Florida Network for Youth and Family Services
Compliance Monitoring Report for

CDS – Interface Central
1400 Northwest 29th Road
Gainesville, FL 32605

Compliance Monitoring Services Provided by
FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) on March 16-17, 2022, at for CDS Family and Behavioral Health Services, Inc. – Interface Central for the FY 2021-2022 at its program office located at 1400 Northwest 29th Road, Gainesville, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the Florida Network of Youth and Family Services (FNYFS) to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. CDS Family and Behavioral Health Services is contracted with the FNYFS to perform 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 Keith Carr, Lead Reviewer/Consultant for Forefront LLC, and Renette Crosby, Regional Monitor, Florida Department of Juvenile Justice. Agency representatives in attendance at the Entrance Interview from CDS Family and Behavioral Health Services included Tracy Ously, Interim CEO, Philip N. Kabler, Project Director/Incoming CEO Cassandra McCray-Evans, Regional Coordinator, Zeke Whiter, Residential Supervisor, and Naomi Thompson, Residential Counselor. The last onsite QI visit was conducted April 13-14, 2021.

In general, the Reviewer found that CDS Family and Behavioral Health Services, Inc. – Interface Central is in compliance with specific contract requirements. CDS Family and Behavioral Health Services, Inc. – Interface Central **received an overall compliance rating of 100% for achieving full 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 03-16-17-2022

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 1400 NW 29th Rd., Gainesville, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 16-17, 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 Berkshire Hathaway Specialty Insurance Company for limits of coverage $1,000,000 each occurrence, $1,000,000 personal injury & adv injury, $3,000,000 general aggregate, and $20,000 medical expense, $1,000,000 employee benefits, effective 01/10/22-01/10/23. Workers Comp insurance through Bridgefield Casualty Insurance Company for limits of coverage $500,000 each accident; $500,000 disease employee; $500,000 disease each policy limit. The policy is effective 05/01/21-05/01/23. Automobile liability insurance is provided through Berkshire Hathaway Specialty Insurance Company for	**No recommendation or Corrective Action.**

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	Explain Rating					Ratings Based Upon:	Notes
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						combined limits of liability/property damage for $1,000,000 each and aggregate. $1,000,000 PIP Basic. The policy is effective 01/10/22-01/10/23. Umbrella Liability is provided by Berkshire Hathaway Specialty Insurance Company for $1,000,000 for each occurrence and aggregate. The policy is effective 01/10/22-01/10/23. At the time of this compliance monitoring review, the Florida Network is listed on the Worker's Compensation certificate 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 fourteen topic sections. The procedures reviewed are generally based on GAAP principles. All policies have revision dates from February 2009 through January 2022.	**No recommendation or Corrective Action.**
b. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and	☐	☐	☒	☐	☐	Observation/Documentation:	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**						The agency has not incorporated any change in the method or practice related to petty cash counts and reconciliation since the last site program review in April 13-14, 2021. The review observed the Residential Supervisor conduct a petty cash reconciliation on day 2 March 17, 2022, of all cash on hand in the shelter. The Petty Cash fund does not exceed the established minimum of $250. Petty cash is stored in a secure locked location known by the Residential Supervisor and the Regional Coordinator. Petty cash is reconciled on a consistent basis (monthly/quarterly) by designated Residential Supervisor and reviewed by the Regional Coordinator. Disbursements and invoices are approved by the Residential Supervisor and Regional Coordinator.	
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 – At the time of this onsite compliance monitoring site visit, the agency reported that they have not purchased any property inventory items with Florida Network funds.	**No recommendation or Corrective Action.**

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	Explain Rating					Ratings Based Upon:	Notes
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
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 $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

CDS Family and Behavioral Health Services, Inc. – Interface Central has met the requirements for the CINS/FINS contract as a result of full compliance with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. One of the five indicators was not applicable because the provider does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is100% percentage.** 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 majority of 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 compliance monitoring eview.

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 CDS Family & Behavioral Health Services, Inc. - Interface Central
CINS/FINS Program

DATE: March 16-17, 2022

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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
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

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: 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

Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Renette Crosby – Regional Monitor, Department of Juvenile Justice

Methodology

This modified review was conducted in accordance with FDJJ-1720 (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		Case Manager		Nurse – Full time
	Chief Financial Officer	X	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
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer	3	# Other (listed by title): Life Skills Coordinator, 2 Youth
X	Counselor Licensed		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	X	Grievance Process/Records	4	# Health Records
X	Logbooks		Key Control Log	4	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log		# Personnel /Volunteer Records
	Contract Monitoring Reports	X	Medical and Mental Health Alerts	7	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	9	# 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
	Recreation	X	Toxic Item Inventory & Storage	X	First Aid Kit(s)
X	Searches		Discharge		Group
X	Security Video Tapes		Treatment Team Meetings	X	Meals
	Social Skill Modeling by Staff		Youth Movement and Counts	X	Signage that all youth welcome
X	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

3	# of Youth	10	# of Direct Staff		# of Other

Comments

This modified review was conducted **on-site**.

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

CDS Family and Behavioral Health Services, Inc. – Interface Central operates three emergency youth/crisis shelters in the State of Florida that are contracted with Florida Network of Youth & Family Services, Inc. (FNYFS). Interface Youth Program-Central is located in Gainesville, Interface Youth Program-East is located in Palatka, and Interface Youth Program-Northwest is located in Lake City.
The CDS Central location contracts to provide Children In Need of Services and Families In Need of Services (CINS/FINS) as an organization specifically to provide CINS/FINS services in Circuit 3: which encompasses Columbia, Dixie, Hamilton, Lafayette, Suwannee; Circuit 7: Flagler, Putnam, St. Johns, Volusia; and Circuit 8: Alachua, Baker, Bradford, Gilchrist, Levy, and Union Counties. The IYP-Central location's shelter is licensed for twenty beds and offers 24- hour availability, youth supervision, food and clothing, life skills education, crisis counseling, individual and family counseling, recreation and leisure activities, and case management services.

Youth are provided educational services at their home schools and transportation is arranged and provided by CDS. CDS provides Community Counseling or non-residential counseling services in the aforementioned service regions. The services provided under the CINS/FINS contract with the FNYFS allow the agency to serve all eligible youth ten to seventeen years old that are runaway, ungovernable and/or truant, locked out, homeless, abused, neglected, or possess other at-risk factors. The agency also provides specialized services to eligible youth with other profiles such as Staff Secure shelter, Domestic Minor Sex Trafficking, Domestic Violence, Probation Respite, and Family/Youth Respite Aftercare Services (FYRAC). The youth census during the onsite QI program review visit was four CINS/FINS youth. The CDS organization is currently accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

Since the last QI visit, the program has had a new leadership team. The agency is currently led by Tracy Ousley, Interim CEO of the organization. Mrs. Ousley oversees all of the agency's Residential and Non-Residential services and programming. The agency has recently hired Phillip Kabler as its new CEO. Mr. Kabler will be starting in his new role in the coming months. The agency's CDS-Interface Youth Program – Central location is located in Gainesville, Florida and is led by Cassandra Evan-McCray, Regional Director. The CDS IYP-Central residential team consists of one residential supervisor, two residential counselors, one life skills educator, six full-time youth care workers, five PRN staff, one .63 staff member and four halftime staff members, one administrative assistant, a halftime house manager, and a halftime cook. The non-residential team consists of one director, two full-time counselors/case managers, two vacant positions, one SNAP supervisor, one SNAP case manager, six halftime SNAP facilitators, and one SNAP school-based lead. The agency also utilized the services of twenty-five volunteers that have been background screened by DJJ. These volunteers participate in the program providing services from June 2021 to present in approved roles by the regional director. The volunteer program has been reinstated since it was interrupted due to the Pandemic in 2020.

The past year and a half has been challenging for the CDS organization as they have had to deal with instability in staffing and constant hiring of staff to fill vacant positions. This instability has resulted in staffing issues due to significant turnover. At the time of this onsite program review, the Non-Residential Family Action Central has two -1.0 FTE Counselor/Case Managers and one -1.0 FTE Administrative Assistant vacancies. The Residential IYP-Central program has 6.46 FTE Youth Care Worker vacancies.
The agency's Interim CEO advised that the agency has been assertively advertising, promoting, and recruiting to fill all open job vacancies. As of the date of this QI program review visit, the agency did report that they have been able to fill positions to address last year's staffing vacancies where the agency had to decide to close the shelter on some weekends due to a lack of staff to cover all weekend work shifts. The agency is also planning to increase its youth care salaries prior to July 1, 2022, to address staff recruitment challenges and retention efforts.

Narrative Summary

The overall findings for this Modified QI Review for CDS Family and Behavioral Health Services, Inc.– Interface Central are summarized as follows:

Standard 1: This standard has a total of three indicators regarding management accountability. Two of the three indicators were rated Satisfactory. Indicator 1.04 Training Requirements was rated Limited. The reasons the agency received this rating for the Limited rating are listed below. Apart from indicator 1.04, all other indicators in this standard were rated Satisfactory with no exceptions.

Standard 2: This standard has a total of one indicator that addresses the agency's adherence to intervention and case management. The indicator 2.03 Case/Service Planning was rated Satisfactory with no exceptions.

Standard 3: This standard has a total of two indicators regarding shelter care. One indicator was rated Satisfactory and one was rated Limited. Indicator 3.01 Shelter Care was rated Satisfactory. Indicator 3.06 Staffing and Supervision was rated a Limited. The basis for this Limited rating is listed below.

Standard 4: This standard has a total of two indicators regarding mental health and health services. Both indicators were rated Satisfactory with no exceptions noted.

Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable):
Standard 1: Indicator 1.04 Training Requirements was rated a Limited due to new hire staff did not complete pre-service required trainings within the first 90 days of employment and staff did not complete their in-service annual training requirements within the required timeframes.

Standard 3: Indicator 3.06 Staffing and Supervision was rated a limited due to the program not being sufficiently staffed to be able to operate seven days a week as required and staff making three falsified bed check entries in the agency logbook. The program reported that they have not been closing on Saturdays and/or furloughing any youth who were at the program that day. However, the agency has reported that staffing full time on the overnight shift has been challenging to ensure that the program is able to cover this work shift. The agency has had to have staff work overtime, additional shifts, and has had to use staff holdover over from the previous shifts to cover.

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)		**Notes** Explain any items that have any deficiencies, exceptions or are not applicable. For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below E.g. 2 out 4 files reviewed were missing the completed needs assessment
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: Indicate policy number, authorized signee, date(s) of last review/revision/approval: P-1025/Tracey Ousley/2/22/22	**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**					Seven out of seven files reviewed included a passing rate on Hire Select the agency's suitability prescreening assessment.	
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	**X**					Seven out of seven files included documentation a background screening was completed prior to hire/start date.	

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			Seven files were reviewed and none of the seven required an additional suitability assessment or background screening due to a break in service.	
Five-year re-screening completed every 5 years from initial date of hire			X			Seven files were reviewed and none of the seven required a five year rescreening.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					The Annual Affidavit of Compliance was completed and submitted to the BSU on January 10, 2022.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Seven of seven files reviewed included documentation of E-Verify for new employee.	
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: Indicate policy number, authorized signee, date(s) of last review/revision/approval: P-1030 Training Policy, Tracey Ousley, 1/19/2022	**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				Four pre-service staff files were reviewed. Two out of four staff demonstrated completion the training was completed within 30 days of hire.	Exception: Two out of four did not have the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days of hire.

All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				Three of four staff completed the following program orientation, Managing Aggressive Behavior, CINS/FINS core training, signs and symptoms of mental health and substance abuse. Two of four staff completed trainings; Florida Network Suicide Prevention, Behavior Management, Understanding Youth Development, and Child Abuse Reporting. Three staff demonstrated evidence of CPR/First Aid, and two staff showed evidence of Universal Precautions. Four staff training files were reviewed for required SkillPro training. Two staff completed Child Recognition, Reporting, and Prevention. One staff completed Information Security Awareness, Serving LGBTQ and Trauma Informed Care, two staff completed Equal Opportunity Employment, Human Trafficking, and In Service Component trainings. Three staff completed PREA, Sexual Harassment, Suicide Prevention 1, Suicide Prevention 2, Fire Safety, Medication Distribution and Cultural Humility trainings as required.	Exception: One of four staff missing program orientation, Managing Aggressive Behavior, CINS/FINS core training, signs and symptoms of mental health and substance abuse. Two of four staff were missing Florida Network Suicide Prevention, Behavior Management, Understanding Youth Development, and Child Abuse Reporting. One staff out of four was missing CPR/First Aid, and two staff missing Universal Precautions. Four staff training files were reviewed for required SkillPro training. Two staff were missing Child Recognition, Reporting, and Prevention, three staff were missing Information Security Awareness, Serving LGBTQ, and Trauma-Informed Care, two staff were missing Equal Opportunity Employment, Human Trafficking, and In-Service Component one staff was missing Prison Rape Elimination, Sexual Harassment, Suicide Prevention 1, Suicide Prevention 2, Fire Safety, Medication Distribution, and Cultural Humility.
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			The agency had no non-licensed clinical shelter staff in first year of employment.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).			X			The agency had no non-licensed clinical shelter staff in first year of employment.	

In-Service Direct Care Staff							
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*		X				Three in service staff files reviewed, one of three had the required twenty-four hours of mandatory refresher Florida Network, SkillPro, and job related training annually.	Exceptions: Two staff missing Suicide Prevention SkillPro, two staff missing Florida Network Youth Suicide Prevention, two staff missing Managing Aggressive Behavior, two staff missing Fire Safety Equipment, one staff missing Prison Rape Elimination, one staff missing Sexual Harassment, two staff missing Human Trafficking, and one staff missing Child Abuse Recognition, Prevention and Reporting.
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 agency maintains an individual training file for each staff. Seven files were reviewed, three in-service and four pre-service.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: Indicate policy number, authorized signee, date(s) of last review/revision/approval: P-1013 Vehicle Use and Safety Inspection Policy, Tracey Ousley, 1/19/2022	**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 has procedures that identify qualified drivers and distinguishes them as acceptable and eliminates unacceptable drivers. The agency utilizes a list of all staff and clients that are approved for single driver and passenger transportation events.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					The agency has a procedure in place that required that qualified drivers possess a valid Florida driver's license and adequate automobile insurance. The CDS agency also covers all drivers under its commercial insurance.	
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 has a comprehensive transportation policy that prohibits transport of a client without a minimum of one additional passenger in the vehicle during the transport event. The agency does have an exception procedure in the event that a third party is not available. The third party may be a an approved volunteer, intern, agency staff member or other qualified participant.	

In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	X					The agency utilizes a process for addressing the scenario when a third party is not available. The agency utilizes a Transportation Exceptions Approval Log for Single/Third Party transportation events. This log documents that clients have had their history, evaluation, and recent behavior evaluated by the agency in order to be approved for transportation exception. The agency also evaluates the drivers to be approved to be able to conduct single driver and single transport events. The agency utilizes a binder called a single third party transportation exceptions approval binder. A review of this binder found that it contains records of the weekly prior approval of the staff approved and the youth approved for single party transport. The agency determines the resident's status by conducting a review of their behavior, history and other factors for them to be pre-approved for single transport if needed. A review of the logbook indicated that there was one single client transport event on March 4, 2022 that did have a third party in the transport vehicle. The staff did however request prior approval prior to the pick up event. An interview was conducted with the CDS-NW Regional Director on day 2 on March 17, 2022. The Regional Director confirmed that there was not a third party in the vehicle, but the staff did obtain prior approval from the supervisor. This request for approval for a single transport event was documented on in the program logbook on page 64 on March 4, 2022.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The agency policy is designed to have a third party present in the transportation vehicle while transporting a client. The third party may be a an approved volunteer, intern, agency staff member or other qualified participant.	
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's vehicle transportation policy requires that the approved driver documents their name, date, time, mileage, passengers and destination. An inspection of the agency driver's log found that the log had evidence of up to date information related to all transportation events dating back to September 2021 to present.	

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: Indicate policy number, authorized signee, date(s) of last review/revision/approval: P-1162 Individual Plan Policy, Tracey Ousley, 02/2022.	**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					A review of the agency's current practice related to case and service planning was conducted. The agency reported that the NIRVANA assessment tool was fully implemented across the entire agency on January 1, 2022.	
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)	X					A review of the agency's current practice related to case and service planning was conducted. A total of nine client files were reviewed onsite for the QI program review. Of these files six were residential and three were non-residential client files. One of the six residential client files were open. Two of the three non-residential client files were open cases. Five out of nine client files reviewed were opened before January 1, 2022. The four files opened after January 1, 2022 had evidence of completed NIRVANA Assessments. The five remaining files are closed files and have evidence of original needs assessments for each file. The nine files contain evidence of service/treatment plans that contain goals that are based on the presenting problems and risks identified during the screening, intake and assessment process. Of the six residential files, two did not have evidence of completed goals. This was due to both clients being discharged early. One client was discharged due to being disruptive and potentially harmful to residents and staff and the other client was exhibiting signs of self-harm acts. Two of the six residential files did not have evidence of completed target and completion dates for goals. In both of these case reviews were conducted via verbal review due to one child being arrested and the other not coming able to review meet in person. Of the three nonresidential files, all files contained completed service plans that were completed as required. All three non-residential client files include evidence of services plans with goals associated with presenting problems from the screening and risks identified during the intake and assessment. The service plans include the type of service, frequency or intervals per week or month, and target, as well as applicable completion dates. Evidence of signatures on the service plans were found in these non-residential client files. However, only one of the two goals were documented as being completed. The second goal was not documented as completed because the client in the case file voluntarily withdrew from	

5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated						the program on 1/24/22. The parent signatures on this case plan review did not have evidence in the second service plan review sessions. However, the counselor requested that the parent sign the plan review. The parent stated that they would complete the signature, but did not complete it. Verbal reviews were conducted, but the parent failed to follow through to provide the signature.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	X					One of the residential files is missing evidence of 30-day reviews. One of the non-residential client files is missing evidence of the youth and parent signature verifying review on two consecutive 30-day plan reviews. However, the counselor requested that parent sign plan review. Parent stated that they would complete the signature but did not complete. Verbal reviews conducted, but parent fails to follow through to get the signature.	
Standard Three – Shelter Care							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: Indicate policy number, authorized signee, date(s) of last review/revision/approval: P-1293 Shelter Environment Policy, Tracey Ousley, 03/2021.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection	X					Date of facility inspection(s) reviewed: 1/26/22 for the residential group care inspection report and the department of health was last completed on 1/22/22 and both were deemed satisfactory. A full tour of the facility was conducted to determine the agency's adherence to the shelter environment requirements. The tour of the facility found that in general, the agency had minimal findings that resulted in the agency having a generally neat, sanitary, and organized shelter facility.	(As Applicable) List any items that were non-compliant and need to be addressed:

Additional Facility Inspection Narrative (if applicable)	A shelter facility tour that included an inspection was conducted. The agency's facility is located in the city of Gainesville adjacent to the University of Florida. The facility is secluded by trees and is a one-story facility with multiple rooms that include sleeping dorm rooms, rooms for both the girls and boys, several administrative offices, a kitchen, dining area, several smaller multipurpose rooms, and an outside area with limited space for recreation. The agency's facility is an older building and the agency has an active capital campaign that is currently raising funds to construct a new shelter facility in the near future. Agency is generally conducting fire and emergency mock drills as required. The agency had its Pyxis machine upgraded by BD CareFusion staff in June 2021. The agency also has had COVID-19 Protocols in place since the Spring of 2020. The agency also added a clear plastic 1/2 inch barrier on all bottom bunk beds in all sleeping areas to promote social distancing. The agency has also upgraded their camera system. The camera system is comprised of 18 digital cameras that have 60-day back up recording capability.						
Fire and Safety Health Hazards		**X**				The agency's annual fire inspection was completed on 3/7/2022 by the Gainesville Fire Rescue - Risk Reduction Bureau. Fire drills are documented in a Emergency Plans and Disaster Drills on 3/9/22, 2/25/22, 2/28/22 (2), 1/13/22, 1/24/22, 1/26/22, 12/9/21, 12/15/21, 11/8/21, 10/15/21, 10/28/21, 10/23/21, 9/2/21, 9/24/21, 9/30/21.	Exception: The agency is not documenting the time with a pm or am time reference on several fire drill log for completed drills. The months of December, November did not have evidence that 3 drills per month were completed. Agency mock drill conducted on the first/day shift in December 2021 did not document the date that the drill was conducted. A review of the chemical items and storage practices revealed that all chemicals stored did not have all material Safety Data Sheets associated with chemicals stored and used onsite.
Additional Fire and Safety Health Hazards Narrative (if applicable)	Evidence of inspections of additional fire safety equipment included all fire extinguishers were inspected and expires June 2022; kitchen overhead hood suppression system expires September 2022. These inspections were conducted by Alachua Fire Extinguisher Company.						

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 agency has a structured activities schedule. The schedule is posted at the entrance to the shelter facility on a bulletin board with other important program-related information and in each day room. The daily schedule list all activities from the time that program residents wake up to prepare for school; eating breakfast; transport to school; leisure and recreation; education services including counseling for individuals and group sessions. The schedule also includes social time and life skills training. The schedule also lists time for school work to be completed doing homework sessions for help with school-related information as needed. The schedule includes a seven-day week listing of structured activities. This schedule includes weekend activities and youth are also offered the opportunity to participate in religious and faith-based activities. During the onsite review, the reviewer spoke with two youths one youth in the girls' day room and another youth in the kitchen eating area. One youth reported that they felt safe, they were fed well and/or able to attend school and contact their parent. The youth mentioned that they were working on 2 to 3 goals with their counselor that they could remember and that they were having no problems during the shelter stay.	

Provider has a written policy and procedure that meets the requirement for Indicator 3.06						YES If NO, explain here: Indicate policy number, authorized signee, date(s) of last review/revision/approval: P-1121 Supervision and Staffing Ratio/Scheduling, last revised Feb 2022 by Tracey Ousley	Add any exceptions below:
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					A review of the schedule over the last 6 months was conducted onsite during the review. The program maintains minimum staffing ratios as required by Florida Administrative Code.	
All shifts must always provide a minimum of two staff present		X				The agency schedule was reviewed onsite. There were some inconsistencies in staffing on the schedule over the last 6 months. The agency has some inconsistencies in staffing on the overnight in terms of staffing per contract requirements to maintain 2 staff members on the overnight schedule.	Exception: There are 5 weeks observed on the schedule that do not display that there were a minimum of 2 staff present on the overnight work shift for the following weeks:2/13/22-2/19/22; 2/22/22-2/17/22; 1/30/22-2/5/22; 12/19/21-12/25/21; and 11/21/21-11/27/21.
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				All staff on duty are required to be screened according the DJJ and CDS standards prior to being hired. All staff on the schedule for the last 6 months have been screened per the agency's policy.	Exception: Some staff members on duty have not met the training requirements for the first year and some annual staff members do not have the required ongoing training requirements as listed in the training indicator.
The staff schedule is provided to staff or posted in a place visible to staff	X					Staff schedule is posted in the main youth work station located in the middle of the facility.	

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					The agency's schedule was reviewed onsite. The schedule includes staff assigned across all shifts. The agency also has a holdover process in place so that all staff on duty are required to stay on duty until relieved by the oncoming staff person. There are also contact numbers for all staff which is available to all staff members to allow staff to reach out to other staff members when needed to advise them that they are late coming on shift or to arrange work shift changes as needed.	
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				The physical layout of sleeping arrangements: The shelter facility has separate dorm sleeping areas for girls and boys. The dorms each houses 4-5 bunk beds in each dorm. The facility also has 2 separate day rooms. There is one day room for girls and one for boys. Staff are conducting overnight bed checks on the night shift. A random sample of rooms were selected to determine the agency's adherence to the standard. Camera backup feature on the girls side was not operating at the time of this onsite program review, however, the program made a service repair request at the time of the review. The camera repair company was able to go onsite on March 24, 2022 to check viewing playback feature and confirmed it is operational for all locations.	Exception: There were observed inconsistencies in documentation of bed checks on the overnight shift. Staff member on the overnight shift documented 3 bed checks that were not conducted when the reviewer cross-checked the onsite video camera.
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: Indicate policy number, authorized signee, date(s) of last review/revision/approval: P-1247 Suicide Assessment, Tracey Ousley, 2/22/2022	**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					Three closed and one open youth files were reviewed for suicide risk screening. All four records included documentation of suicide risk screening at initial intake. All four included a signature of review by the supervisor in the youth's case file.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The suicide risk assessment has been 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					Four youth files were reviewed for youth with suicide risk. One youth files was applicable and documentation included youth was placed on appropriate level of supervisor based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					The one applicable youth file included documentation a staff was assigned to monitor the youth's behavior. An observation log was present in the youth's file to include time, behavior and initials of the staff monitoring.	
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					The one applicable youth file included documentation that the supervision level was not changed until a licensed professional completed further assessment.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES** If NO, explain here: Indicate policy number, authorized signee, date(s) of last review/revision/approval: P-1120, Tracey Ousley, 1/19/22	**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 had no youth on medication during the annual compliance review. The Pyxis Med-Station 4000 Medication Cabinet is secured behind a locked door inaccessible to youth. The Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management. No youth were on oral medications during the annual compliance review. The program had no narcotics or controlled medications stored in the Med-Station during the annual compliance review. The Pyxis keys are accessible to staff in the event they need to access medication if there is a Pyxis malfunction.	

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 has two staff and a nurse trained as Super Users for the Med-Station. Only the designated Super Users have access to secured medications, and limited access to controlled substances. A medication distribution log is utilized when the agency has youth on medication for distribution of medication by non-licensed and licensed staff. The agency verifies medication using one of four methods listed in the FNYFS Operations Manual when youth are on medication.	
Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly			X			The agency has no youth on medication during the annual review.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					The agency has monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	
Medication discrepancies are cleared after each shift.			X			No youth on medication during annual compliance review.	