FLORIDA NETWORK
of youth and family services

Florida Network for Youth and Family Services
Compliance Monitoring Report for

FAMILY RESOURCES – ST. PETERSBURG

3821 5th Avenue North
St. Petersburg, FL 33713

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 Family Resources St. Petersburg SafePlace2B for the FY 2021-2022 at its program office located at 3821 5th Avenue North, St. Petersburg, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Family Resources St. Petersburg is contracted with FNYFS to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective for July 1, 2021 through June 30, 2022.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and DJJ Peer Reviewer. Agency representatives from SafePlace2B present for the entrance interview were: Andrew Coble, Chief Operating Officer; Amaoge Acholonu, Director of Client Success, and Joseph Mabry, Residential Supervisor. The last onsite QI visit was conducted March 3, 2021.

The Reviewer found that Family Resources St. Pete is in compliance with specific contract requirements. Family Resources St. Pete **received an overall compliance rating of 100% for achieving full compliance** with 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. There were no corrective actions or recommendations made as a result of the monitoring visit.

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-13-2021-2022

Agency Name: Family Resources – St. Petersburg	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 3821 5th Ave. North, St. Pete, FL 33713**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 13-14, 2022**

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 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 Alliance of Nonprofits for Ins. RRG, for limits of coverage $1,000,000 each $3,000,000 aggregate and medical expenses of $20,000 for any one person, effective 6/1/2021-6/1/2022 Workers Compensation through Benchmark Insurance Company with limits of $2,000,000 each and aggregate, effective 6/1/2021-6/1/2022 Automobile insurance through North American Elite Insurance Company with combined single limits of $1,000,000, effective 6/1/2021-6/1/2022 An umbrella policy through Alliance of Nonprofits for Ins. RRG, with limits of $4,000,000 each/aggregate, effective	

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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		
						6/1/2021-6/1/2022 Directors and Officers Liability insurance through Alliance of Nonprofits for Ins. RRG with limits of $1 million each/ $2 million aggregate, effective 6/1/2021-6/1/2022 Florida Network is listed on the Worker's Compensation certificate as certificate holder.	
Fiscal Practice 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 last reviewed July 2020. 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, budget process, capital assets, and other relevant financial processes.	
Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and	☐	☐	☒	☐	☐	Observation/Documentation: Reviewed petty cash Policy and Procedure included in the Fiscal	

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Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**						Manual. Petty cash is maintained by the Residential Supervisor and is stored in a secured cash box. The fund is $150 but a small amount usually $25 is kept in the shelter for youth care workers (YCWs) to access for emergency items for the youth. Petty cash is reconciled at least monthly by the custodian. All receipts are submitted to finance at the main office for reimbursement as needed. Reimbursement comes in the form of a check made out to the designee who will then cash it and place money in petty cash box.	
Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A No DJJ inventory	
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	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2021 and 2020 was completed by Assurance Dimensions CPA and Associates in a report dated September 30, 2021. A Management Letter was issued solely for the	

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Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**						purpose of information by the auditor as there were no findings cited or question costs. A copy of the audit is on file with the Reviewer.	

CONCLUSION

Family Resources St. Petersburg has met the requirements for the CINS/FINS contract as a result of full compliance with 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, t**he overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations 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.

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 Family Resources - St. Petersburg
CINS/FINS Program

DATE: April 13-14, 2022

Compliance Monitoring Services Provided by

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CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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: 77.78 %
Percent of indicators rated Limited: 11.11 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Marvin Bliss – 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		Counselor Non-Licensed	X	Nurse – Part time
X	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
X	Clinical Director		Volunteer		# Other (listed by title): ___
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
	CCC Reports		Grievance Process/Records		# Health Records
X	Logbooks		Key Control Log	4	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	12	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	5	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	2	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

Surveys

7	# Youth	11	# Direct Care Staff		# 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

Family Resources, Inc. is a non-profit community-based corporation contracted with the Florida Network of Youth and Family Services (Florida Network) to operate Children in Need of Services/Families in Need of Services (CINS/FINS) residential and non-residential services to youth and families. The central office is in Pinellas Park, Florida and shelters are located in Clearwater, St. Petersburg, and Bradenton, Florida. This QI review was conducted for the St. Petersburg SafePlace2B program located at 3821 5th Avenue North St. Petersburg. The shelter is licensed for 12 beds and offers 24-hour availability, youth supervision, food and clothing, life skills education, crisis counseling, individual and family counseling, recreation and leisure activities, and case management services. Educational services are provided by the local school districts in the counties served by the shelter. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old who are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides specialized services to youth who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). The agency is also contracted to provide Intensive Case Management (ICM) services SNAP. During the QI visit the youth census was 7 CINS/FINS youth. Family Resources is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through December 31, 2024.

Since the last QI in March 2021, the agency restructured its leadership team which includes the below changes:

Agency

Andy Coble was previously the Vice President (VP) of Community Services and was promoted to Chief Operations Officer (COO) in July 2021.

Nicole Leslie was previously the VP of Residential Services and shifted to VP of Impact (quality assurance for the agency) in July 2021.

Community Supervisors titles were changed to Directors of Client Success, adding four positions with 3 of the 4 directors overseeing both the counseling programs and the clinical staff/requirements of the shelters on each respective campus as well as a fourth director to oversee all community-based programming (including SNAP).

A new staff member was hired as the Director of Client Success at the South Campus and joined the agency in January 2022.

A staff member was promoted from SNAP supervisor to Director of Client Success for the community-based programs in December 2021.

SafePlace2B/Staffing:

Like so many organizations throughout the state Family Resources also experienced turnover, resulting in the addition of a new shelter Counselor who was hired in January 2022 and many new faces on the YDS team. The program continues to recruit additional staff until all positions are filled.

Community Counseling is currently accommodating telehealth and in-person counseling sessions, based on family requests/needs. The program is continuing to conduct outreach in the community and working with partners to establish and maintain referral relationships.

SNAP program was chosen by the Florida Network to pilot the SNAP for Youth Program for youth ages 12-17 and the team completed required training. The team will be implementing this pilot.

Narrative Summary

Family Resources Inc. is under the leadership of a management team that consists of a Chief Executive Officer, a Chief Operating Officer, a Vice President of Impact, and four Directors of Client Success. The Director of Client Success for the St. Petersburg location is responsible for overseeing both the residential and community counseling programs. SafePlace2B shelter is staffed by a residential supervisor, counseling and case management staff, Youth Development Specialists (YDS), a cook, part time nurse, and administrative assistant.
At the time of the QI visit, the program did not report any specific issues, problems, or current corrective actions with any funding sources. There were 4 vacancies reported for YDS positions.

The overall findings for the QI Review for Family Resources - St. Pete are summarized as follows:

Standard 1:
Three indicators were reviewed for this standard. Two indicators (1.01 and 1.04) were rated Satisfactory but indicator 1.04 was found to have exceptions. Indicator 1.06 received a Limited rating.

Standard 2:
One indicator was reviewed for standard 2. Indicator 2.03 was rated Satisfactory with exceptions.

Standard 3:
Two indicators were reviewed for standard 3, indicators 3.01 and 3.06. Both indicators were rated Satisfactory with exceptions noted.

Standard 4:
There are 2 indicators were reviewed for standard 4, indicators 4.02 and 4.03. Both indicators were rated Satisfactory with no exceptions.

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

Standard 1: Indicator 1.06 – Limited
During the review period, a total of forty-nine (49) single transports required prior approval by a supervisor. Twenty-eight (28) of the forty-nine (49) single transports had the program manager's signature of approvals on the transportation logs but were not documented as being approved prior to the transports. Per manager, verbal consents were provided but not documented. An open line was established for 14 additional single transports; however, 11 of these transports were not documented as being approved by the supervisor. There were also 4 other single transports observed on the transportation logs, but no supervisory approval was documented on the logs or in the logbook.

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: The agency has the required policy and procedure # 1.01 in place that was approved July 2021 by the 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 agency uses the Berke pre-employment assessment for direct-care positions. Candidates must score medium or high in order to be considered for employment. The assessment was implemented prior to January 2020 and was administered to six new staff hired since the last Quality Improvement (QI) review. All six staff received scores of medium or high on the Berke assessment.	
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					The background screenings for all six new staff hired were initiated prior to hire dates with eligibility documented on the Clearinghouse results. No exemptions were applicable. The program also completed background screenings prior to the start dates of two interns who provided service during the review period.	

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 new staff hired were previously employed by the agency.	
Five-year re-screening completed every 5 years from initial date of hire	X					The program had four eligible staff who met the criteria for 5-year re-screening. A review of the agency's clearinghouse staff list shows re-screenings were conducted and the staff have valid retained prints in the clearinghouse.	
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 had a signed and notarized Annual Affidavit of Compliance with Level 2 Screening Standards that was completed, notarized, and sent to the Background Screening Unit on January 11, 2022 prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Proof of E-Verify work authorizations from the Department of Homeland Security were maintained in all six new hire files.	
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: The program has the required policy and procedure in place #1.04, that was approved October 2020 by the 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 three new staff files reviewed have documentation supporting completion of the Civil Rights training during the 30-day required timeframe.	Exception: One staff hired in September 2021 did not complete the Civil Rights training until December 2021.

All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				Staff training was rated based on the 90-day training requirement applicable to all three staff hired prior after January 1, 2021. One of three staff met all 90-day new hire mandatory training requirements. The Program Manager indicated the agency has experienced staffing shortages due to COVID-19 and staff vacancies that impacted staff completing all required trainings as they were required to work overtime covering shifts for a period of time. Documentation was provided by Human Resources to support vacancies of direct care positions ranging from 88-287 days. The agency also provided documentation of recruitment effort including participation in virtual job fairs on 9/16/21 with USF St. Pete and in person job fair 2/28/22 at Daystar Life Center. Vacant positions are also currently linked to 24 free and sponsored websites and employer hiring platforms. Consequently, the findings observed for training are rated as exceptions due to these external control factors.	Exception: One staff had not completed the following required trainings: Youth/Adolescent Development (YD) and Prison Rape Elimination Act with in the two year requirement. The following trainings were completed late after the 90-day requirement: Managing Aggressive Behaviors (MAB), CINS/FINS Core, Signs and Symptoms of Mental Health and Substance Abuse (SSMHSA), Universal Precautions, Child Abuse Reporting, Human Trafficking (HT), Fire Safety (FS), Serving LGBTQ and Cultural Humility (CH). A second staff was also late completing eleven trainings: MAB, Suicide Prevention, SSMHSA, YD, CPR/ First Aid, HT, FS, Medication Distribution, LGBTQ, and CH.
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					One applicable non-licensed clinical shelter staff file was reviewed for assessment of suicide risk training. There was evidence of the staff completing 5 suicide risk assessments with written confirmation of completion by the licensed professional.	

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					Verification of training by the licensed professional included date of confirmation, signature and license number.	
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					The training files of 3 in-service staff were reviewed. One staff exceeded the 40 hour requirement with two months remaining, Two staff had not met the 40 hours requirement. One of the two staff had 39.3 hours of training with no time remaining and one staff had 20.5 hours of training with two months remaining.	Exceptions: Two staff did not meet the required training hours. Two staff had not met the 40 hours requirement. One of the two staff had 39.3 hours of training with no time remaining and one staff had 20.5 hours of training with two months remaining. One staff did not complete annual Suicide Prevention part two is overdue for completing Child Abuse Recognition, Reporting and Prevention. Another staff is also overdue for completing the annual Child Abuse Recognition, Reporting and Prevention 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					The program has training files for each staff that contains training hours tracking forms, certificates, sign-in sheets and other training material.	

Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: The agency has the required policy and procedure #1.08 that was last reviewed September 2021 and approved by the COO.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**X**					The agency maintains a list of approved drivers approved by HR to drive clients in agency approved vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**X**					All drivers named on the approved drivers' list have current driver's licenses and are covered under the agency's insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**X**					The agency's transportation policy outlines the importance of avoiding single youth transports. It also specifies that in the event of a single transport, open lines are initiated and documented in the logbook.	

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				A total of 130 single transports occurred between Oct 2021-April 11, 2022. Of those, eighty-one (81) were conducted by the program manager and forty-nine (49) were conducted by direct care staff, four of which were noted in the logbook as approved by the manager.	Exceptions: During the review period, a total of forty-nine (49) single transports required prior approval by a supervisor. Twenty-eight (28) of the forty-nine (49) single transports had the program manager's signature of approvals on the transportation logs but were not documented as being approved prior to the transports. Per program manager, verbal consents were provided but not documented. An open line was established for 14 other transports; however, 11 of these transports were not documented as being approved by the supervisor. There were also 4 additional single transports observed on the transportation logs, but no supervisory approval was documented on the logs or in the logbook.
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					Transportation logs for the review period showed third party was agency staff or other youth.	
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					Transportation logs reviewed included initials of driver and youth; date and time of transport; mileage; number of passengers; and destination/purpose of trip.	
Standard Two – Intervention and Case Management							
						YES	
						If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 2.03						The agency has the required policy and procedure #2.03 that was last reviewed October 1, 2020 and approved by the COO.	
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					Six youth records were reviewed to include two open and four closed. Case/service plans were observed to be developed on time in all six files reviewed.	
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				All six records were found to have individualized and prioritized needs and goals, service type, frequency, location, target date(s) for completion and person(s) responsible. Four applicable closed records reviewed found three to have completion dates as required; however, one did not. All six records included signatures of the youth, parent/guardian, counselor, and supervisor. All six records included the date the service plans were initiated.	Exception: One of four closed youth records did not have a completion dates, indicating whether or not youth made progress in completing planned goals.
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					Four applicable closed records reviewed demonstrated timely reviews for progress by the counselor during the required timeframes.	
Standard Three – Shelter Care							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: The agency has the required policy and procedure #3.01 that was last reviewed September 2021 and approved by the COO.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		

Facility Inspection		X				A tour of the facility was conducted with the Program Manager during the onsite QI visit. During the tour, the furnishings were observed to be in good condition with no rips or tears. All beds appeared sturdy and functional. No insect droppings or infestation was noticeable. The exterior areas are well maintained and landscaped. The facility has a soft playground in the backyard with a basketball hoop, barbeque grill, picnic tables, and shed. Large trash receptacles were observed to be covered during the visit. All bathroom facilities were clean and functional. Facility has 4 bedrooms, 2 for boys and 2 for girls. Each bedroom has 3 beds and a bathroom equipped with a walk-in shower, toilet, and sink. Bathrooms were clean with no foul smell. Walls appeared clean and void of soil, stains, or graffiti. The facility is well lit throughout. Agency has one vehicle used to transport youth, a 2017 Ford Transit 350. The vehicle is equipped with a fire extinguisher, flashlight, compact device with seatbelt cutter, window breaker/airbag deflator, and mobile first aid kit. The program has 3 full set of keys: 1 for program manager, 1 that rotates through shifts, and 1 spare. Doors are kept locked throughout the residential areas and accessible only with a key.	Exceptions: 1) Graffiti was observed on bed in girl's bedroom # 4 during tour and was removed when informed during the visit. 2) MSDS sheets were not initially found for 2 chemicals: Great Value All Purpose Cleaner and Member's Mark hand soap. Lysol disinfectant was replaced by Great Value All Purpose Cleaner but name was not updated on the inventory and manufacturer/brand of hand soap was not indicated. During the review of the inventory it was observed some of the chemicals were used and/or added with no updated inventory to accurately document the amount on hand.

Additional Facility Inspection Narrative (if applicable)	Egress plans are located in hallways, in common areas and in each youth bedroom. Rights and responsibilities and abuse hotline number is posted on wall in lobby and in youth lounge. Grievance box and forms are accessible to youth at the entrance to youth lounge. DJJ CCC number is posted on staff desk. SOGIE signage was observed posted throughout the facility. Each youth has a dresser for personal clothing and secured storage for valuables. No contraband was observed. There are 2 separate chemical storage areas - pantry closet and cabinet in the laundry room. Inventories are not maintained for each storage location. The inventory is done weekly but not maintained on a perpetual basis to accurately reflect reduction in count due to usage. The program has one laundry room equipped with two washers and two dryers. All were observed to be in great condition and were clean and free of lint. During the tour, all beds had a pillow and was covered with bed sheets and a comforter. DCF license is posted in the lobby. The facility is licensed by DCF for 12 beds effective through December 15, 2022.						
Fire and Safety Health Hazards		**X**				St Petersburg Fire Rescue conducted fire inspection on 10/21/21 that required re-inspection on 11/12/21 due to citations of the portable fire extinguishers and lint found in the clothes dryer. All were cleared during the re-inspection. Fire extinguishers in the facility had valid inspections effective through November 2022. Hood inspection was conducted and valid through 8/17/2022. Piper Fire Protection completed an annual inspection of the alarm and sprinkler system on 10/19/21 and fire extinguisher, hood inspection, and suppression system in November 2021.	
Additional Fire and Safety Health Hazards Narrative (if applicable)	Satisfactory Department of Health (DOH) Group Care inspection was completed 6/14/21. DOH Group Care Assisted Living Facility Certificate expires 9/30/22. Satisfactory DOH Food inspection was completed 10/15/21 - no violations were noted. DOH Food Hygiene Assisted Living Facility Certificate expires 9/30/22. Fire drills were completed on each shift October 2021-January 2022 , on the 1st and 2nd shift in February 2022, and on the 3rd shift in March 2022. During the period October 2021 - February 2022, the 7a-3p shift conducted three emergency drills (October, December & February) and the 11p-7a shift conducted two drills (December and February); however, the 3p-11p shift only conducted one emergency drill in the past six months with the last one completed in October 2021. Two large first aid kits are located in the facility, one adjacent to the youth lounge and another in the dining room. Refrigerator temperature is 38 degrees Fahrenheit. Freezer temperature minus 5 degrees Fahrenheit.						Exception: 3) The 3pm-11pm shift only conducted 1 emergency drill in the past six months with the last one completed in October 2021. Quarterly drills are required on each shift.
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					Youth are engaged in meaningful, structured activities seven days a week during wake hours. Some of the activities include but not limited: educational, recreational, life, counseling, and social skill training. Idle time is minimal. Daily schedules reflect at least one hour of physical activity is provided daily at 6pm. Youth are provided the opportunity weekly to participate in faith-based activities. Non-punitive structured activities such as reading, journaling, tutoring, education, recreational board game and counseling are offered to youth as an alternative to youth who do not choose to participate in faith-based activities. Daily programming includes opportunities for youth to complete homework at 3pm and 7pm. Daily programming schedule is publicly posted on wall at the entrance to shelter.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: The agency has the required policy and procedure #3.06 that was last reviewed September 2021 and approved by the COO.	
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	X					Reviewed staff schedules and youth census for the past 6 months. The program maintained the required ratio of 1 staff to 6 youth during awake hours and community activities and 1 staff to 12 youth during the sleep period.	

• 1 staff to 12 youth during the sleep period							
All shifts must always provide a minimum of two staff present		X				Reviewed staff schedules for October 2021 - April 2022. Agency provided a report of vacancies and recruiting efforts to support staffing challenges and actions taken to fill vacancies. These findings observed are rated only as exceptions due to the aforementioned external control factors.	Exceptions: Several shifts were observed on the schedule during the review period with only one staff working predominantly on the 1st and 2nd shifts and occasionally on weekend days. The program manager frequently assists staff on the 1st shift during his scheduled hours. The number of shifts with single staff coverage ranged from 4 in December 2021 to thirteen in March 2022.
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					Shelter staff included in the staff-to-youth ratio included only background screened and trained youth care workers who had received necessary training to work supervise youth.	
The staff schedule is provided to staff or posted in a place visible to staff	X					The staff schedule is posted at the youth care staff station in the 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	X					Staffing challenges experienced by the program impacted availability and access to additional staff to create a holdover roster; however, program manager, supervisors, team leads, and other trained agency staff are utilized to fill gaps.	
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					Staff observe youth every 15 minutes while in their sleeping room and document in the bed check log. Reviews of bed checks and resident activities was conducted for the following randomly selected dates: October 3, 2021, November 8, 2021, December 15, 2021, Jan 28, 2022, February 5, 2022, and March 8, 2022.	
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: The program has the required policy #4.02 that was last reviewed August 1, 2021 and approved by the COO.	
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					Four youth records were reviewed, one open and three closed residential. All four youth were applicable for having a suicide risk screening completed during intake. All four youth had a screening completed at the time of admission to the shelter. All four screening results were reviewed and signed by the supervisor and documentation of the review was found in all four youth records reviewed.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The program's suicide risk assessment has not been changed since last approved by the Florida Network of Youth and Family Service.	
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					All four youth were placed on sight and sound supervision due to an indication of suicide risk based on screening results. A review was completed by the licensed professional.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Observation logs for all four youth included documentation by staff person assigned to monitor youth's behavior at a minimum 30-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	X					All four youth had a suicide assessment completed by a licensed professional or 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 review of the suicide assessment.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES** If NO, explain here: The program has the required policy #4.02 that was last reviewed August 1, 2021 and approved by the COO.	
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	X					The program employs a part time nurse who works 12 hours/week in the mornings. Oral medications, controlled medications, and narcotics are stored separately from injectables epi-pens and topical medications in the required Pyxis Med-Station medication cabinet. The Pyxis machine is located in a locked room and is not accessible to youth. There is a refrigeration unit stored in the medical clinic for medication requiring refrigeration. When a youth is admitted with prescribed medication, the shelter ensures the medication is in its original prescription bottle with a legible label. The shelter does not accept youth who have to be administered injectable medication. Observation of the keys verified the top cover back panel, left tall cabinet lock, left back panel, right tall cabinet lock and right back panel keys are maintained.	

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							
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 program submitted a list that includes the names of four super users trained for the use of the Pyxis Med-station and fourteen additional designated staff authorized to distribute medication. There were no youth on medication at the time of the review. The agency does not accept youth currently prescribed injectable medications, except for epi-pens. No youth were prescribed injectables as required and staff received the required training on how to use an epi-pen.	
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 Pyxis Med - Station maintains a perpetual inventory of controlled substances and over the counter medication. A running balance and a shift-to-shift count is conducted with the staff coming on duty. In this instance both staff will initial the form to verify accuracy. The shelter does not maintain syringes or sharps.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					Monthly reviews of medication management practices are done by the nurse and/or residential supervisor.	
Medication discrepancies are cleared after each shift.	X					The Pyxis Med-Station identifies any discrepancies which are cleared and witnessed by a second staff. Medication discrepancies are cleared prior to the next shift.	