible. At the time of the program review, it was observed that all shifts provided a minimum of two direct care staff with the required training requirements for the period of review.	
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 employed by the agency have documented proof of background screen results indicating all have received an eligible rating from the DJJ Background Screening Unit. All on the schedule have received the required trainings. Additionally, all staff meetings and clinical staffing are mandatory.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The schedule is maintained in the Youth Specialist offices located adjacent to the Dayroom in the main area of the youth shelter.	

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**	In scheduling, equitability and fairness are required. No staff member can be guaranteed that the shifts and days s/he is scheduled to work will not change. They are considered scheduled work time and, therefore, staff are excused only in the case of illness or with prior approval from the Shelter Manager. There is a holdover or overtime rotation when 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**	Five dates were reviewed via video for bed checks: May 6, 2023, May 16, 2023, May 31, 2023, June 5, 2023, and June 9, 2023 with the assistant facility administrator for the shelter. The program requires staff to conduct bed-checks every ten minutes.	There was one bed check completed three minutes late, however, it was still within the fifteen-minute requirement for Florida Network.
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: ACH-HH-SS-006 Suicide Prevention and Intervention is the title and policy number and was approved by the CEO 7/11/2022.	
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	A total of six youth client file records were reviewed which included five residential files and one community counseling file (5 closed and 1 open). All six records show the youth had a suicide risk screening completed upon intake. All were signed by the supervisor and documented in the youth record.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The agency has not changed its practice which includes the use of its existing suicide risk evaluation and tools. The agency continues to use the suicide risk assessment that was approved by the Florida Network of Youth and Family Services.	

Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Each of the five residential youth were placed on sight and sound and monitored by staff every fifteen minutes based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	Monitoring was documented on a Sight and Sound Observation Log. Observation logs for all five residential client files included documentation by a staff person assigned to monitor youth's behavior at a minimum 15-minute intervals until the youth were removed from sight-and-sound supervision.	
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	**Exception**	All five residential youth had a suicide assessment completed by a licensed professional or supervised unlicensed mental health professional the day of admission to the shelter and were promptly stepped down from sight and sound supervision by the licensed mental health professional following the consultation with the licensed professional and review of the suicide assessment.	One of the five resident clients being stepped down from Constant Sight and Sound Status did not have evidence of an entry made in the program logbook that documented the client being taken off of this status and placed into the general population status.
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**Compliance**	One community counseling client record was reviewed for youth identified as having suicidal behaviors by the staff at intake. An assessment of suicide risk was completed by a licensed professional or non-licensed professional under direct supervision of a licensed professional.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**Compliance**	The licensed mental health professional was contacted and approved the community referral. Notification of the suicide risk findings and referral was made to the parent/guardian. Parent was onsite during the screening process.	

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**	One youth was not referred for services in the community. Youth was not sent to Emerald Coast, a local mental health facility, due to low risk. Youth had no intentions and no actual plan to self-harm. The agency provided information and resources and referral sources for services, if needed, in the future. Parents informed to use, Mobile Crisis Unit, Law Enforcement for Baker Act and Life Management and Safety Plan if applicable. These actions steps taken with parent are documented in the youth's file and signed by the parent/guardian.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	The parent was onsite during the screening process and was contacted and provided all safety and suicide related precautionary information by the agency immediately.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	None of the reviewed 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: ACH-HH-HC-006 Medication Management 3/6/23 is policy number and was approved by the CEO 7/11/2022.	
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 agency has a Registered Nurse (RN) and her credentials were verified. A copy was obtained.	

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 agency will ensure safe and secure storage access, disposal and distribution of oral medications and pharmaceutical products, this includes over the counter medications. If the nurse is on site, medications are provided by a licensed nurse. Youth specialist are to be trained in medication distribution by licensed register nurse. It was observed that injectable epi-pens are stored in a locked cabinet on the wall separately from oral medication. There was no medication needing refrigeration in the last review period. According to the RN, she had only needed to refrigerate one antibiotic in the nine years she has been employed and it was about seven years ago. All narcotics were observed in the Pyxis ES Station. Two Pyxis keys of each: TOP COVER, BACK PANEL - LEFT TALL CABINET LOCK - LEFT, BACK PANEL - RIGHT TALL CABINET LOCK were all labeled and located in the locked cabinet on the wall. The RN stated she had an emergency pair in her office as well.	

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 agency has a policy that addresses the process for delivery or assisting in the self-administration of medications. The site currently has four Site-specific System Managers. Two youth were observed taking medications and a medication distribution log was maintained during the process. Agency verifies medication using one of the three methods per policies and procedures. The RN administers the medication when on-site. The delivery process of medications is consistent with the Medication Management Policy. The RN confirmed the agency does not accept youth currently prescribed injectable medications, except for epi-pens. The RN provides all the training for the non-licensed staff.	

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**	The agency states a medication log is completed on each youth and on each medication, prescription and over-the-counter, that the youth receives while at Hidle House. Each time medication is self-administered, the Nurse/Youth Specialist and youth sign the medication log indicating that the medication was taken according to the procedure stated in the policy. Two youth were observed taking medications on-site during the review period (note the numbers indicate the remaining count of medication). First youth: Metformin (10), Tapiramate (18), Zonisamide (15), Omeprazole (11), Levetiracetam (47), Latuda (6), over the counter Iron. Second youth: Hydroxyzine (9), Clonidine (40), Controlled medication Adderall (18). The agency does not maintain any syringes or sharps in the youth shelter. Over the counter medications accessed regularly are inventoried weekly by maintaining a perpetual inventory. The reviewer confirmed the agency's practice of shift to shift counts being conducted and documented for controlled substances at the close of each work shift with a staff that is a witness.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The RN confirmed there are monthly reviews of the Pyxis reports to monitor medication management practice. The RN also stated she conducts training twice a month during staff meetings to discuss topics on this subject matter.	
Medication discrepancies are cleared after each shift.	**Compliance**	There were no medication discrepancies needing to be cleared during the on-site review, however, the RN reported medication discrepancies are cleared after each shift. Further, the RN was able to show the process on how to clear discrepancies and confirmed they are completed after each shift.	
Additional Comments: **There are no additional comments for this indicator.**			