Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth Crisis Center
3015 Parental Home Road
Jacksonville, FL 32216

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Youth Crisis Center for the FY 2021-2022 at its program office located at 3015 Parental Home Road Jacksonville, FL 32216. 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. Youth Crisis Center is contracted with FNYFS to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 1, 2021 through June 30, 2022.

The review was conducted by Baldwin Davis, Consultant for Forefront LLC and Megan Thrasher Department of Juvenile Justice Regional Monitor, Peer Reviewer. Agency representatives from Youth Crisis Center present for the entrance interview were Kim Sirvedan President and CEO; Jenny Sanchez, Director of Human Resources; Stephen Durham, Chief Operations Officer; Tamika Gloston, Residential Director; Eric Anderson, SNAP Program Manager; Logan Farrelly, CINS/FINS Clinical Director. The last QI visit was conducted August 26-27, 2020.

In general, the Reviewer found Youth Crisis Center is in compliance with specific contract requirements. Youth Crisis Center received **an overall compliance rating of 100% for achieving partial compliance with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool**. There were no corrective actions as a result of the monitoring visit and no recommendation was made.

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 05-25-2021-2022

Agency Name: Youth Crisis Center	Monitor Name: Baldwin Davis, Lead Reviewer
Contract Type: CINS/FINS	Region/Office: 3015 Parental Home Road, Jacksonville, FL 32216
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): May 25-26, 2022

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☐	☒	☐	Documentation: General Liability through Philadelphia Indemnity Insurance Co. for limits of coverage $1,000,000 each $3,000,000 aggregate, and $20,000 medical expense, effective 7/01/21-7/01/22. Workers Comp insurance through Bridgefield Employers Insurance Company for limits of coverage $500,000 each accident, effective 7/1/2021 – 7/1/2022. Automobile insurance through Philadelphia Indemnity Insurance Co. for combined limits of liability/property damage for $1,000,000 each and aggregate. Policy effective for 7/1/2021-7/1/2022. Professional Liability Claims through Philadelphia Indemnity Insurance Co.	**No recommendation or Corrective Action.**

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Contract Type: CINS/FINS						Region/Office: 3015 Parental Home Road, Jacksonville, FL 32216	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): May 25-26, 2022	
	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)**
						for limits of coverage $1,000,000 each/$3,000,000 aggregate effective 7/1/2021-7/1/2022. Student accident coverage of $500, 000 and sexual abuse molestation at $1,000,000 each/$3.000,000 aggregate effective 10/3/2021-10/3/2022 and 7/1/2021-7/1/2022 respectively through Philadelphia Indemnity Insurance Co. Florida Network is listed on the certificate of liability insurance as a 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 financial manual is divided into forty-three sections. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for general ledger, cost accounting, payroll, petty cash, computer backup, and other relevant financial processes.	**No recommendation or Corrective Action.**

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Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): May 25-26, 2022	
	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)**
						The agency's annual accounting firm indicates the provider's net assets and cash flows for the year ended are acceptable and are in compliance with US generally accepted accounting principles (GAAP).	
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: There is one change in practice that was reported for the agency since the last onsite program review in August 2020. Reviewed petty cash policy and procedure and the Petty Cash float which is now $400. Petty cash is stored in a secure locked location and is maintained by the Residential Director. All staff must secure receipts after a purchase is made. The receipts are turned into Finance, which is reviewed and posted to QuickBooks before issuing a check to replenish. Petty cash is usually replenished once a month or more frequent if necessary.	**No recommendation or Corrective Action.**
c. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**

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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		
equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**							
d. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2021 and 2020 was completed by Masters, Smith & Wisby, P.A. A separate Management Letter was not required as there were no corrective actions. The audit was completed on 02.21.2022. However, a copy of the audit was reported as being submitted to the FNYFS.	**No recommendation or Corrective Action.**

CONCLUSION

Youth Crisis Center 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 any current inventory purchased with DJJ/FN funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%**. There are no corrective actions cited and no recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

SUMMARY OF RECOMMENDATIONS

Recommendation
There were no recommendations as a result of this review.

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 Youth Crisis Center
CINS/FINS Program

May 25-26, 2022

Compliance Monitoring Services Provided by

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	**Satisfactory**

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

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	**Satisfactory**
3.06 Staffing and Youth Supervision	**Limited**

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

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	**Satisfactory**
4.03 Medications	**Satisfactory**

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 75 %
Percent of indicators rated Limited: 25 %
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

Baldwin Davis - Lead Reviewer, Forefront LLC/Florida Network of Youth and Family Services
Megan Thrasher – Regional Monitor, Department of Juvenile Justice

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the 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		Counselor Non-Licensed	X	Nurse – Part time
	Chief Operating Officer		Advocate	2	# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
X	Program Director		Direct – Part time	1	# Food Service Personnel
X	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	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		Fire Prevention Plan	X	Youth Handbook
X	CCC Reports		Grievance Process/Records		# Health Records
X	Logbooks		Key Control Log		# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	13	# 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	3	# 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
	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
X	Security Video Tapes		Treatment Team Meetings		Meals
	Social Skill Modeling by Staff	X	Youth Movement and Counts	X	Signage that all youth welcome
X	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

8	# of Youth	5	# 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

Youth Crisis Center (YCC) reports that since the last Quality Improvement Review in August 2020, it has seen ups and downs throughout programming, most of which were affected by the hiring crisis and the continued impacts of COVID-19. Despite the aforementioned ups and downs, YCC is proud to report that they did not experience any lapse in services and were able to continue programming throughout the period. Additionally, another major success for the agency was receiving a full reaccreditation from the Council of Accreditation (COA) in October 2021. The agency has also reported their residential program has made some adjustments regarding returning to some post-COVID 19 pandemic normalcy. They have resumed in-person visitation and have also begun to offer in-person family sessions, an integral aspect of clinical services delivered. The agency's current onsite activities, including yoga and art, have resumed in-person sessions after being based on Zoom for the last two years. YCC intends to begin offsite field trips. In addressing staffing needs, the Director of Residential Programs spent a significant amount of time working the third shift due to staff vacancies. That particular staffing void has been filled and the program is waiting for the employee to commence work, pending successful screening results. YCC community counseling program lost several therapists as the new fiscal year of 2021-2022 began. As a result, YCC had a reduction in clients served as all therapists were at capacity; however, they have now built up the team throughout the year and as of May 2022, they are in the hiring process for several positions and reported there is only one vacancy. The agency is preparing and looking forward to serving the Teen Leaders of America summer camp as they have done in years past. YCC camp provides group therapy to about seventy-five (75) campers spanning multiple environments. While the SNAP program is not part of the modified QI Review Process, they reported the SNAP program is operating at a reduced staffing level but noted the impressive teamwork and leadership the team has utilized to continue to have a successful year serving youth and families. Staff members are covering groups and schools across both locations. This year, one staff was promoted to SNAP Program Manager from SNAP Program Supervisor. At this time, 246 groups have been completed this year in St. Johns and Duval counties. Over the past year, the agency increased partnerships across various schools' bachelor's and master's programs including Florida State University, University of North Florida, University of West Florida, and Walden University. They also received several interns from these programs and have utilized them in the residential, community counseling, and SNAP programs. For YCC, the interns have provided them with a great deal of assistance for programming and several have successfully transitioned into employees throughout the year.

Narrative Summary

The overall findings of the QI Review for Youth Crisis Center (YCC) are summarized as follows:

Standard 1: Management Accountability has a total of seven (7) indicators. For the Modified QI Review process, there was a review of three (3) priority indicators; 1.01 - Background Screening, 1.04 - Training, and 1.06 - Transportation. Indicator 1.01 was reviewed in Standard 1 and was rated Satisfactory with exceptions; There was no exception noted for Indicator 1.06 and Indicator 1.04 Training received a Limited rating. See below for an explanation.

Standard 2: Intervention and Case Management has a total of ten (10) indicators. For the Modified Review process, there was a review of one (1) priority indicator, Indicator 2.03 - Case/Service Plan. Indicator 2.03 was rated Satisfactory with no exceptions.

Standard 3: Shelter Care & Special Populations has a total of seven (7) indicators. For the Modified Review process, there was a review of two (2) priority indicators; 3.01 - Shelter Environment and 3.06 Staff and Youth Supervision. One Indicator, 3.01 was rated Satisfactory with an exception and Indicator 3.06 received a Limited rating.

Standard 4: Mental Health and Health Services, has a total of five (5) indicators. For the Modified Review process, there was a review of two (2) priority indicators; Indicator 4.02 - Suicide Prevention and Indicator 4.03 - Medications. Indicator 4.02 was rated Satisfactory and Indicator 4.03 were rated Satisfactory with an exception.

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

Standard 1: Indicator 1.04- Limited - One (1) of three staff files reviewed for first year direct care staff training did not complete the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from the date of hire. Of the three (3) first year direct care staff files reviewed, there were none who had the required 80 hours of training during the initial 90 days of hire. Two of three in service staff were missing required annual DJJ SkillPro trainings and one staff was missing Fire Safety training that is required every two years.

Standard 3: Indicator 3.06- Limited - Due to the significant inconsistencies with bed checks conducted by staff that were reviewed over the 30-day period of recorded video surveillance footage.

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 a Policy, #1.07. It is titled: Background Screening of Employees and Volunteers. The policy was last reviewed by the Chief Executive Officer on July 1, 2021.	
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 utilized an employee suitability prescreening assessment for a total of four (4) of the thirteen (13) new staff who were hired since the last on-site QI review. All four (4) staff met the criteria for a pre-screening assessment. The agency used the Berke Assessment tool at the last QI review but has changed to using the Indeed Employment Assessment Tool since 07/02/2021.	Exception: Eight (8) of the thirteen (13) direct care staff employees did not have the suitability assessment completed.
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				Twelve (12) of the thirteen (13) staff who were hired were background screened prior to hire. One (1) background screening result was still pending when he was employed and that staff had since left the employment of the agency.	Exception: One of thirteen staff had a date of hire prior to the completion of the background screening.This employee never had access to youth during their two week employment status due to completing virtual training offsite.

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
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			There were no employees since the last review period who had a break in service and were reemployed by the agency.	
Five-year re-screening completed every 5 years from initial date of hire	X					There was one staff due for five-year rescreening during the review period and their re-screening completed within the required time frame.	
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 the Annual Affidavit of Compliance with Level 2 Screening via email to the Background Screening Unit on 01/22/2022.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Documentation of approval of E-Verify work eligibility was provided for all 13 thirteen (13) newly hired staff.	
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 a Policy, #1.05. It is titled Staff Training. The policy was last reviewed by the Chief Executive Officer on July 21, 2021.	
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				There were three (3) first year direct care staff files reviewed and two completed the United States Department of Justice (DOJ) Civil Rights& Federal Funds training within 30 days from the date of hire.	Exception: One staff has yet to complete this training and has been employed since November 10, 2021.

All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				There were three (3) first year direct care staff files reviewed and there were none who had the required 80 hours of training during the initial 90 days of hire. Staff had the following number of hours completed respectively; thirty-three, sixteen, and twenty-five.	Exception: Two staff were missing a program orientation, CINS/FINS Core Training, CPR and First Aid, and Fire Safety training. One staff was missing LGTBQ and another missing Human Trafficking for Direct Care Staff training. All three staff were missing Managing Aggressive Behavior, Behavior Management, Information Security Awareness, Equal Employment Opportunity, Trauma-Informed Care, and Cultural Humility training, One staff, although completed Mental Health and Substance Abuse, Child Abuse Reporting, Suicide Awareness Prevention, and Medication Distribution, completed it past the required 90 day time-frame. Another staff also completed Medication Distribution training past the 90 day required timeframe.
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training			X			There were no non-licensed clinical staff that required this training during the review period.	

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			There were no non-licensed clinical staff that required this training during the review period.	
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 (3) in-service employee training files were reviewed. Staff had a total number of hours completed as follows, respectively; twenty six and a half, seventy-nine and a half, and twenty-four and a half.	Exception: Two staff were missing required annual SkillPro trainings to include Human Trafficking for Direct Care Staff, Child Abuse Reporting, and Suicide Awareness Prevention training. One staff was missing Fire Safety training required every two years.
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					The program maintains individual training records for each staff. Documentation contained within included SkillPro and Bridge reports of completed training, training certificates, and sign-in sheets for trainings attended.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: The agency has a policy # 6.02, titled Agency Vehicles. The policy as last reviewed July 1, 2021 by the Chief Executive Officer	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The agency provided a list of approved drivers that was reviewed.	

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					Review of personnel files and insurance policy. Revealed that all staff have a valid Florida driver's license and are covered under the company's insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	X					Agency's Transportation policy was reviewed and prohibits transporting a client without maintaining at least one other passenger in the vehicle during the trip and includes exceptions in the event that a 3rd party is NOT present in the vehicle while transporting,	
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					Reviewed Transportation Authorization Logs. There were a total of seven (7) single client transports over the past six months back to December 2021, all documented supervisor approval prior to transport on the log and in the program log book.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The 3rd party an approved volunteer, intern, agency staff, or other youth, per policy 6.01 as reviewed.	
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					Reviewed Vehicle Logs from December 2021 through to May 2022. All logs documented required information and were filled out in their entirety.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** If NO, explain here: The agency has a policy # 2.08 titled Service Plans and # 2.09 Service Plan Implementation, The policy was last reviewed on July 1, 2021 by the Chief Executive Officer.	

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 (6) case files were reviewed and service plans were completed within seven working days of Needs Assessment in all six records that were reviewed.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	X					Five (5) of the six (6) records reviewed included all elements required by the indicator.	
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					Applicable to all records reviewed. At the time of review, no records were older than three months, however, all records demonstrated reviews every 30 days.	

<table>
<tr><td colspan="6" rowspan="3">Provider has a written policy and procedure that meets the requirement for Indicator 3.01</td><td>YES</td><td rowspan="3"></td></tr>
<tr><td>If NO, explain here:</td></tr>
<tr><td>The agency has policies in place titled 1.03 Licensure Requirements, 3.01 Classification/Room Assignment, 3.02 Program Orientation, 3.03 Daily Programming, 3.05 Youth Hygiene, 3.10 Youth Supervision, 5.01 Nutritionally Balanced Meals, 6.01 Agency Keys, 6.02 Agency Vehicles, 6.03 Comprehensive Safety and Emergency/Disaster Preparedness, 6.04 Facilities Equipment, 6.05 Flammable, Toxic, and Poisonous Control, 6.06 Facility Environment, and 6.08 Weekly Safety and Maintenance Inspections. All policies were last reviewed on July 1, 2020 by the Chief Executive Officer.</td></tr>
<tr><td>Rating Criteria</td><td>Satisfactory</td><td>Non-compliant</td><td>No Eligible Items for Review</td><td>No Practice</td><td>Not Applicable</td><td></td><td></td></tr>
<tr><td>Facility Inspection</td><td>X</td><td></td><td></td><td></td><td></td><td>An on-site tour of the facility revealed furnishings and fixtures were in good repair. The program was observed to be free of insect infestation and the grounds were landscaped and well-maintained. Exterior areas were free of debris and grounds were free of hazards. Dumpster and garbage cans were covered. Bathrooms were clean and functional and no graffiti was observed. Doors are secure with key access as required. Lighting was adequate and egress plans were posted in several locations along with grievance forms, abuse hotline number, and DJJ Incident Reporting numbers.</td><td></td></tr>
<tr><td>Additional Facility Inspection Narrative (if applicable)</td><td colspan="6">Agency vehicles were secure and contained required equipment including fire extinguisher, first aid kit, seat belt cutter-glass breaker, air bag deflator tool, and flashlight. Interior areas did not contain contraband and were free of hazardous items. Chemicals were stored behind locks and inventories and Materials Safety Data Sheets were maintained. All washers and dryers were operational and clean of lint. Current DCF license is current up to 3/21/2023 and is displayed with other agency credentials. Each youth has their own individual clean bed with covered mattress, pillow, and sufficient linens.</td><td></td></tr>
</table>

Fire and Safety Health Hazards	X					Date of fire inspection(s) reviewed: September 14, 2021	
Additional Fire and Safety Health Hazards Narrative (if applicable)	The annual fire inspection was completed on September 14, 2021 and shows that the facility is in compliance with fire safety codes. All fire safety equipment inspections are up to date, including the fire suppression unit, dated May 22, 2022, the sprinkler system dated March 12, 2022 and the fire extinguishers, fire alarm and kitchen overhead extraction hood was last serviced March 4, 2022. At least one fire drill was completed monthly on each shift for the past six months prior to this review. Mock emergency drills were completed at least monthly for the past six months as indicated by the log. Residential Group Care and Food Service inspection was completed on March 7, 2022. Menus were posted and signed by a licensed dietician on January 25, 2022. Cold food is properly stored, marked and labeled as well as dry storage/pantry areas being clean. Refrigerators/freezers are clean and temperatures are maintained for all refrigeration equipment.						Exception: The agency reviews the chemicals inventory monthly when it should be done weekly, at a minimum. They do not have a perpetual inventory that tracks ongoing use of chemicals when it leaves the closet.
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					Observed daily schedule posted and observed shelter activities on virtual tour. The daily schedule reveals that youth are engaged in meaningful, structured activities seven days a week. The schedule also provides for at least one hour of physical activity. Youth are given the opportunity to participate in faith-based activities with nonpunitive activities offered for those who choose not to participate in those activities. Youth are given the time and opportunity to do homework and read. The program has a substantial library with a variety of books for the youth to read.	

Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: The agency has a policy in place titled 3.10 Staffing and Youth Supervision. The policy was last reviewed July 1, 2021 by the Chief Executive Officer.	
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**					Review of the monthly and weekly staff schedules for December 2021 – May 2022 found the required staffing ratios were met for both awake hours and sleeping hours.	
All shifts must always provide a minimum of two staff present	**X**					Log book checks, staffing schedules, interviews and observations confirmed all shifts always provide a minimum of two staff present	
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**					Program staff supervising youth in ration, includes only staff background screened and properly trained youth care workers, supervision staff, and treatment staff.	
The staff schedule is provided to staff or posted in a place visible to staff	**X**					Observed staff schedule as being posted in the main shelter office.	
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**					Residential Contact List was reviewed which documented staff names, phone numbers, and times for on call purposes.	

Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction		X				Staff assisted with the review of eighth (8) random nights of video surveillance which was an hour behind the actual time. Overnight staff is located in the main office from where they go and conduct bed checks to the male and female dorm, this random review taken from the log book yielded the following results: 5/2/2022 at 3:30 a.m. - done 5/25/2022 at 9:50 p.m. – not done 4/28/2022 at 5:00 a.m. – female beds only 4/28/2022 at 4:11 a.m. – bed check completed but not in log book 4/28/2022 at 5:15 a.m. – not done 5/14/2022 at12.04a.m. – female beds only 5/17/2022 at 1:18 a.m. – female beds only 5/17/2022 at 2:13 a.m. – not done	Exception: Due to the following inconsistencies with sample bed checks over the 30 day period of recorded video surveillance footage, the agency has not met this requirement. 5/25/2022 at 9:50 p.m. – not done 4/28/2022 at 5:00 a.m. – female beds only 4/28/2022 at 4:11 a.m. – bed check completed but not in log book 4/28/2022 at 5:15 a.m. – not done 5/14/2022 at12.04a.m. – female beds only 5/17/2022 at 1:18 a.m. – female beds only 5/17/2022 at 2:13 a.m. – not done
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES** If NO, explain here: The agency has policies in place titled 4.03 Mental Health, Substance Abuse, Suicide Risk Screening for Residential Services and 4.05 Mental Health, Substance Abuse, Suicide Risk Screening in Non-Residential programs thru Telehealth Services. The policies were last reviewed on July 1, 2021 by the Chief Executive Officer.	

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					Eight (8) records were reviewed, five (5) open and three (3) closed. All records contained a suicide risk screening completed during intake screening process that was signed by a supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					Reviewed the program's Suicide Risk Assessment tool. It is 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 (3) of the eight (8) youth were placed on sight and sound supervision until assessed by a mental health professional. An Assessment of Suicide Risk (ASR) was completed by a licensed professional or non-licensed professional under the direct supervision of the licensed professional.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Observation logs were reviewed and documented youth were monitored at least every thirty minutes while on sight-an-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					Each youth was removed from sight-and-sound supervision after the ASR was completed by or reviewed with the 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 a Policy 4.06 in place titled Medications. The policy was last reviewed on July 1, 2021 by the Chief Executive Officer	
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					An on-site tour of the Pyxis Med-Station and medical room was completed with the Registered Nurse (RN) on-site. The Pyxis Med-Station is located in the medical room and is inaccessible to youth. All medications are stored in the Pyxis Med-Station 4000 medication cabinet. Oral medications are stored separately in a locked cabinet apart from topical medications; however, at the time of review there were no prescribed oral medications on site. There is a secure refrigerator in the medical room used only for medical purposes and maintained within the required temperature range. At the time of the review, there were no medications on-site requiring refrigeration. All narcotic and controlled medications are stored in the Pyxis Med-Station 4000 medication cabinet.	

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					A virtual tour of the Pyxis Med-Station and medical room was completed with the RN. A list of Super Users was provided, as well as a list of designated staff delineated to have access to the secure medication. Training documents support all applicable staff were trained by the program's medical staff in medication distribution. A review of three youth records supported they took medication while in the program. All records contained a Medication Distribution Log completed as required. All staff trained in the use of epi-pens are posted within the medical room.	

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					At the time of the review, there was one youth currently at intake who is prescribed a controlled substance; however, no other youth on site are taking narcotics or controlled substances. A review of closed files verified through documented Medication Distribution Logs controlled substances were inventoried perpetually and shift-to-shift. Over-the-counter (OTC) medication inventories were reviewed and documented. OTC meds are inventoried perpetually and weekly by the RN. Sharps are inventoried at the end of each shift and an inventory email is distributed to staff. There are no syringes on -site.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.		X				There are no monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	Exception: The RN is not completing monthly reviews of medication management via the Knowledge Portal; however, does conduct a review after any discrepancy. The RN has been advised to begin conducting monthly reports as an additional check and balance per standard and policy.
Medication discrepancies are cleared after each shift.	X					Discrepancy reports confirmed discrepancies are cleared after each shift. There were no open discrepancies at the time of review.	