FLORIDA NETWORK
of youth and family services

Florida Network for Youth and Family Services
Compliance Monitoring Report for

Lutheran Services Florida Southwest - Oasis

3642 Central Avenue
Fort Myers, Florida 33901

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 Southwest (LSF Southwest), for FY 2021-2022 at its program office located at 3642 Central Avenue, Fort Myers, 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. LSF Southwest is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 1, 2021 through June 30, 2022.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and DJJ Peer Reviewer. Agency representatives from LSF Southwest present for the entrance interview were Shelia Dixon, Regional Director; Samuel Laguerre, Shelter Manager; and Erick Scott, Shelter Supervisor. The last onsite QI visit was conducted March 10, 2021.

The Reviewer found LSF Southwest is compliant with specific contract requirements. **LSF Southwest received an overall compliance rating of 100% for achieving full compliance** with all five applicable indicators of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit.

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 05-11-2021-2022

Agency Name: Lutheran Services Florida Southwest	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 3642 Central Avenue, Fort Myers, Fl 33901**
Service Description: Comprehensive Compliance Monitoring I	**Site Visit Date(s): May 11-12, 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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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		
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 Finance section 4 of the Fiscal Manual. The shelter supervisor is the custodian of the petty cash fund. Petty cash is stored in a locked box in the supervisors office. All receipts are submitted for accounting and requesting reimbursement as needed and the fund is reconciled. Petty cash was reconciled onsite with the supervisor. Cash and receipts totaled $275.35.	
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. 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	☐	☐	☒	☐	☐	Documentation: The provider submitted a copy of the Financial audit conducted for year ending June 30, 2021 and 2020 for the review. Due to	

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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**						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 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 Southwest has met the requirements for the CINS/FINS contract as a result of full compliance with all five applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. **Consequently, the 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. All of 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 Review of Lutheran Services Florida/Southwest – Oasis
Residential Program

May 11-12, 2022

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 33.333 %
Percent of indicators rated Limited: 66.667 %
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	**Limited**

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 62.5%
Percent of indicators rated Limited: 37.5%
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Shakela Minns – 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	X	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
X	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer		# Other (listed by title): ___
X	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		# Health Records
X	Logbooks		Key Control Log	4	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	21	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	7	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	3	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	3	# 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	X	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	X	Staff Interactions with Youth	X	Census Board

Surveys

7	# of Youth	8	# of Direct Staff		# of 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/or community counseling services.

Strengths and Innovative Approaches

Lutheran Services Florida Southwest (LSF SW), Inc. contracts with the Florida Network to operate the Child in Need of Services and Family in Need of Services (CINS/FINS) program in Fort Myers, Florida. Funding through CINS/FINS allows the agency to provide residential, community counseling, and case management services over five counties, Collier, Hendry, Glades, Charlotte, and Lee, across Circuit 20. 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. LSF SW participated in the Council of Accreditation (COA) re-accreditation in November 2021 and received notice of re-accreditation.

The Stop Now and Plan (SNAP) program continues to be fully implemented in Circuit 20 and achieved all its SNAP In Schools contract goals. The contract goals for the last fiscal year were met. COVID-19 pandemic continued to produce challenges for SNAP groups as referrals did not start coming in until the end of the previous year and difficulties were faced to do outreach during the pandemic. This year the program received an increase in the number of referrals at the beginning of the year which had a positive impact on its ability to serve more families compared to numbers last year. LSF SW continues to have the SNAP facilitator part time positions available to youth care and counseling staff at an enhanced rate of pay for professional growth opportunities. The SNAP and community counseling staff were selected for an opportunity to be housed in the Charlotte County's Family Services Center which is a one-stop-shop for human services resources for families in Charlotte County. This is an exciting opportunity to be able to collaborate with other human services providers to obtain referrals and meets the needs of these families in real time. We have recently connected with the Boys and Girls Club in this area and plan to do groups with the youth over the summer.

LSF SW Intensive Case Management team has had turnover since the last QI review. One of the staff was promoted to ICM Coordinator in January 2022. This team continues to work very hard serving the most challenging court involved families. The Community Counseling program has also experienced significant turn over since the last QI review but is now currently fully staffed.

In the last year, the agency has promoted and transitioned from within its CINS/FINS program to provide growth opportunities to internal staff. LSF SW promoted Youth Care I staff to a Youth and Community Engagement Coordinator position. The former residential counselor has transitioned to its Family Counselor position. Following the sudden loss of its beloved Executive Director in November 2021, the former community counseling program manager has assumed the leadership role in the Southwest Region.

The agency has struggled with staff shortages in several of its CINS/FINS programs, particularly Oasis shelter. During the QI review, it was reported there are 4 fulltime vacancies and 9 part-time vacancies for direct care staff at the shelter. Outreach efforts continued throughout the year with participation in various community events and participating in standing/regular community meetings virtually or in person.

A fruit and vegetable garden was created in the backyard of Oasis, spearheaded one of the staff. This project has allowed youth to learn gardening skills, encourage healthy and holistic lifestyles, and advocate for a more organic sense of well-being. So far, the garden has produced various fruits, vegetables, and herbs that have been used at mealtime for the youth. Staff utilize vegetables from the garden to prepare a meal for youth who are vegetarian.

In December 2021, the agency applied for the Lee County CDBG grant and were recently awarded $896, 200 to complete renovations/rehabilitation of the Oasis Shelter as well as renovating the Community Counseling building into a drop in/community resource center.

Narrative Summary

LSF SW is under the leadership of a regional director who manages a team that is responsible for clinical services, prevention/intervention, quality assurance, ICM, SNAP, community counseling, and residential services. Oasis youth shelter is staffed by a residential manager, a case manager, a youth care supervisor, nine youth care specialist II, three youth care specialist I, and a part time nurse. At the time of the QI visit, the program did not report any specific issues, problems, or current corrective actions with any funding sources.

The overall findings for the modified QI Review for Family Resources St. Petersburg are summarized as follows:
Standard 1
Three indicators were reviewed for this standard. Indicator 1.01 was rated Satisfactory, and indicators 1.04 and 1.06 received a Limited rating.
Standard 2:
One indicator was reviewed for standard 2. Indicator 2.03 was rated Satisfactory with no 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. Indicator 4.02 was rated Satisfactory and indicator 4.03 received a Limited rating.

Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable):
Standard 1:
Indicator 1.04– Limited
Three of four pre-service staff did not complete the DOJ Civil Rights & Federal Funds training within thirty days from the hire date. All four pre-service staff were missing various required trainings, and training was not completed within ninety days as required. Two of the three in-service staff did not complete all annual required trainings.

Indicator 1.06– Limited
Twenty-three (23) of the forty-eight (48) single transports were approval by the program manager; however, time of approval was not documented to support knowledge and consent prior to transporting youth. The remaining twenty-five (25) single transports were documented on the transportation logs but no approvals by the program manager were noted.

Standard 4:
Indicator 4.03– Limited
The medication refrigerator does not have a temperature device to determine if the medication is being kept at the approved temperature level. On May 11, 2022 only one staff initialed the daily inventory sheet for controlled substance. The other staff who conducted the inventory signed after the missing signature was brought to the program manager's attention. The program was unable to provide documentation to validate monthly reviews of medication practice.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	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 that was last reviewed on February 7, 2022 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 tool with established passing score greater than 5. The tool was administered to five applicable newly hired direct care staff. All five staff successfully completed the Predictive Index assessment tool prior to date of hire.	
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 ten new staff were hired and five interns were utilized since the last QI review. All fifteen had eligible background screenings completed prior to hire/start dates.	
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 with the agency.	
Five-year re-screening completed every 5 years from initial date of hire	X					The program had six applicable five-year rescreen staff since the last QI review. All six staff had evidence of DJJ Clearinghouse valid retained prints.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					Provider emailed the Annual Affidavit of Compliance with Level 2 Screening form to DJJ BSU on 1/10/2022, prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					E-verify and proof of employment authorization from the Department of Homeland Security was verified for all ten 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 that was last reviewed on February 7, 2022 by the Regional Director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applica		
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 direct care staff training records were reviewed. One of the four staff completed the DOJ Civil Rights training within 30 days of hire.	Exception: Three of four staff did not complete the DOJ Civil Rights & Federal Funds training within thirty days from their hire date.
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				A review of four pre-service direct care staff training records was conducted to ensure each staff completed all mandatory training within ninety days of employment.	Exceptions: All four staff were missing various trainings and training was not completed within ninety days. One staff was missing program orientation and Florida Network suicide prevention training. The staff also did not complete behavior management, sexual harassment, serving LGBTQ, medication distribution, and cultural humility training within ninety days. A second staff was missing program orientation, cultural humility, security awareness, equal employment opportunity (EEO), trauma informed care, and fire safety training. The staff also did not complete medication distribution within ninety days. The third staff was missing managing aggressive behavior, Florida Network suicide prevention, and behavior management training. The staff also did not complete Nirvana, civil rights, motivational interviewing, cardiopulmonary resuscitation (CPR), first- aid, equal employment opportunity (EEO), suicide awareness, serving LGBTQ, and understanding youth development training within ninety days. The fourth staff did not complete universal precautions, prison rape elimination act (PREA), suicide awareness, fire safety, medication distribution, cultural humility, signs and symptoms of mental health/substance abuse, and human trafficking training within ninety days. The staff was also missing trauma informed care and equal employment opportunity (EEO) training.
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 non-licensed mental health clinical staff record was reviewed. The staff was recently hired in March 2022 and is still within the first year of employment.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).			X			The staff has not completed the required assessment of suicide training due to recent hire but has ample time to complete the 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 in-service direct care training records were reviewed to confirm each staff completed forty hours of mandatory refresher Florida Network, SkillPro, and job-related training annually. One staff completed all mandatory training annually.	Exception: One staff completed the Florida Network Suicide Prevention training late during the QI review on May 12, 2022. Another staff last completed the bi-annual Sexual Harassment course February 12,2020. The course is overdue for completion.
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					All six direct care training records reviewed indicate each staff record included an annual employee training tracking form, certificates, sign-in sheets, and agendas.	
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 1.06 that was last reviewed on February 7, 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					The program maintains a list of staff approved to transport youth in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					All approved drivers 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 three vans to transport youth, a 2018 Ford Transit 350, a 2010 Honda Odyssey, and a 2014 Ford E350. A total of 48 single transports were reviewed for the 2014 Ford van	Exception: Twenty-three (23) of the forty-eight (48)single transports were approval by the program manager; however, time of approval was not documented to support knowledge and consent prior to transporting youth. The remaining twenty-five (25) single transports were documented on the transportation logs but no approvals by the program manager were noted.
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					Program staff conducts regular vehicle inspections and maintains documentation of vehicle use on the mileage log. Transportation logs include the date, driver's name, number of passengers, beginning and ending odometer, time out/in, and activity/location. Activity and location is used to indicate purpose of travel and location.	
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 that was last reviewed on February 7, 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 one open and two closed residential records and two open and one closed community counseling record. All six files contained a case service plan completed with 7 days of the needs assessment or Network Inventory of Risks, Victories, and Needs Assessment (NIRVANA).	
Case plan service Plan includes:	X					A review of all six records found 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. Signatures were documented for all required parties.	

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							
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					Three of the six records were applicable for thirty day reviews. All three records were revised by the parent and counselor when applicable and reviews were conducted timely.	
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 on February 7, 2022 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practic**	**Not Applica**		
Facility Inspection		X				A tour of the facility was conducted with the shelter 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 with fresh mulch and flowers. The facility has a large backyard with adequate recreational space including a large covered gazebo. A large dumpster in front of building is behind an enclosed gate and is kept locked. The facility has a male and a female bathroom; each is equipped with 2 shower stalls, sinks, and 2 toilets. Each bedroom is equipped with 2 bunkbeds, bookshelf/shoe shelf, four lockers, and a posted board with attached schedule, grievance policy, behavior management system, emergency procedures, and chore schedule. The facility is well lit throughout. The program uses three 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 manager and team lead has a full set of keys and each staff has 2 master keys for entry doors. Doors are kept locked throughout the residential areas and accessible only with a key.	Exceptions: 1) Graffiti was observed on wall adjacent to sink in the boy's bathroom and on locker #4 in boy's bedroom #6 2) Locker #4 in room #6 is missing handle and has sharp edges where handle needs to be replaced; also loose handle on locker #2 in room #6.

Additional Facility Inspection Narrative (if applicable)	Egress plans are located in hallways, in common areas, and in the kitchen. Abuse hotline number is posted in each bedroom and on wall in youth lounge. Grievance box and forms are accessible to youth in the dayroom. SOGIE signage was observed posted throughout the facility. Youth has a locker for personal clothing. No contraband was observed. Chemicals are stored in the laundry room and closet in the medication room. Inventory is conducted daily 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. DCF license is posted in the lobby and is effective through January 31,2023.						Exception: 3) Chemical inventory does not reflect accurate count of all chemicals stored in the facility to include locations such as laundry room/other storage locations.
Fire and Safety Health Hazards	**X**						
Additional Fire and Safety Health Hazards Narrative (if applicable)	Fort Myers Fire Department, completed annual inspection for shelter facility and nonresidential offices on 3/7/2022 and reinspection on 3/24/2022. The shelter failed the reinspection that occurred 5/2/2022 due to pending hood inspection report. Contractor for hood inspection was out of the country and the program was not able to obtain the needed certificate. Per the shelter manager, as of 5/12/22, the fire department received the necessary documentation and is processing a clearance letter that will be emailed to the provider. The clearance inspection report was received 5/12/22 via email and is on file with the reviewer. All of the fire extinguishers had valid inspection tags with expiration dates of August 2022 or October 2022. An annual sprinkler system inspection was conducted by Wayne Automatic Fire Sprinklers Inc. on 7/29/01 and 5-year inspection was completed December 22, 2021. Fire extinguishers were inspected by Fyr-Fyter Inc. on 8/17/21 and 2/22/22. Alarm testing and inspection was completed by Fyr-Fyter Inc on 8/17/21. A review of fire drills indicated the program conducted on average three fire drills per month, one on each shift. One of the eighteen drills exceeded the two minute evacuation time because a youth did not want to wake up and evacuate. The program also completed mock emergency drills, including at a minimum, one per shift per quarter. Satisfactory combined food and group care inspection was conducted by the DOH on 11/19/21. Four week cycle menus were posted and signed by a licensed dietician effective until 8/5/22. The registered dietician's license is valid through 5/31/2023. Cold food was properly stored, marked, and labeled, and dry storage/pantry areas were clean. Refrigerators/freezers were clean, and optimal temperatures were maintained.						
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	

Provider has a written policy and procedure that meets the requirement for Indicator 3.06						If NO, explain here: The agency has the required policy and procedure 3.06 that was last reviewed on February 7, 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					Review of log book entries and staff schedules demonstrate at least two staff were present on all shifts during the last six months reviewed.	
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 staff are background screened and received adequate training to work with youth.	
The staff schedule is provided to staff or posted in a place visible to staff	X					The staff schedule is posted in the camera room.	
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 four randomly selected overnight shifts as follows: 2/12/22- 12am-3am 3/17/22 - 3am-5am 4/5/22 - 2am-4am 5/2/22 - 1am-3am	Exceptions: Three bed checks on 2/12/22 exceeded 15-minute requirement: between 1:20 - 1:36am (16 minutes), 2:11 - 2:30am (19 minutes), and 2:41 - 3:07am (26 minutes).
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 that was last reviewed on February 7, 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 records, two open and two closed, was conducted for suicide risk screening. All four records included a suicide risk screening tool completed during the initial intake. Each suicide screening was reviewed and signed by the supervisor and maintained in the record.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The agency's suicide risk assessment was approved by the Florida Network of Youth and Family Services and has not been revised.	
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					The four youth placed on sight and sound supervision were 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					All four youth were removed from sight and sound supervision after a suicide assessment was completed by a licensed professional.	
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 that was last reviewed on February 7, 2022 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practic**	**Not Applica**		
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		X				An observation of the medication room found all medications were stored in the Pyxis Med-Station 4000 medication cabinet inaccessible to youth. Oral medications are stored separately from topical medications in the locked medical cabinet. All narcotic and controlled medications are stored in the Pyxis Med-Station 4000 medication cabinet. Pyxis keys were stored behind the machine in clear a Ziplock bag. Each key was labeled separately. The program also utilizes a secure refrigerator for medication only.	Exception: The refrigerator does not have a temperature device to determine if the medication is being kept at the approved temperature level.

d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med-Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT							
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**					An observation of the medication room found the program maintains a list of Super Users and a list of designated staff delineated to have access to secured medication. The program has identified three Super Users for the Med-Station. A review of three youth records included a Medication Distribution Log (MDL) completed as required. Each youth's medication was distributed as required. The registered nurse reported medication verification is conducted by way of calling the pharmacy. The registered nurse confirmed distributing all medications while on-site. Reviewed documentation confirmed trained direct care staff distribute medication when the nurse is not on-site. A review of staff training records confirmed staff are trained in the use of epi-pens by the nurse.	
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				An observations of the Medication Distribution Log (MDL) found controlled substances are counted shift-to-shift with two staff members present and documented on the youth's MDL. A perpetual inventory with running balances is also maintained on the MDL's for all medications. All medications are stored in the Med-Station, including all over-the-counter (OTC) medications are inventoried weekly by the registered nurse. An informal interview with the residential supervisor in comparison with an observation of the kitchen found razors are secured in a locked file cabinet and are inventoried weekly and as used.	Exception: On May 11, 2022 only one staff initialed the daily inventory sheet for controlled substance. The other staff who conducted the inventory signed after the missing signature was brought to the program manager's attention.
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.		X				The registered nurse is responsible for running weekly and monthly reports via the knowledge portal. Since the nurse started December 2021, the shelter manager stated she has not received training on running pyxis reports.	Exception: The program was unable to provide documentation to validate monthly medication management reviews.
Medication discrepancies are cleared after each shift.	X					There were no open discrepancies during the annual compliance review. The registered nurse and supervisor reported all discrepancies are cleared at the end of shift.	