Florida Network for Youth and Family Services
Compliance Monitoring Report for

Lutheran Services Florida Southeast - Lippman Youth Shelter

221 NW 43rd Court
Oakland Park, Florida 33309

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 Lutheran Services Florida Southeast (LSF Southeast), for FY 2021-2022. The agency has two program locations: 1) Lippman Youth Shelter located at 221 NW 43rd Court, Oakland Park, Florida, and 2) Administrative office located at 2700 W. Cypress Creek Road, Suite D131, Fort Lauderdale Florida. 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. LSF Southeast 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 LSF Southeast present for the entrance interview were Raymond Ballinger, Regional Director; Shelia Dixon, SW Regional Director; Scoundrel Oliver, Shelter Manager; Laura Saldana, Director of Compliance; Ivonne Fusco, Executive Administrative Assistant; and Counselors Diana Davila and Dellanira Calvet Noda. The last onsite QI visit was conducted April 14, 2021.

In general, the Reviewer found LSF Southeast is compliant with specific contract requirements. **LSF Southeast received an overall compliance rating of 100% for achieving full compliance** with four applicable indicators of the CINS/FINS Monitoring Tool. One of the five indicators was not applicable because LSF Southeast uses purchase cards in lieu of petty cash. 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 04-06-2021-2022

Agency Name: Lutheran Services Florida Southeast	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 221 NW 43 Ct., Oakland Park, FL 33309**
Service Description: Comprehensive Compliance Monitoring I	**Site Visit Date(s): April 6-7, 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 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**	☐	☐	☐	☒	☐	General Liability through Markel Global Reinsurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, and medical expense for $10,000, effective 6/01/2021 – 6/01/2022 Automobile insurance through Markel Global Reinsurance Company for combined limits of liability/property damage for $1,000,000. Policy effective date 6/01/2021 – 6/01/2022 Workers Compensation through United WI Insurance Company with limits of $1,000,000 each/aggregate, effective 6/01/2021 – 6/01/2022	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						Umbrella liability through Century Surety Company with limits of $4,000,000 each/aggregate, effective 6/01/2021 – 6/01/2022 Professional Liability/Abuse Molestation through Markel Global Reinsurance Company for $1,000,000 each and $3,000,000 aggregate, effective through 6/01/2021 – 6/01/2022 Florida Network is listed 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. Agency maintains an Accounting Procedures Manual that is consistent with GAAP and provide for limited internal controls. The fiscal manual was last approved 4/12/2017 by the Chief Financial Officer and is updated as necessary with revised policies showing a revision/approval date.	

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Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☐	☐	☒	Observation/Documentation: Reviewed petty cash Policy and Procedure 4.32 included in section 4 of the Fiscal Manual. LSF SE does not currently have a petty cash account. All purchases are made using a purchase card issued to the program manager.	
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**	☐	☐	☒	☐	☐	Documentation: Provider maintains an inventory for computer and periphery equipment purchased from 12/2002. No additional items were purchased with FN funds within the last year.	
A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: The provider submitted a copy of the Financial audit conducted for year ending June 30, 2021, and 2020 for the review. Due to pandemic, the audit was completed after December 31st by RSM US, LLP and letter from the auditor was dated February 10, 2022. Per the audit, a corrective action plan was completed and submitted by LSF for two items	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						cited: 1) evaluation and monitoring risk assessment for 72 subrecipient, and 2) federal funding accountability and transparency for 4 LSF subcontracts in its Head Start Program. Corrective actions were implemented in February and March 2022, respectively.	

CONCLUSION

LSF Southeast 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 LSF Southeast uses purchase cards in lieu of petty cash. **Consequently, the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendation 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 Lutheran Services Florida - Southeast
CINS/FINS Program

DATE: April 6-7, 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
Teves Bush – 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
	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
X	Program Manager		Direct – Care On-Call	1	# 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
X	CCC Reports		Grievance Process/Records	0	# Health Records
X	Logbooks		Key Control Log	4	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	11	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	7	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	4	# 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

0	# Youth	6	# Direct Care Staff	0	# Other: ___

Comments

Due to COVID-19, this review was conducted onsite 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

Lutheran Services Florida is a statewide, non-profit, human services agency with its headquarters located in Tampa, Florida. LSF Southeast (LSF SE) contracts 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 in Broward County. The program operates out of two locations: 1) the Lippman Youth Shelter, located in the City of Oakland Park, Florida, and 2) the administrative office and non-residential program (also known as Broward Family Center) is located at 2700 W. Cypress Creek Rd., Suite D131, Fort Lauderdale, Florida. 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, truant, homeless, abuse, neglected, or at-risk. The agency provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking (DMST), and youth referred by the Juvenile Justice Court System for domestic violence respite. LSF SE is not currently contracted to provide Probation Respite, Intensive Case Management, or Family and Youth Respite Aftercare services (FYRAC) and is not a SNAP provider. The census during the QI visit was 8 CINS/FINS youth. LSF SE was recently reaccredited by the Council of Accreditation (COA) in December 2021.

The following programmatic updates since the last Quality Improvement review in February 2020 were reported to the QI team during the visit:
During the past review year, the global pandemic has continued to have an impact on the agency and its services to children, youth and families. In particular, the agency has faced unprecedented challenges with recruitment and retention. As a result of the challenges faced with regards to staffing, the program had to put a cap on its census at different points in the year in order to maintain compliance with client/staff ratios. Despite the staffing challenges presented, the programs have continued to provide services uninterrupted. The Residential Services Manager continues to provide steady leadership for youth and staff. Her leadership has helped to navigate the hiring crisis and provide a safe environment for youth and staff.
In August of 2020, the LSF development team organized a committee to embark on a capital campaign to raise $250,000 for renovations at Lippman Youth Shelter. The undertaking of the capital campaign was to bring beauty and operational integrity to the facility. The mission of the campaign was to significantly enhance the aesthetics and programming capabilities for the most vulnerable youth who come through the doors, providing the optimal environment for program objectives to succeed. Construction for facility renovations began in February 2022.
In the last year, the program experienced a 100 percent turnover with the clinical team at the shelter. The long-time clinical director resigned in March 2022. The Program Director in the SW region is currently providing support to the clinical team and assisting with interviewing for the position.
The Community Counseling team has remained stable during the current review period as there has been no turnover in this program. All three counselors have continued outreach efforts and maintained a presence in the Broward Community during this review period. Outreach efforts continue to be successful as the community counseling program continues to thrive. In February 2022, spearheaded by a community counselor, the program partnered with Feeding South Florida to provide a weekly food pantry for clients. To date, the program has assisted in feeding over 300 individuals. The community counseling program, in partnership with Boys Town, provides weekly parenting groups to families with a focus on Spanish speaking families.
In September 2021, the agency was awarded funding for Street Outreach under the Family and Youth Services Bureau's (FYSB) Runaway and Homeless Youth (RHY) Program. The funding is intended to implement, enhance, and/or strengthen strategies that provide a runaway and/or homeless youth, under the age of 18, access to emergency shelter, reunite with their families, or offer connections to school and employment. Furthermore, these services are designed to enhance social and emotional well-being, self-sufficiency, and help them build permanent connections with families, communities, schools, and other positive social networks.

Narrative Summary

LSF SE is under the leadership of a management team consisting of a regional director; a shelter services manager; a licensed clinical director; and a senior administrative assistant. At the time of the onsite visit, there were three fulltime and three part time youth care positions vacant. The program has not reported any major challenges, incidents, administrative review, or current external investigation.

The overall findings for the modified QI Review for LSF SE are summarized as follows:

Standard 1:

Three indicators were reviewed for this standard; indicators 1.01, 1.04, and 1.06. Two indicators (1.01 and 1.04) were rated Satisfactory but indicators 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. 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 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

Thirty-one (31) of the sixty-six (66) single youth transports were not approved by a supervisor. The remaining transports that were approved did not include an approval time to indicate program supervisor was aware prior to transportation. Also, some of the approvals did not document the name of the party approving transport. In addition, the transportation log does not include purpose of travel, as required.

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 December 27, 2021 by the regional director.	
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 Predictive Index (PI) pre-employment assessment that was implemented July 2018. The tool was administered prior to the hiring of six (6) applicable youth care staff during the review period. All six employees obtained passing scores greater than the passing score of 5 on a scale of 1-10. Two additional new staff were master's level counselors and were not required to complete the suitability assessment per agency's policy.	
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**					A total of eight new staff were hired since the last onsite QI visit. The program had two applicable interns during the review period. All ten background screenings were initiated prior to hire/start dates with eligibility documented on the Clearinghouse results. There were no exemptions required.	
Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.			**X**			None of the new hires were previously employed and/or had a break in service for 90 days or less.	

Five-year re-screening completed every 5 years from initial date of hire	X					The program had one eligible staff who met the criteria for 5-year re-screening. A review of the agency's clearinghouse staff list shows valid retained prints on file 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 emailed to the Background Screening Unit on January 20, 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 employment authorization from the Department of Homeland Security was obtained through E-verify and maintained on file for all 8 new hires.	
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 agency has the required policy and procedure # 1.04 in place that was approved December 27, 2021 by the regional director.	
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					A review of four pre-service training records verified each staff completed the United States Department of Justice Civil Rights and Federal Funds training within the required thirty days of hire.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				A review of four pre-service training records indicated staff were not consistent with completing the required training within 90 days of hire. One of the four new staff is a non-licensed clinical shelter staff (DOH 11/15/2021) who has not completed 20 hours of supervised suicide assessment training. Per the interim clinical director, this was due to the vacancy of the former clinical director as well as there being no applicable assessments of suicide risks since supervision started with the interim licensed professional.	Exception: Two staff completed cardiopulmonary resuscitation (CPR) and first aid training after the ninety-day hire timeframe and one staff's CPR and first aid training was not completed. Two staff had no behavior management training completed within the ninety-day hire timeframe. One non-licensed clinical shelter staff did not complete medication distribution training, and completed motivational interviewing beyond the ninety days of hire date.
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 staff was applicable for receiving the non-licensed mental health assessment of suicide risk training. Staff began on November 15, 2021	
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	One staff was applicable for receiving the non-licensed mental health assessment of suicide risk training. Staff began on November 15, 2021 and is still within the timeframe to complete this training.	
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 staff in-service training records were reviewed. Each record was missing some of the required trainings to satisfy the required twenty-four hours of in-service training. The regional director indicated the agency has experienced staffing shortages across programs that impacted staff completing all required trainings as they were required to work overtime covering shifts for a period of time. Consequently, the agency implemented recruitment and retention strategies as follows: 1) recruiters were hired and assigned to the SE region 6/2021 to assist with job fairs, applicant screenings and scheduling interviews; 2) onboarding training was provided to hiring managers 9/2021; 3) agency participated in a Job Fair at BB&T Center 10/2021; 4) recruitment committee was developed with representation from programs and HR to address the most critical staffing needs on an ongoing basis; 5) LSF implemented overall referral bonus policy in 2021; 6) hourly wages for direct care staff were increased from $10.50 to $13.00 with an expected increase to $15.00 by 7/2022; 7) initiation of $500 sign on bonus for direct staff and $1000 sign on bonus for Case Mangers; 8) retention bonuses are paid to all staff in good standing with a year or more with the program; and 9) incentive bonuses are paid to salaried staff for covering shifts. Additional strategies are applied to social media advertisement such as the creation of recruitment videos and postings of jobs on Facebook.	Exception: One staff was missing the annual Florida Network suicide prevention training and another staff did not complete SkillPro suicide part 2, SkillPro human trafficking, and child abuse recognition, reporting and prevention trainings. One staff training completed all trainings but SkillPro Suicide, Florida Network suicide, Prison Rape Elimination Act (PREA), sexual harassment, human trafficking, and Child Abuse were completed after their due dates.
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 maintains individual training records for each staff. Each of the training records contained an annual training tracking form indicating the name of the training, date it was taken, and the number of training hours received. Further review of the files contained sign-in sheets, certificates and agendas of the training received.	
						YES If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 1.06						The agency has the required policy and procedure # 1.06 in place that was approved March 5, 2022 by the regional director.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					Agency maintains a list of eleven agency drivers approved to drive in agency's 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. The agency's auto insurance policy is current and was also provided for review.	
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 policy outlines the importance of avoiding single youth transports. In the event of a single transport of youth, per the policy, approval is required by the Residential Supervisor.	
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 uses two vans to transport youth, a 2005 grey Ford 350 and a 2005 white Ford Freestar. A total of 66 single transports were reviewed across the two vehicles.	Exception: Thirty-one (31) of the sixty-six (66) single youth transports were not approved by a supervisor. The remaining transports that were approved did not include an approval time to indicate program supervisor was aware prior to transportation. Some of the approvals also did not document the name of party approving transport.
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					Transportation logs for the review period showed third party present in vehicles 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 include the driver's name, names of youth, beginning and ending odometer, time out/in, and destination.	Exception: As required, purpose of travel is not listed on the transportation log.
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: The agency has the required policy and procedure # 2.03 in place that was approved March 5, 2022 by the regional director.	

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. Five files contained a case service plan completed within 7 days of the Network Inventory of Risks, Victories, and Needs Assessment (NIRVANA).	Exception: One youth record had a completed needs assessment; however, the service plan was not developed within seven days of the needs assessment.
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated		X				Each of the six records contained a case plan which was individualized, identified the service type, frequency and location of services, and the person responsible.	Exception: Each of the reviewed plans contained target dates for completion; however, two of the four closed records had no documentation of the actual completion dates. One plan had no parent signature and one plan had no supervisor's signature.
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 youth records were reviewed to include two open and four closed. Each file contained progress notes by the counselor every thirty days for the first three months. None of the files were applicable for progress notes after three months.	
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 in place that was approved March 5, 2022 by the regional director.	
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 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 large backyard with adequate recreational space including a basketball court. Large trash receptacles are located on the west side of the facility and were observed to be covered during the visit. All bathroom facilities were clean and functional. Girls have access to 2 full bathrooms and boys also have access to 2 full bathrooms. Each bathroom is equipped with a toilet, sink, and shower and is shared between two bedrooms. Walls appeared clean and void of soil, stains, or graffiti. The facility is well lit throughout. The program uses two vans to transport youth. The vans are equipped with a first aid kit, flashlights, fire extinguishers, flashlight, glass breaker, and seat belt cutter. The program has 3 master sets of keys used by staff. Doors are kept locked throughout the residential areas and accessible only with a key.	Exceptions: 1) Baseboards are lifting off the wall in bedrooms 6 and 7 2) Rug in lounge area presents trip hazard where it's curling up on one edge 3) Remove hazardous bulk trash containing damaged furniture and building material in backyard 4) Replace broken window screen outside room #10
Additional Facility Inspection Narrative (if applicable)	Egress plans are located in hallways, in common areas and in each youth bedroom. Abuse hotline and CCC information is posted on each bedroom and on the wall in youth lounge. Rights/responsibilities is posted in the youth lounge. Grievance box and forms are accessible to youth at the entrance to youth lounge. SOGIE signage was observed posted throughout the facility. Youth has a closet for personal clothing. No contraband was observed. There are 2 separate chemical storage areas - kitchen and locked chemical storage container on back deck. Inventories are not maintained for each storage location. It was observed that the program does not maintain a perpetual inventory of chemicals for accuracy of counts in-between the weekly inventory. MSDS were available for all but two chemicals. The inventory is done weekly but not maintained on a perpetual basis to accurately reflect reduction in count due to usage. Program has one laundry room equipped with 2 washers and 2 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. A locked storage area is available to secure youth belongings needing lock up. DCF license is posted in the lobby and is effective through June 27, 2022.						Exceptions: 5) MSDS is missing for 2 chemicals, Palmolive Dish detergent and Member's Mark pods detergent. (MSDS sheets were printed and added during the review) 6) A bottle of bleach and bottle of fabuloso was observed to be stored in unlocked kitchen cabinet.

Fire and Safety Health Hazards		X				A annual fire inspection was conducted by the city of Oakland Park on 2/8/22 and followed up by successful reinspection on 3/7/22. Fire extinguishers in the facility had valid inspections effective through February 2023. Hood inspection was conducted 8/17/2021.Wiginton conducted fire sprinkler inspection 10/26/21. Documentation was provided regarding correspondence with Wiginton and receipt of a work estimate 2/3/22 to conduct necessary inspections/repairs which is pending.	Exceptions: 7) Hood suppression inspection in kitchen -expired February 2022 8) Grease build-up was observed on either side of stove in kitchen
Additional Fire and Safety Health Hazards Narrative (if applicable)	A combined Department of Health group care and food inspection was completed 1/13/2022; violations cited were corrected by staff. A total of 11 fire drills were conducted since October 2021; 10 of 11 were completed within the 2 minute requirement. Emergency drills were conducted quarterly on each shift. The pantry is located adjacent to kitchen behind a locked door. Sharps are secured in a locked box. Two large first aid kits are located in the facility, one adjacent to the youth lounge and another in the dinning room. Refrigerator temperature was observed to be 38 degrees Fahrenheit; freezer temperature was 2 degrees Fahrenheit.						Exception: 9) One of eleven exceeded the 2 minute requirement by one minute.
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 and notated in the logbook. 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 and access books in the facility library that have been approved by the agency. Daily programming schedule is publicly posted in the two areas (living room and provided to the youth) and accessible to both staff and youth.	
						YES If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 3.06						The agency has the required policy and procedure # 3.06 in place that was approved March 5, 2022 by the regional director.	
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					Reviewed staff schedules 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.	
All shifts must always provide a minimum of two staff present		X				During the review period, the program has experienced staffing shortages of up to 3 youth care staff in the recent months. As a result of this external control factor, the agency was unable to maintain two staff on each shift. Several shifts, mostly on the overnights, had only one staff on duty as follows: November 2021 - 7 shifts; December 2021 - 9 shifts, January 2022- 15 shifts, February 2022 - 3 shifts, and March 2022 - 2 shifts. As previously documented, the agency has implemented various recruitment and retention strategies to address its staffing challenges.	Exception: The review of staff schedules revealed timeframes where the program was not able to meet the requirement of two staff per shift. There is evidence management implemented a corrective action plan with demonstrated improvement in staff recruitment and staffing. Consequently, the rating is Satisfactory with the exceptions mentioned above.
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 properly trained youth care workers.	
The staff schedule is provided to staff or posted in a place visible to staff	X					Staff schedule is posted in the office area accessible to staff. A copy of the schedule was observed during the onsite tour.	
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, counselors, 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				Reviewed overnight bed checks for the following randomly selected dates during the past six-month period: September 5th; October 11th; November 17th; December 24th; January 2nd; and February 8th.	Exceptions: Fifteen-minute bed checks were observed to missing as follows: 1) October 11th, missed 3 bed checks between 6:01am and 7:01am 2) November 17th, missed 1 bed check between 6:30am - 6:59 am
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 agency has the required policy and procedure # 4.02 in place that was approved March 5, 2022 by the regional director.	
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					A review of four youth records indicated each youth was screened for suicide risk upon admission and during the intake processes. Each screening was reviewed and signed by a supervisor and maintained in the youth record as required.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					A review of the shelter's suicide risk assessment verified it was approved by the Florida Network of Youth and Family Services.	
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 four reviewed youth suicide risk assessment indicated a need for sight and sound supervision. A review of the assessment validated each youth was placed on the appropriate level of supervision based on their suicide risk.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Each of the four youth placed on sight and sound supervision was monitored using the Alert System Precautions Observation Log which document youth behavior every thirty minutes while on 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					In each of the four youth records reviewed, their level of supervision was not changed or reduced until a licensed mental health professional or non-licensed mental health professional under the supervision of a licensed professional completed a further suicide risk assessment or the youth was Baker Act.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES** If NO, explain here: The agency has the required policy and procedure # 4.03 in place that was approved March 5, 2022 by the regional director.	
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 b. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) 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 shelter utilizes the Pyxis Med-Station Medication Cabinet to maintain and store medication. Observation of the cabinet indicated it is located in a locked room with no access to youth. The nurse, youth care specialist II and the shelter manager are Super Users for the Pyxis Med-Station; however, when the nurse is on duty, medical procedures are done by the nurse. All oral medications including narcotics, controlled and over the counter medications are stored in the Pyxis and stored separately from topical medication. Medications requiring refrigeration is maintained in a refrigerator designed for medication only. Observation of the refrigerator indicated the temperature inside was approximately thirty-six degrees Fahrenheit. The shelter maintains emergency keys to the Pyxis which are kept in the Shelter Manager's office. 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 nurse, youth care specialist II and the shelter manager are Super Users for the Pyrix Med-Station; however, when the nurse is on duty, medical procedures are done by the nurse. The shelter maintains a list of staff who are trained in medication distribution and the use of the epi-pen. A review of three applicable training records validated each staff received training in medication distribution and the use of an epi-pen. The shelter utilizes the Six Rights method to verify medications when administering prescription medication to youth. 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 will contact the pharmacist to verify the youth is proscribed the medication and dosage. The shelter does not accept youth who have to be administered injectable medication.	
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 and do not accept youth who require the use of them.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					The nurse generates a monthly Pyxis report which is used to review the program's medication management practices. Trends are discussed with the program manager and staff.	
Medication discrepancies are cleared after each shift.	X					Medication discrepancies are cleared prior to the next shift. The Pyxis Med-Station identifies any discrepancies which are cleared and witnessed by a second staff.	