FLORIDA NETWORK
of youth and family services

Florida Network for Youth and Family Services
Compliance Monitoring Report for

CDS – Interface Youth Program East
2919 Kennedy Street
Palatka, FL 32177

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 CDS Family and Behavioral Health Services, Inc. – Interface Youth Program East for the FY 2021-2022 at its program office located at 2919 Kennedy St, Palatka, FL 32177. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. CDS Family and Behavioral Health Services 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, 2021 through June 30, 2022.

The onsite compliance monitoring review was conducted by Keith Carr, Lead Reviewer/Consultant for Forefront LLC, and Kamille Payne, Regional Monitor, Florida Department of Juvenile Justice. Agency representatives in attendance at the Entrance Interview from CDS Family and Behavioral Health Services included Cindy Starling, Chief Operations Officer and Alex Culbreth, Regional Coordinator. The last onsite compliance monitoring visit was conducted May 5, 2021.

The performance results for this compliance monitoring review indicates CDS Family and Behavioral Health Services, Inc. – Interface Youth Program East is in compliance with specific contract requirements. CDS Family and Behavioral Health Services, Inc. – Interface Youth Program East **received an overall compliance rating of 100% for achieving full compliance** with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. There were no corrective actions as a result of the monitoring visit and no recommendation was made.

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-20-21-2022

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Youth Program – East	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2919 Kennedy St, Palatka, FL 32177**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 20-21, 2022**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: General Liability through Berkshire Hathaway Specialty Insurance Company for limits of coverage $1,000,000 each occurrence, $1,000,000 personal injury & advertising injury, $3,000,000 general aggregate, and $20,000 medical expense, $1,000,000 employee benefits, effective 01/10/22-01/10/23. Workers Compensation insurance through Bridgefield Casualty Insurance Company for limits of coverage $500,000 each accident; $500,000 disease employee; $500,000 disease each policy limit. The policy is effective 05/01/21-05/01/23. Automobile liability insurance is provided through Berkshire Hathaway Specialty Insurance Company for	**No recommendation or Corrective Action.**

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Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): April 20-21, 2022	
	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		
						combined limits of liability/property damage for $1,000,000 each and aggregate. $1,000,000 PIP Basic. The policy is effective 01/10/22-01/10/23. Umbrella Liability is provided by Berkshire Hathaway Specialty Insurance Company for $1,000,000 for each occurrence and aggregate. The policy is effective 01/10/22-01/10/23. At the time of this compliance monitoring review, the 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 the Financial Services Policy and Procedures Manual. The manual is divided into fourteen topic sections. The procedures reviewed are generally based on GAAP principles. This policy has a series of revision dates from February 2009 through January 2022.	**No recommendation or Corrective Action.**
b. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and	☐	☐	☒	☐	☐	Observation/Documentation: The agency has not incorporated and	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**						change in the method or practice related to petty cash counts and reconciliation since the last site program review in May 5-6, 2021. The reviewer requested copies of all petty cash reconciliations completed in the last 6 months (October 2021-April 2022). The reconciliations include all petty cash expenses for all cash on hand in the shelter. The petty cash fund does not exceed the established minimum of $250. Petty cash is stored in a secure locked location known by the Residential Supervisor and the Regional Coordinator. Petty cash is reconciled on a consistent basis (monthly/quarterly) by designated Residential Supervisor and reviewed by the Regional Coordinator. Disbursements and invoices are approved by the Residential Supervisor and Regional Coordinator.	
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 – At the time of this onsite compliance monitoring site visit, the agency reported they have not purchased any property inventory items with Florida Network funds.	**No recommendation or Corrective Action.**

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Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): April 20-21, 2022	
	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)
equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**							
d. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2021, and 2020 was completed by James Moore, C.P.A. and Consultants and dated December 1, 2021. Per the audit report, a separate Management Letter requiring a Corrective Action Plan is not required and was not issued by the auditor. A copy of the audit was submitted to the FNYFS.	**No recommendation or Corrective Action.**

CONCLUSION

CDS – Interface Youth Program East has met the compliance monitoring requirements for the Modified 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 recommendations are made as a result of the contract monitoring visit. Overall, the provider is performing Satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

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

Florida Network of Youth and Family Services
Quality Improvement Program Report

Review of CDS Family and Behavioral Health Services, Inc. Interface Youth Program East (Palatka)
CINS/FINS Program

DATE: April 20-21, 2022

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 66.67 %
Percent of indicators rated Limited: 33.33 %
Percent of indicators rated Failed: 0 %

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	Satisfactory

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

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory

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

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 87.5 %
Percent of indicators rated Limited: 12.5 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

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

Methodology

This modified review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused in particular 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 January 2022).

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization	X	Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	8	# Health Records
X	Logbooks	X	Key Control Log	4	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	7	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	7	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	4	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	6	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

X	Intake	X	Posting of Abuse Hotline	X	Staff Supervision of Youth
X	Program Activities		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

4	# of Youth	10	# of Direct Staff		# of Other		

Comments

Due to COVID-19, this review was conducted **on-site using the Modified QI Review Plan.**

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 non-residential services.

Strengths and Innovative Approaches

CDS Family and Behavioral Health Services, Inc. (CDS) operates three emergency youth/crisis shelters in the State of Florida that are contracted with the Florida Network of Youth & Family Services, Inc. (FNYFS). Interface Youth Program-East (IYP-East) is located in Palatka, Florida, Interface Youth Program-Central is located in Gainesville, and Interface Youth Program-Northwest is located in Lake City.
The CDS Children In Need of Services and Families In Need of Services (CINS/FINS) as an organization specifically provide CINS/FINS services in Circuit 3 encompasses Columbia, Dixie, Hamilton, Lafayette, Suwannee; Circuit 7: Flagler, Putnam, St. Johns, Volusia: and Circuit 8: Alachua, Baker, Bradford, Gilchrist, Levy, and Union Counties. The IYP-East shelter is a Child Care Agency (CCA) that is licensed for twelve beds and offers 24 hour availability, youth supervision, food, clothing, life skills education, crisis counseling, individual/family counseling, recreation, leisure activities, and case management services. Youth are provided educational services at their home schools and transportation is arranged and provided by CDS. CDS provides Community Counseling or non-residential counseling services in the aforementioned service regions. The services provided under the CINS/FINS contract with the FNYFS allow the agency to serve all eligible youth ten to seventeen years old who are runaway, ungovernable or truant, locked out, homeless, abused, neglected, and/or possess other at-risk factors. The agency also provides specialized services to eligible youth with other profiles such as Staff Secure shelter, Domestic Minor Sex Trafficking, Domestic Violence, Probation Respite, and Family/Youth Respite Aftercare Services (FYRAC). The youth census during the onsite Quality Improvement (QI) program review visit was four CINS/FINS youth. The CDS organization is currently accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

Since the last QI visit, the program has a new leadership team. The agency is in the process of being led by Tracy Ousley, Interim CEO of the organization. Mrs. Ousley oversees all of the agency's Residential and Non-residential services and programming. The agency has recently hired Philip Kabler as its new CEO who will assume his role full-time Spring or Early Summer 2022. The agency's CDS-Interface Youth Program – East location located in Palatka, Florida is led by a Regional Director. The CDS IYP-East residential team consists of one residential supervisor, one administrative assistant, one house manager, one non-residential counselor, one non-residential counselor(vacant), one life skills educator, four full-time youth care workers, and one PRN staff, one .80 time and one .63 time staff member and four .40 time staff members, one outreach/Safe Place specialist, and one .25 time registered nurse, and a .25 vacant registered nurse position.

The past year and a half have been challenging for the East location, and the CDS organization as a whole, as the agency has had to deal with instability in staffing and constant hiring of staff to fill vacant positions. The agency's Interim CEO advised the agency has been assertively advertising, promoting, and recruiting to fill all open job vacancies.

The agency also utilizes the services of volunteers background screened by the Department of Juvenile Justice (DJJ). These volunteers participate in the program by providing services and support to agency operations.

The CDS-IYP East agency Director reported the agency has faced many obstacles, most of which have resulted from the ongoing pandemic and shortage of available workers. The agency had a major setback with three key staff members being in the hospital with COVID-19, one of which was the Residential Supervisor, who was also providing the counseling sessions since the shelter did not currently have the position of Residential Counselor filled. The Residential Supervisor was continuing to provide this coverage until a new Residential Counselor was hired. The agency continued to operate in this manner for over 6 months with no formal Residential Counselor which created added stress on the current staff to provide these services until a qualified Residential Counselor was hired. The agency recently hired a Life Skills Educator after the position was covered by existing staff on duty. This was necessary to ensure these Life Skills classes were still being provided. During this time, the agency also was without a Registered Nurse (RN) for approximately seven months. The agency had an RN who was in the hospital twice with Covid and resigned in September 2021. Two months after this, a newly hired RN resigned that had only been with the agency for two months. An existing Senior Youth Care worker was off-duty in September 2021 for three months for several medical reasons. These staffing disruptions resulted in the agency experiencing challenges in several program areas, especially medication distribution. The agency received the new Pyxis medication cabinet upgrade and rollout while these key staff members were out for medical reasons.

The CDS-East shelter was closed from August 19, 2021, through August 27, 2021, due to a COVID-19 exposure. The remainder of the employees not hospitalized were being tested. After staff were cleared, due to the overwhelming staff shortage, the agency transported clients on weekends to the CDS-IYP Central shelter in Gainesville from September 3, 2021, through November 7, 2021, to ensure the continuation of services. During this time, they experienced unprecedented challenges in recruiting, hiring and maintaining youth care workers. In particular, the agency reported that youth care workers needed for weekend shifts have been extremely difficult to hire. The agency reported that they had received the resignation of a full-time youth care worker which put an added burden on the staff. In order to recruit more youth care workers, the agency has put into place many added benefits for not only referrals/new hires, but for current staff who refer potential new hires. Some of these benefits include hiring bonuses and referral bonuses for current staff who refer new candidates that get hired. Additional benefits include bonuses and raises to foster the retention of current employees. The agency has added additional platforms to recruit staff by having Safe Place/Outreach Specialist and the Senior Youth Care workers visit local businesses to recruit staff. Further, the agency is working on partnering with the local college to recruit new staff members. The agency has had to utilize core supervisory staff to fill in to cover supervision of youth in order to maintain coverage in the shelter. The Regional Director, Residential Supervisor, and Senior Youth Care worker have all covered work shifts to maintain coverage and the ability to remain open. The agency has previously had many community partners come to the shelter to provide group sessions before COVID, but since this time, have not had any community partners assisting with this service. The agency has had a registered dietician, counselors from the health department, counselors from the Lee Conlee House, the local domestic violence shelter, the Hanley Foundation, local law enforcement, who also brought their therapy dog for the youth, and several others offered their services prior to the pandemic. The agency has experienced a high amount of transition and bringing on new hires. The agency foresees that they will continue to experience this ongoing uncertainty in being fully staffed for the next several months. The agency reported that the Residential Supervisor was promoted to the position of Regional Director when the former Regional Director was promoted to Chief Operations Officer. This left a vacancy in the Residential Supervisor position, which was filled in March 2022. The Residential Counselor has taken on a high number of client cases that is difficult to manage effectively with one staff person. The agency reported that their ability to bring on new hires, train them properly and provide services has directly impacted their ability to provide training on a consistent basis.

It is the agency's goal to be fully staffed as soon as reasonably possible in order to maintain its ability to provide CINS/FINS services to eligible participants and their families.

Narrative Summary

The overall findings for this Modified QI Review for CDS Family and Behavioral Health Services, Inc.– Interface East are summarized as follows:

Standard 1: This standard has a total of three indicators regarding Management Accountability. Two of the three indicators were rated Satisfactory. Indicator 1.04 Training Requirements was rated Limited. The indicator received these rating for this Limited rating are listed below. Apart from indicator 1.04, all other indicators in this standard were rated Satisfactory with no exceptions.

Standard 2: This standard has a total of one indicator that addresses the agency's adherence to intervention and case management. The indicator 2.03 Case/Service Planning was rated Satisfactory with exceptions.

Standard 3: This standard has a total of two indicators regarding shelter care. Both indicators were rated Satisfactory. Indicator 3.01 Shelter Care was rated Satisfactory with exceptions. Indicator 3.06 Staffing and Supervision was rated a Satisfactory with no exceptions.

Standard 4: This standard has a total of two indicators regarding mental health / health services. Both indicators were rated Satisfactory. Indicator 4.02 Suicide Prevention was rated Satisfactory with no exceptions noted. Indicator 4.03 Medications was rated Satisfactory with exceptions.

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

Standard 1: Indicator 1.04 Training Requirements was rated a Limited due one pre-service staff not completing the required trainings in the first 90 days and three in-service staff not completing specific annual training requirements.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators: Add an "**X**" in the applicable column *Satisfactory* *Non- Compliant (E.g. Exceptions)* *No Eligible Items for Review* *No Practice* *Not Applicable*	Satisfactory (S)	Non-compliant (E)	No Eligible Items for Review (N)	No Practice (NP)	Not Applicable (N/A)	**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							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						**YES** If NO, explain here: 1.01 Background Screening of Employees/Volunteers (last updated 2/22, last approved 1/19/22 by COO)	
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.	**X**					The program had six newly hired staff during the annual compliance review period, each of which completed an employee suitability assessment with a passing rating.	
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	**X**					Each of the six newly hired staff had a completed and eligible background screening in the agency for the Clearinghouse system prior to hire.	

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.			X			None of the newly hired staff had an indication of a break in service.	
Five-year re-screening completed every 5 years from initial date of hire			X			There were no staff applicable for a five-year background rescreening.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					The program submitted their Annual Affidavit of Compliance with Level 2 Screening Standards within the required timeframe.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Each of the six newly hired staff records contained proof of E-Verify obtained from the Department of Homeland Security.	
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						**YES** If NO, explain here: 1.04 Training Requirements (1/19/22 by COO)	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
First Year Direct Care Staff							
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)*		X				Two of the three reviewed pre-service staff completed Civil Rights and Federal Funds training within the first thirty days of employment.	One staff completed Civil Rights and Federal Funds training fifty-two days late.

All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				One staff completed EEO, PREA, Trauma Informed Care, Fire Safety, Medication Distribution, and SOGIE training after the first ninety days of hire. One staff did not complete Behavior Management, Youth Development, Fire Safety, Medication Distribution, and Cultural Humility training. The staff also completed Mental Health and Substance Abuse, Child Abuse Reporting, Confidentiality, Universal Precautions, SkillPro Suicide Prevention, and SOGIE training after the first ninety days of hire. The remaining staff did not complete Managing Aggression, CINS FINS Core, Youth Development, Child Abuse Reporting, Confidentiality, Information Security, PREA, Sexual Harassment, Trauma Informed Care, SkillPro Suicide Prevention, Fire Safety, Medication Distribution, SOGIE, and Cultural Humility training.	Exception: None of the three reviewed new hire staff completed all required trainings within the required timeframe.
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training	X					The program had one new non-licensed clinical shelter staff during the annual compliance review period and there was documentation the staff completed training in the assessment of suicide risk.	
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).			X			The program had one non-licensed mental health clinical staff who completed training in the Assessment of Suicide Risk; however, the supervised practice of assessments was on-going at the time of the annual compliance review.	
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).*	X					Three in-service training records were reviewed and each staff completed all required in-service training.	
Required Training Documentation							

The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					Three pre-service and three in-service staff records were reviewed and each staff had a training file which included all required training documentation.	.
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: Policy is called Vehicle Use and Safety Inspection. The policy was reviewed and approved on January 19, 2022 by COO.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The agency has procedures that identify qualified drivers and distinguishes them as acceptable and eliminates unacceptable drivers. Each qualified employee's driver's record is reviewed to assess if there any disqualifying infractions. If there are none, then the personnel department determines them to be eligible to be able to drive insured agency vehicles and clients. The agency utilizes a list of all staff and clients who are approved for single driver and passenger transportation events.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					The agency has a procedures in place that requires qualified drivers possess a valid Florida driver's license and adequate automobile insurance. The CDS agency also covers all drivers under its commercial vehicle insurance.	
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	X					The agency has a comprehensive transportation policy that prohibits transport of a client without a minimum of one additional passenger in the vehicle during the transport event. The agency does have an exception procedure in the event that a third party is not available. The third party may be an approved volunteer, intern, agency staff member or other qualified participant.	

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	X					The program had 268 transportation events in the last three months and 126 of those were single transports for at least part of the trip; however, approval was documented for each of the single transport events. The program reported they complete school pick-up and drop-off at multiple schools where a youth may be the only passenger for a period of time; therefore, they get approval for a single transport for any transports where a youth may be alone for any period of time even if the transport appears to have multiple youth. When approving the single transports, the supervisor considers the clients' history, evaluation, and recent behavior.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The program documents each transportation event, including the driver and other staff in the vehicle. All documented parties were agency staff.	
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.	X					The program reported each transportation event is required to be documented and include all required information. The agency's vehicle transportation policy requires the approved driver documents their name, date, time, mileage, passengers and destination. An inspection of the agency driver's log found the log had evidence of information related to all transportation events dating back to October 2021 to present.	
Standard Two – Intervention and Case Management							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** If NO, explain here: Policy is called Case/Service Plan. P-1162 Individual Plan Policy. Reviewed and approved by Tracey Ousley, Interim CEO on 02/2022.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		

Case/Service plan is developed within 7 working days of NIRVANA	X					A review of the agency's current practice related to case and service planning was conducted. The agency reported that the NIRVANA assessment tool was fully implemented across the entire agency on January 1, 2022.	
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		X				A review of the agency's current practice related to case and service planning was conducted. A total of seven client files were reviewed to assess the agency's adherence to this indicator. Of these seven client files, there were 3 that were opened after January 1, 2022. Each of these 3 client files opened after January 1, 2022 contained evidence of a completed NIRVANA assessment (2 residential and 1 non-residential). The remaining 4 client case files (2 residential and 2 non-residential) contained evidence of services plan assigned and initiated on each of these clients. One open and two closed cases were non-residential client files. Two open and two closed cases were residential client files. The seven client files contain evidence of service/treatment plans that goals have that are based on the presenting problems and risks identified during the screening, intake and assessment process. All seven residential and non-residential client files contain evidence of date the service plan was initiated service types, weekly or monthly frequency assignments/tasks and location for service plan efforts to be completed. All four closed cases have evidence of completed target dates. All three open cases have evidence of each client file having target and completion dates that are in progress. All closed cases have evidence of signatures verifying youth and parent confirmation of service plan review sessions. All three closed cases have documented evidence of discharge that reflects the official completion of program.	Exception: There is no documentation of actual completion dates for 2 residential and 1 non-residential client files.

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	X					Six of seven client files reviewed have evidence of signatures of youth, counselor, parent and supervisor documented in residential and non-residential client service plan review sessions.	Exception: There was no evidence of Parent/Caregiver signature in one non-residential client files.
Standard Three – Shelter Care							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** **NO (explain below)** If NO, explain here: Policy is called Shelter Environment. P-1293 Shelter Environment Policy, Tracey Ousley, 03/2021.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection		X				A full tour of the facility was conducted on April 20, 2022, to determine the agency's adherence to the shelter environment requirements. The tour of the facility found the agency had minimal findings and overall the building was found to be neat, sanitary and organized youth shelter. The bathrooms were clean and sanitized. All areas are free from foul odors, leaks, dust, mold and mildew. All equipment including hot water and toilets are operating as required. There was no evidence of graffiti visible during the tour or found while onsite during the 2-day onsite program review.	Exceptions: Lighting fixtures in each of the girls dayroom and boys dayroom was not working at the time of the onsite tour. One light fixture was not operational in the boy's sleeping room. Emergency light in the hallway between the boy's dayroom and sleeping room was not working. On day 2 of the onsite program review, the agency provided evidence that all lights were repaired.

Additional Facility Inspection Narrative (if applicable)	A comprehensive shelter facility tour was conducted onsite on April 20-21, 2022 that included an inspection of all living, sleeping, eating, bathing, common, office and leisure areas. The agencies facility is located in the city of Palatka, Florida. The facility is located near the County Health Department and a residential neighborhood. The facility has several rooms that include administrative offices, kitchen, dining area, dorm style sleeping rooms, and separate multi-purpose girls and boys rooms. The exterior includes a partially fenced in open field with green space for recreation. In addition, the exterior also includes outdoor seating, covered tent, picnic table, ping pong table, volleyball net, and a basketball goal. There are also two outdoor storage sheds on the property. The agency is conducting fire and emergency mock drills as required. The agency had their Pyxis machine upgraded by BD CareFusion staff in 2021. The agency also has COVID-19 Protocols in place since Spring of 2020. The agency has also upgraded their camera system. The camera system is comprised of 16 digital cameras views that exceed the 30-day back up recording requirement. The annual Department of Health County Health Department - Residential Group Care Inspection Report was conducted on 1/25/22. The agency has posted egress plan of the facility in the foyer entry way, both girls and boys dayrooms, the kitchen and in the Youth Care Worker Control room.						
Fire and Safety Health Hazards		**X**				Date of fire inspection(s) A record of fired drill completed by the agency were conducted. The agency provided documentation of drills completed in October 2021: 10/25/21 day, 10/29/21 evening, 10/1/21 overnight; November: 11/1/22 overnight, 11/2/21 evening,11/11/21 day; December: 12/4/21 day, 12/5/21 evening, 12/1/21 overnight ; January 2022: 1/1/22 evening, 1/1/22 overnight and 1/3/22 day shift; February: 2/1/22 day, 2/1/22 overnight, 2/4/22 evening; and March: 3/2/22, 3/6/22 evening, 3/1/22 overnight. The Palatka Fire Department Fire Safety Inspection was completed on 09/29/21. The annual range hood systems report was completed on 11/15/21. At the time of this onsite program review, the refrigerator temperature is 38 degrees. The Freezer temperature is 8 degrees.	Exception: A package of bacon that was thawed from the freezer was observed in the refrigerator with a March 18, 2022 date of expiration. This item was in a zip lock bag, but no date was marked on the packaging to indicated when it was removed from the freezer to allow the inspector to determine amount of time lapsed.
Additional Fire and Safety Health Hazards Narrative (if applicable)	Annual fire alarm inspection was conducted by Security Engineering and Design was tested and completed on 10/19/21. The Palatka Fire Department Fire Safety Inspection was completed on 09/29/21. The annual range hood systems report was completed on 11/15/21. The annual fire extinguisher inspection was conducted by Lightfoot Fire Extinguisher Service on 9/2/21. At the time of this onsite tour of the facility, the chemical items and storage practices were review and found all chemicals stored onsite included the corresponding Material Safety Data Sheets.						
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.	X					The CDS-IYP East program agency has a structured daily activities schedule. The agency schedule posted in each day room. The schedule is also posted in the main hall leading to sleeping areas. The shelter also posts laminated copies of other important program related information. The daily schedule for all CDS residential group car programs list all activities from the time program residents wake up to prepare for school; eating breakfast; transport to school; leisure and recreation; education services including counseling for individuals and group sessions. The schedule also includes social time and life skills training. The schedule also includes time for school work to be completed and homework sessions to help clients with school-related information as needed. The schedule includes a seven day week listing of structure activities. This schedule includes life skills, chores, weekend activities and youth also are offered the opportunity to participate in religious and faith based activities. Youth also have the option to not participate in religious activities on the daily activity schedule if they chose to do so.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: Policy is called Supervision and Staffing Ratio/Scheduling P-1121. Reviewed and approved by Tracy Ousley on 2/2/22.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
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	X					Logbooks were sampled for the last six months and found the program met the one staff to six youth ratio for awake hours and one staff to twelve youth ratio for overnight hours. Video was reviewed for March 26, April 4, April 13, and April 17 and confirmed ratio was maintained as required.	

All shifts must always provide a minimum of two staff present	X					Logbooks were sampled and reviewed for the review period and found at least two staff were on each shift as required. Video was reviewed for March 26, April 4, April 13, and April 17 and found at least two staff were observed on each shift.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	X					Each staff observed on video or documented on shift in the program logbook was approved staff on the agency employee roster and had current and eligible background screenings.	
The staff schedule is provided to staff or posted in a place visible to staff	X					The staff schedule is maintained where staff can easily access.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	X					Overtime is conducted as needed, but there is no holdover schedule for it. Holdovers and covering shifts is worked out between the staff. A staff contact list is available to all staff if needed and any changes are communicated to supervisors.	
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	X					Video was reviewed for March 26, April 4, April 13, and April 17 and found all checks were conducted at least every fifteen minutes while youth were in their sleeping rooms and the times were documented in the program logbook in real time. Boys and girls dormitories are in separate areas with separate bedrooms. The bedroom doors are kept open and staff completing the checks were observed entering the rooms with a flashlight to ensure the safety and security of the youth.	
Standard Four – Mental Health/Health Services							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES** If NO, explain here: Policy is called Suicide Assessment - Residential P-1247 and Non-Residential P-1262. Reviewed and approved by Tracy Ousley, CEO on 08/2011.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Suicide Risk Screening and Approval							
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.	X					Three youth records were reviewed and each youth received a suicide risk screening during their initial intake. Each of the three screenings was completed by a licensed clinical staff who was also the program's supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The program utilizes the standardized Department of Juvenile Justice Assessment of Suicide Risk which was approved by the network.	
Supervision of Youth with Suicide Risk							
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	X					Each of the three reviewed youth was placed on the appropriate level of supervision based on the results of their suicide screening and subsequent assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Each of the three youth were maintained on suicide precautions after the screening until the assessment could be conducted and behavior checks were conducted and documented at least every thirty minutes as required for the during of the precautions. Behavior checks were documented on the standardized Department of Juvenile Justice form and were signed by the program supervisor.	
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	X					Each of the three records documented the youth's supervision was not reduced until the licensed clinical staff member completing the assessment conferred with the regional director.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES** If NO, explain here: Policy is called Medication Provision, Storage, Access, Inventory, and Disposal. P-1120 was reviewed and approved by CEO on 02/2022.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 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 Med 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	X					The agency has a Pyxis Med-Station 4000 Medication Cabinet that is located in a secure room in the youth shelter. The room houses medication, emergency equipment, sharps, and camera system. This room is locked and not accessible to the residents'. All prescription medications, over the counter, injectables, and topicals are stored in the Pyxis medication cart are stored separately. The agency has a mini refrigerator that is specifically designated for medication that requires refrigeration. The refrigerator has a temperature gauge and there are no medications onsite that require refrigeration. The Pyxis keys are accessible to staff in the event they need to access medication if there is a Pyxis malfunction. Pyxis cart keys to access the medication cabinet are not secure. Keys are laying on top of the Pyxis Machine. Agency COO stated the CDS-EAST staff will meet and determine a more secure location for all Pyxis medication cart keys and advise staff accordingly. One medication incident was reported to the CCC in October 21, 2021 parent issue not providing medication. Another medication incident was documented for failing to provide a medication to the child as scheduled on March 19, 2022.	

Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-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 four methods listed in the FNYFS Operations 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	X					The agency has staff members who are trained to use the Pyxis Medication. The agency practice is to have all non-licensed staff trained by a Registered Nurse (RN) to be able to operate the Pyxis Med station. At the time of this program review, the agency has recently hired a RN at the CDS-East shelter and was receiving orientation training and shadowing the RN at CDS-NW. The agency exceeds the minimum of 2 Super Users who are the only licensed and non-licensed staff that can access to the secure medication cabinet. The agency has medication verification steps that are required to be used to verify all medications that adhere to Florida Network operations manual. The agency does not accept eligible youth who require injectable medications to be provided to them during their shelter stay. The only exception to this policy of not accepting youth who require injectable medication are youth who require medication provided by 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		X				The agency maintains a perpetual inventory for all medication. The agency conducts counts on all controlled at shift-change of every work shift. This is done with a witness and the session is documented. The agency also conducts counts on medication when distributed. All medications are also inventoried weekly and when the medication is distributed to the client. The agency Regional Director reported that all sharps are counted once per week. The sharps list contains items tracked on a weekly basis that include kitchen knives, can openers, and other kitchen utensils, medical supply scissors, tweezers, and client scissors. The current sharps count is pre-populated.	Exception: The current method that evidences how sharps are documented reflects that the count is pre-populated and does not account for perpetual (actual date of check-out and check-in use) use of the sharps.
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.		X				The agency recently hired a new RN who was currently receiving orientation training. There is documentation the agency was using the knowledge portal to produce monthly Pyxis Med-Station Reports during the tenure of the last RN.	Exception: No consistent evidence of recent practice of the agency producing monthly reviews of the Med-Station reports generated by the Knowledge Portal.
Medication discrepancies are cleared after each shift.		X				The agency requires medication discrepancies be cleared following each work shift.	Exception: At the time of this review, the agency is not currently reviewing and clearing discrepancies on a consistent basis.