Florida Network for Youth and Family Services
Compliance Monitoring Report for
Safe Children Coalition

1106 South Briggs Avenue, Sarasota, FL 34237

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) with Florida Network of Youth and Family Services (FNYFS) monitoring visit for the Safe Children Coalition (SCC) for the FY 2021-2022 at its program office located at 1106 South Briggs Avenue, Sarasota, 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. Safe Children Coalition 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 2021 through June 30, 2022.

The review was conducted by Baldwin Davis, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from SCC present for the entrance interview were: Stacey Schaeffer, Senior Director of Prevention and Diversion Services; Jill Steiner, Senior Director of Out of Home Care; Charles Harris, Director of Residential Programs; Jennifer Warwick, Clinical Supervisor; Alan Abernathy, Residential Manager; Aaron Bellamy, Youth and Family Advocate Manager. The last onsite QI visit was conducted May 19-20, 2021.

In general, the Reviewer found Safe Children Coalition is in compliance with specific contract requirements. Safe Children Coalition received an overall compliance rating of 100% for achieving compliance with four applicable indicators of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit or recommendations made for any conditionally acceptable item.

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 03-23-2021-2022

Agency Name: Safe Children Coalition	Monitor Name: Baldwin Davis, Lead Reviewer
Contract Type: CINS/FINS	Region/Office: 1106 South Briggs Ave. Sarasota FL
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): March 23-24, 2022

Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
I. Administrative and Fiscal							
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: General Liability through Alliance of Nonprofits for Insurance for limits of coverage $1,000,000 each $3,000,000 aggregate, and $20,000 medical expense, effective 6/30/21-6/30/22. Workers Comp insurance through Accident Fund Insurance Company of America for limits of coverage $1,000,000 each accident, effective 4/1/2021 – 4/1/2022. Automobile insurance through Alliance of Nonprofits for Insurance for combined limits of liability/property damage for $1,000,000 each and aggregate. Policy effective for 07/01/2021-07/01/2022. Professional Liability Claims insurance through Alliance of Nonprofits for Insurance for limits of coverage	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						$1,000,000 each/$2,000,000 aggregate effective 6/30/2021-6/30/2022. Florida Network is listed on the Certificate of Insurance as certificate holder.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in the Financial Services Policy and Procedures Manual. The manual is divided into eight sections with subsections in each. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. All policies have a revision date of May 2019.	**No recommendation or Corrective Action.**
b. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: No change in practice was reported for the agency since the last site program review. The agency has a policy that oversees Petty Cash Funds. It maintains a petty cash system that is secured in a locked box and managed by the Director of Residential Services, the petty cash float is $450.00. The finances are disbursed and reconciliations are verified by the	**No recommendation or Corrective Action.**

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	Explain Rating						
Major Programmatic Requirements	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)
						designee in the finance department before reimbursement is made. Agency uses an agency reconciliation form to capture beginning cash balance, ending cash balance and to list all receipts. Total amount on hand and counted and reconciled by shelter program staff was $450.00	
c. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	Agency maintains an inventory in accordance with a written policy and FNYFS contractual requirements. The document that was presented for the contract management review shows that the agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
d. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2021, and 2020 was completed by James Moore, C.P.A. and Consultants and dated December 1, 2021. Per the audit report, a separate Management Letter requiring a Corrective Action Plan is not required and was not issued by the auditor. A copy of the audit was submitted to the FNYFS.	**No recommendation or Corrective Action.**

CONCLUSION

Safe Children Coalition 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. One of the five indicators was not applicable because the provider does not have a current inventory purchased with DJJ/FN funds for the reporting period. Consequently, **the overall compliance rate for this contract monitoring visit is 100% percentage**. There are no corrective actions cited and no recommendation 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 Safe Children Coalition - Sarasota
CINS/FINS Program

DATE: March 23-24, 2022

Compliance Monitoring Services Provided by

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

Indicator	Rating
2.03 Case/Service Plan	**Satisfactory**
2.04 Case Management & Service Delivery	**Not Applicable**

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

Standard 3: Shelter Care & Special Populations

Indicator	Rating
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

Indicator	Rating
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: 77.78 %
Percent of indicators rated Limited: 22.22 %
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

Lead Reviewer Baldwin Davis, Consultant-Forefront LLC/Florida Network of Youth and Family Services
Peer Reviewer – Kara Brown, 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

X	Chief Executive Officer	X	Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
	Chief Operating Officer		Advocate	3	# Case Managers
	Executive Director	X	Direct – Care Full time	2	# Program Supervisors
X	Program Director		Direct – Part time	0	# Food Service Personnel
X	Program Manager		Direct – Care On-Call	1	# Healthcare Staff
X	Program Coordinator		Intern	0	# 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		# Health Records
X	Logbooks		Key Control Log	4	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	16	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	3	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	4	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

6	# of Youth	9	# of Direct Staff		# of Other

Comments

This review was conducted on-site using the Modified QI Review plan.

Monitoring Purpose:

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and non-residential services.

Strengths and Innovative Approaches

Safe Children Coalition (SCC) Inc. is a multi-facetted and multiple funded non-profit community-based care provider that focuses on education, prevention, diversion, and child welfare services and serves Sarasota, Manatee, and Desoto counties in Florida. The corporate headquarters office is located at 1500 Independence Blvd., Suite #210, Sarasota, Florida. Program offices include the shelter which is located at 1106 S. Briggs Ave., Sarasota, and the Youth Prevention Services (YPS) community counseling program is located at 5284 Paylor Lane, Lakewood Ranch, Florida. Funding received through the statewide CINS/FINS program allows the agency to serve both male and female youth up to seventeen years old who are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk.

The agency also 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 and probation respite. SCC is not contracted to provide any other CINS/FINS services. The youth census during the QI visit was 7 youth. SCC is currently accredited by the Council on Accreditation (COA) through June 30, 2025. The agency has adjusted their services to meet the effects of the global pandemic that had a tremendous impact on all programs serving youth and families. Despite the challenges presented, the agency continues to focus on ensuring the safety for their staff and participants by implementing current Coronavirus Protocols. Community based staff are all settled into the new Lakewood Ranch office they moved into nearly a year ago. With staffing challenges experienced across the state and programs, SCC had its own share of challenges and recruited a total of twelve new staff, including a staff member who was hired as a Residential Counselor to replace the previous staff member who left the agency in June 2021.

The agency has acquired two new vans recently and since the last review, a 2021 Honda Oddessy and a 2022 Toyota Sienna. The shelter's residential program is currently under notice to cease its lease at the facility located at 1106 S. Briggs Ave., Sarasota, FL. The landlord notice requires the agency vacates the building by March 2023 as it is needed to expand the landlord’s nearby private school. The leadership and management are seeking an alternative and appropriate shelter facility, so both interim and long term needs are being explored. Long term plans are in place for a permanent replacement whereby the agency has acquired a parcel of land from an endowment it received. They have started a major capital campaign and have secured an architect who have now developed plans and submissions to the local city to initiate development. The Director of Philanthropy indicates the capital funding amount sought is in the region of $8.7 million.

While the QI Review surveys are not mandated for agency participation, it is strongly recommended as it adds another of set of value to the QI Review process. SCC clients (75% of those on census) participated in this survey and results found that they all (100%) felt safe at the shelter facility. All clients gave positive feedback on orientation and one anonymous client wrote “It was a good experience. The staff and other youth here seemed welcoming and they explained the rules to me before I could ever slip up.”

Narrative Summary

The Senior Director of Prevention and Diversion oversees the Community Counseling Program and the Senior Director of Out-Of-Home Care oversees the Residential Programs. The residential counseling program consists of one master's level counselor. The non-residential counseling program is housed off-site and is approximately a 30 minute drive away from the shelter location, in a business park office that serves the full spectrum of community-based services provided by the agency, including CINS/FINS. The non-residential program consists of two bachelor's level, counselors/case managers combined with master's level counselor/case managers. The residential program staffing consists of a Residential Manager, a Youth and Family Advocate Manager, a Residential Counselor, and youth care staff that includes full-time and part-time Behavior Coaches. SCC is under the leadership of a CEO, a Senior Director of Prevention and Diversion Services, a Senior Director of Out-of-Home Care, a Clinical Supervisor, and a Director of Residential Programs. The program has not reported any major challenges, critical incidents, administrative reviews, or any current external investigations. The agency had a successful accreditation review since the last CINS/FINS QI Review.

The overall findings for the modified QI Review for Safe Children Coalition are summarized as follows:

A total of eight indicators were reviewed during the modified QI visit. These indicators include: 1.01 - Background Screening, 1.04 – Training, 1.06 – Transportation, 2.03 – Case/Service Plan, 3.01 – Shelter Environment, 3.06 – Staffing and Youth Supervision, 4.02 – Suicide Prevention, and 4.03 – Medication.

Standard 1: Three indicators were reviewed for this standard; indicators 1.01, 1.04, 1.06.
Indicator 1.01 was rated Satisfactory with exception because dates were missing from some assessments and had to be sought from staff for QI review completion.
Indicator 1.04 was rated Limited due to two of three staff not completing the required DJJ Civil rights training within 30 days; two staff did not complete all their mandatory training within the 90-day period of hire.
Indicator 1.06 was rated Satisfactory with no exceptions.

Standard 2: One indicator was reviewed for standard 2.
Indicator 2.03 was rated as Satisfactory with no exceptions noted.

Standard 3: Two indicators were reviewed for standard 3; indicators 3.01 and 3.06.
Indicator 3.01 was rated Satisfactory with exceptions pertaining to the chemical count and the fire drill log recording.
Indicator 3.06 was rated Satisfactory with finding regarding scheduled staff times and actual shift start times.

Standard 4:Two indicators are reviewed for standard 4; 4.02 and 4.03.
Indicator 4.02 was rated Satisfactory with no exceptions.
Indicator 4.03 received a Limited rating with the explanation provided below.

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

Standard 1:
Indicator 1:04 - Limited
A review of six staff files found two of three staff were not completing the required DJJ Civil rights training within 30 days; two staff did not complete all their mandatory training within the 90-day period of hire.

Standard 4:
Indicator 4.03 – Limited
As a result of the on-site review of the elements of Indicator 4.03 was rated Limited as the standards require the use of a Pyxis medication cart which is not used by the agency per standards.

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 procedures 1.01 Background Screening that was reviewed by the Chief Executive Officer (CEO) in January 2022.	**Add any exceptions below:**
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 their own Safe Children Coalition Candidate Evaluation Form preassessment tool with a passing score of 80% or higher. All 13 new hire staff had a documented a pre-employment suitability assessment that was completed prior to hire using the tool. Each staff exceeded the passing score.	Exceptions: Dates were missing from some of these assessments and had to be sought from staff for QI review completion.
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					Thirteen new staff were hired since the last onsite Quality Improvement review. All thirteen staff were background screened with eligible ratings received prior to their hire date. The program did not use any applicable volunteers or interns during the review period.	

Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.			X			Agency has no employee who 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.	
Five-year re-screening completed every 5 years from initial date of hire	X					There were three eligible five-year rescreenings conducted during this review period. Clearinghouse background screening documentation demonstrated current/active retained prints for all three staff members.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					The agency submitted an Affidavit of Annual Compliance with Level 2 Screening Standards to the Department of Juvenile Justice Background Screening Unit via fax on January 13,2022, before the January 31, 2021 deadline. The agency received email confirmation of receipt on March 13, 2022.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					HR requests the authorization verification from E-Verify and documents the case number provided, date of authorization and signature of HR staff completing verification on the lower section of the I-9 form rather than printing the E-Verify authorization and maintaining printed copy in the employee record.	

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 procedures 1.04 Training Requirements that was reviewed by the Chief Executive Officer (CEO) in January 2022.	**Add any exceptions below:**
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				Three new staff training records were reviewed. One of the reviewed staff completed the United States Department of Justice Civil Rights and Federal Funds training within thirty days from their date of hire. The remaining two completed the training; however, it was not completed within thirty days of hire.	Exception: Two of three eligible staff did not complete the United States Department of Justice Civil Rights and Federal Funds training during their initial thirty days of hire. Both staff completed the training during the annual review.
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				One of the three reviewed new staff received all mandatory training during their first ninety days of employment from their date of hire.	Exception: Two reviewed new staff files did not complete Serving LGBTQ Youth or Cultural Humility during their initial ninety days of employment; however, both staff completed both trainings during the annual compliance review.
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 record was reviewed for non-licensed mental health clinical shelter staff within their first year of employment. The reviewed staff is working on their training; however, they have not been employed for a full year and their training is not yet complete.	
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 records was reviewed for non-licensed mental health clinical shelter staff within their first year of employment. The reviewed staff is working on their training; however, they have not been employed for a full year and their training is not yet complete.	
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				A sample of three in-service training records were reviewed. One of the two records reviewed included all required annual trainings.	Exception: One of the reviewed staff's CPR/First-Aid certification expired on January 14, 2022. The agency provided documentation showing the staff was supposed to attend the last training but was unable to attend due to a family emergency. The agency stated the staff will attend the next available training. One reviewed staff did not complete the Florida Network Suicide Prevention training.
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					Three reviewed records each included an annual employee training hours tracking form, as well as certificates and sign-in sheets for trainings attended.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** **NO (explain below)** If NO, explain here: The agency has the required policy and procedures 1.06 titled Client Transportation and was reviewed by the Chief Executive Officer (CEO) In January 2022.	**Add any exceptions below:**
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The agency did not provide a list of agency approved drivers. The policy and procedure states all staff employed must have driver's license and pass an agency driver training which automatically qualifies them to be covered by the agency's vehicle insurance. HR confirmed this practice and reiterated that all staff are employed under the condition that they qualify to drive the agency's vehicles and are covered under the agency insurance.	

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					The agency's policy and procedures indicate that staff who provide transportation to youth while at the shelter must pass a driver's license background check prior to employment and have a valid Florida driver's license that is in good standing with the state of Florida. The agency maintains auto insurance policy to provide coverage for all authorized agency drivers.	
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 policy was reviewed which addresses one-on-one staff-to-client transport and the exception that can be made if a 3rd party is not available. The Note Active tablet/logbook provides documentation of authorization given by a supervisor/manager for single client transports. The transportation logs provide details of the vehicle used, staff names/initials, destination, mileage, and date and time of transport. A total of six randomly selected transportation entries were reviewed on 3/8/22;3/8/22;1/10/21;1/25/22;2/18/22;2/23/222 and all had supervisor permission granted.	
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					As indicated in the agency transportation policy, Managers/Supervisors reviewed the client's behavior history prior to approving single client transport. All single transports reviewed during the review period were approved by the supervisor.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The agency transportation policy states an approved 3rd party can be a volunteer, intern, 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					The agency transportation logs consistently supports names/initials of all staff and youth in the vehicles, date and time of transport, mileage, and destination of the vehicle.	
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 procedures 2.03 Case/Service Plan that was reviewed by the Chief Executive Officer (CEO) in January 2022.	**Add any exceptions below:**

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					Seven youth records were reviewed, two open residential, two closed residential, two open community counseling, and one closed community counseling. Each record included a case/service plan which was completed within seven working days of NIRVANA. Residential's practice is to complete the initial case/service plan upon admission, prior to completion of NIRVANA. Updates will be made as needed after completion of NIRVANA.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	X					All seven reviewed case/service plans included individualized and prioritized needs and goals, service type, frequency, location, person responsible, target dates for completion and actual completion dates, signatures of youth, parent/guardian, counselor, supervisor, and 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 reviewed records were applicable for thirty day reviews. Each of the three plans were reviewed for progress/revised as required.	
Standard Three – Shelter Care							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**NO** If NO, explain here: The agency has the required policy and procedures 3.01 Shelter Environment that was reviewed by the Chief Executive Officer (CEO) in January 2022.	Exception: The agency Policy 3.01 does not address fire or emergency drills, chemicals, key control or the trash/dumpster management. These items were noted on the last two reviews.

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Facility Inspection		X				Date of facility inspection(s) reviewed: 3/10/22 Annual Fire Inspection, 12/09/21 from the Health Department A facility tour was conducted in order to review the shelter environment standard. Throughout the tour it was evidenced that all furnishings were adequate, the shelter was clean and there was no evidence of insect infestation and the grounds were all landscaped and maintained adequately. There was no evidence of graffiti anywhere and the lighting throughout the facility appeared to be adequate for the required tasks performed in the specific locations. The interior areas did not appear to contain contraband and were free from hazardous unauthorized metal/foreign objects. The on-site reviewer observed one potential safety hazard, these were ropes hanging on the patio areas that are used to harness a canopy that was not currently in use.	

Additional Facility Inspection Narrative (if applicable)	During the inspection of the outside of the facility, it was evident the exterior areas were free of debris and hazards and the designated garbage cans were covered. For the vehicle inspections, it was noted all doors and vehicles were locked and secured for agency and private vehicles. All three agency vehicles were equipped with first aid kits, a fire extinguisher, flashlight, glass breaker, seat belt cutter but none of the three vehicles inspected had an air bag deflater. The agency has two new vans that were purchased recently, upon further inspection they did not have the required insurance documents which were later updated before site visit ended. The facility fire extinguishers were up-to-date with inspections. It was also noted that facility access is limited to staff members and key control is in compliance with policy and procedure. The bathrooms and shower areas appeared to be clean and functional. During the walk through it was evident a detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ incident reporting number and other related notices were visibly posted. These items were posted in the main entrance/lobby and also in the girl's and boy's day and bedrooms. In the laundry room, the washers and dryers were clean and functional and on the dryers the lint traps were clean. Upon inspection of the bedrooms, it was evident each youth has their own individual bed with clean covered mattress, pillow, linens, and blanket. It was also witnessed that each youth has a safe, lockable place to keep their personal belongings. The agency has a current DCF Child Care License displayed in the facility in the lobby that is effective June 2021 through May 31, 2022. All chemicals were listed but not fully accounted for in the designated storage area as the agency has one main inventory that is reviewed weekly per policy but they do not utilize a secondary daily chemical use log.						Exception: The chemical count was inaccurate as the agency uses one control sheet that is checked weekly as is required, and on Sundays. When staff remove chemical from the inventory during the week, it is not updated and therefore not accounted for as required.
Fire and Safety Health Hazards		X				Date of fire inspection(s) reviewed: March 10, 2022	

Additional Fire and Safety Health Hazards Narrative (if applicable)	An annual facility fire inspection was conducted on 03/10/22 by Sarasota County Fire Department and the facility was in compliance with local fire marshal and fire safety code within the jurisdiction. A new local code was in effect since the last review that required the agency to install emergency lights in two locations, these were being installed while the on-site review was in process. All annual fire safety equipment inspections are valid and up-to-date (extinguishers, sprinklers, alarm system, and kitchen overhead hood). Cintas Fire inspected the extinguishers, lights, and signs on 1/6/2022 and no deficiencies were noted and Piper Fire Protection conducted the annual alarm inspection on 1/22 and no deficiencies were found. The agency completed all but two fire drills per month at exactly two minutes for the logs that were reviewed covering October 2021 to March 2022. These two minutes drills indicated that staff were not timing the drills but were indicating two minutes as a general time, not establishing if the actual time was above or below two minutes. The agency completed 1 mock emergency drill per shift per month as evidenced by review of logs from October 2021 to March 2022. The agency has a current Satisfactory Residential Group Care and Food Service Inspection report that was issued 12/09/21 from the Health Department, no issues were reported. The food menus are posted and signed by Licensed Dietician with a date of 8/30/21. All cold food is properly stored, marked and labeled and dry storage/pantry area is organized with items that are properly stored. The refrigerators and freezers are adequately maintained and all small and medium sized appliances are operable for use as needed. Upon inspection of the temperature logs, all appliances were in the normal range for the majority of the readings. The large freezer stayed almost consistently below zero degrees with only two instances above and the small stayed below zero with only two instances of above and the case was the same for the refrigerator where it stayed at or below forty degrees. Staff do a daily temperature log that was inspected as being up-to-date for all appliances.						Exception: There were no real times accounted for seventeen of the nineteen fire drills conducted between September 2021 and March 2022. Staff evidently were not timing these drill and were recording all of these drills to take place at a set two minute timeframe.
Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**X**					The youth are engaged in meaningful, structured activities seven days a week during awake hours and idle time is minimal as evidenced by the daily schedule of activities provided and posted around the facility. Youth in the program are provided at least one hour of physical activity daily and they are also provided the opportunity to participate in a variety of faith-based activities and provided alternatives for those that chose not to participate in these activities. Youth are also provided opportunities to complete homework and have access to computers, a variety of age-appropriate and program-approved books for reading and are allowed quiet time to do so. The schedule is publicly posted and accessible to youth and staff, these could be found in the common areas.	

Provider has a written policy and procedure that meets the requirement for Indicator 3.06						YES If NO, explain here:	Add any exceptions below:
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	The agency has the required policy and procedures 3.06 that was reviewed by the Chief Executive Officer (CEO) January 2022.	
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	X					The QI review of staff schedules and agency logbook entries documented the required staffing ratios were met for both the awake and sleeping hours.	
All shifts must always provide a minimum of two staff present	X					A review of staff schedules and logbook entries documented the required two staff minimum.	
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					Review of staffing schedules and logbook documented that only staff who are background screened and properly trained are included on the staff schedules and shifts.	
The staff schedule is provided to staff or posted in a place visible to staff	X					The program staff schedule is posted in the staff office and was observed during the tour of the facility. The schedule is visible to all staff. Finding: While the staff schedule is posted, it inaccurately reflected the times that staff begins their daily 2:00 p.m. shift. It was reported that the three incoming staff staggered their start times but while maintaining correct ratio for coverage.	
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					There is a holdover or overtime rotation roster which includes only staff who are background screened and properly trained youth care workers, supervision staff, and treatment staff.	
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					Physical layout of sleeping arrangements: The facility has a girl's dorm, boy's dorm, and single girl's and boy's rooms that are directly accessible from the main living area. The following six nights of bed checks were randomly selected to review: 3/23/22; 3/5/22; 2/4/22; 2/17/22 1/21/22 and 1/15/22. On each dates and times, the times in the log book reflected the times that staff were observed as doing these bed checks.	

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 procedures 4.02 Suicide Prevention that was reviewed by the Chief Executive Officer (CEO) in January 2022.	Add any exceptions below:
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Suicide Risk Screening and Approval							
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	X					Four youth records were reviewed. Each youth was screened for suicide risk during the initial intake and screening process. Each youth's suicide screening results were signed by the supervisor indicating they had been reviewed.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The program's suicide risk assessment has not been changed since 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					Three of the four youth were placed on constant sight and sound following their suicide risk screening. Following the assessment of suicide risk they were all stepped down to standard supervision, the appropriate level of supervision based on the results of the suicide risk assessment. The remaining youth was not placed on constant sight and sound, as they were a non-residential youth and their assessment of suicide risk was completed at the time of intake, indicating standard supervision was appropriate.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					All three applicable youth records included a supervision log documenting the youth's behavior at thirty minute intervals.	
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					None of the reviewed youth's supervision levels were changed or reduced until a licensed professional or a non-licensed professional under the supervision of a licensed professional completed a further assessment.	

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 procedures 4.03 Medication that was reviewed by the Chief Executive Officer (CEO) in January 2022.	Add any exceptions below:
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med-Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT		X				The agency does not store all of the medications in a Pyxis Med-Station 4000 Medication Cabinet. The program has a Med-Station that is inaccessible to youth; however, it is not currently being utilized. The program is currently storing their medication in the staff office, behind two locks. The agency provided documentation indicating Safe Children Coalition and The Florida Network is aware of the current medication management storage practice, and the Florida Network has been coordinating with SCC management for months to effectively resolve the issue. A Pyxis training conducted by The Florida Network is scheduled this week for the registered nurse and identified staff. The agency is currently storing all oral medications separate from epi-pens and topical medications. Each type of medication is stored in a separate box within the locked cabinet. The agency maintains a separate refrigerator for medication only. The program maintains labeled keys for the Pyxis, in the event the Pyxis is utilized.	Exception: The agency does not store all their medications in a Pyxis Med-Station 4000 Medication Cabinet. The program has a Med-Station that is inaccessible to youth; however, it is not currently being utilized. The program is currently storing their medication in the staff office, behind two locks. There was no thermometer to determine the temperature of the refrigerator, however, one was placed in there during the time of the review.

Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse		X				The agency maintains two super users for the med-station; although, the agency is not currently utilizing the Pyxis. The agency indicated all staff have access to secured medications, as they have the codes to the locks in the staff office, where medications are currently locked up. The agency utilized a Medication Distribution Log for the distribution of all medication. The agency verifies medication using one of four methods listed in the FNYFS Operations Manual. The agency checks each prescription when it comes in and contacts the pharmacy to verify. The agency indicated when the nurse is on-site, medication processes are only conducted by them. The delivery process of medications is consistent with the Medication Management and Distribution Policy. The agency has a medication book including what medications each youth takes, as well as a photograph of the youth. The agency utilized the Medication Distribution Log and ensures it is the correct youth, correct medication, and correct dose. The youth is asked what medication they take, given their medications, and a mouth sweep is done. The Medication Distribution Log is then signed by the nurse and the youth, and a count is documented. The program does not accept youth currently prescribed injectable medications, except for epi-pens. Non-licensed staff who are trained to assist in the delivery of medication have been trained by a registered nurse.	Exception: All agency staff have access to the secured medications as they are locked in the staff office and not in the Pyxis med cart.

Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly			X			The agency did not have any controlled substance at the time of the review; however, there is a process in place for a perpetual inventory with running balances, as well as a shift-to-shift count to be conducted and documented on the medication distribution log. A perpetual count is completed as a youth is given medication and there is a spot to document shift-to-shift counts at the bottom of the form. Over the counter medications are inventoried weekly. The agency also utilizes a perpetual inventory where they document anytime a dose is given. The agency does not have any syringes. Sharps counts are conducted daily, on each shift.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.			X			The agency receives monthly Pyxis Med-Station Reports; however, the reports are blank, as the program is not currently utilizing the Pyxis.	
Medication discrepancies are cleared after each shift.		X				Medication discrepancies are not cleared after each shift, as the Pyxis is not being utilized.	Exception: Medication discrepancies are not cleared after each shift, as the Pyxis is not being utilized.