Florida Network for Youth and Family Services
Compliance Monitoring Report for

Family Resources - Clearwater
1615 Union Street
Clearwater, FL 33755

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 Family Resources - Clearwater for the FY 2021-2022 at its program office located at 1615 Union Street Clearwater, FL 33755. 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. Family Resources - Clearwater is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 1, 2021 through June 30, 2022.

The review was conducted by Baldwin Davis, Consultant for Forefront LLC, and Peer Reviewer Kara Brown, Department of Juvenile Justice Quality, Improvement Regional Monitor. Agency representatives from Family Resources - Clearwater present for the entrance interview were Andrew Coble, Chief Operations Officer, Kelli Yeazell, Director of Community Programs, Scott Brown, Director of Client Success, Amaoge Acholonu, Director of Client Success and Jarma Morgan, Residential Supervisor. The last QI visit was conducted January 20-21, 2021.

In general, the Reviewer found that Family Resources - Clearwater is in compliance with specific contract requirements. Family Resources - Clearwater received an overall compliance rating of one hundred percent (100%) for achieving 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 03-16-2021-2022

Agency Name: Family Resource Clearwater	**Monitor Name: Baldwin Davis, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 1615 Union Street, Clearwater FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 16-17, 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**	☐	☐	☒	X☐	☐	Documentation: General Liability through Alliance of Nonprofits for Insurance for limits of coverage $1,000,000 each $3,000,000 aggregate, and $20,000 medical expense, effective 6/30/21-6/30/22. Workers Comp insurance through Benchmark Insurance for limits of coverage $2,000,000 each accident, effective 6/1/2021 – 6/1/2022. Automobile insurance through Alliance of Nonprofits for Insurance for combined limits of liability/property damage for $1,000,000 each and aggregate. Policy effective for 6/01/2021-6/01/2022. Professional Liability Claims insurance through Alliance of Nonprofits for Insurance for limits of coverage $1,000,000 each/$2,000,000 aggregate effective 6/01/2021-6/01/2022.	**No recommendation or Corrective Action.**

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						Florida Network is listed on the general insurance summary 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**	☐	☐	X☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in the Financial Services Policy and Procedures Manual. The manual is divided into eight sections with subsections in each one. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. All policies have a revision date of November 2021.	**No recommendation or Corrective Action.**
b. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	x☒	☐	☐	Observation/Documentation: No change in practice was reported for the agency since the last site program review in January 2021. Reviewed petty cash Policy and Procedure FS0305. The Petty Cash fund does not exceed the established minimum of $150. Petty cash is stored in a secure locked location in the shelter. Petty cash was observed as being reconciled by Shelter Supervisor and which was correct. Disbursements and invoices are approved by the Program Supervisor as required.	**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.	☐	☐	OBJ☒	☐	X☐	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site January 2021..	**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		
In the event the provider has purchased computer 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**	☐	☐	X☒	☐	☐	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

Family Resources Clearwater 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 states they do not have any current inventory purchased with DJJ/FN Funds. Consequently, the overall compliance rate for this contract monitoring visit is 100% percentage**.** There are no corrective actions cited and no recommendation is made because 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 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 responsibility. 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 Family Resources South - Clearwater
CINS/FINS Program

DATE: March 16-17, 2022

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	Limited
2.04 Case Management & Service Delivery	Not Applicable

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

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory

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

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 66.67 %
Percent of indicators rated Limited: 33.33 %
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 Consultant-Forefront LLC/Florida Network of Youth and Family Services
Kara Brown – 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

	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed	X	Nurse – Part time
	Chief Operating Officer		Advocate		# Case Managers
	Executive Director		Direct – Care Full time	1	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
X	Program Coordinator		Intern		# Maintenance Personnel
X	Clinical Director		Volunteer		# Other (listed by title): ___
	Counselor Licensed		Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports		Grievance Process/Records	4	# Health Records
X	Logbooks		Key Control Log	4	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	5	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	6	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	2	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Surveys

6	# of Youth	8	# of Direct Staff		# of Other		

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
	Security Video Tapes		Treatment Team Meetings		Meals
	Social Skill Modeling by Staff		Youth Movement and Counts	X	Signage that all youth welcome
	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Comments

Due to COVID-19, this 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

Since the last Quality Improvement Program Review (QI) in January 2021, the agency took the opportunity to restructure its leadership team. Andy Coble, who was previously the VP of Community Services, was promoted to Chief Operations Officer in July 2021. Nicole Leslie was previously the VP of Residential Services and was promoted to VP of Impact, which oversees quality assurance for the agency, in July 2021.
The agency shifted from 'Community Supervisors' to 'Directors of Client Success', adding four positions with three of the four Directors overseeing both the counseling programs and the clinical staff and clinical components of the shelter. The current Director of Client Success, joined the agency in October 2021 and another staff was promoted from SNAP supervisor to Director of Client Success for our community-based programs in December 2021.
Family Resources Inc. has also experienced unusual staff turnover, like so many organizations throughout the state, significantly Covid 19 related. Changes in the last year included a new Shelter Supervisor who was promoted to that position after being a YDS for more than eight (8) years. A new shelter Counselor joined the team in September 2021. While there are many new staff on the YDS team, they continue to recruit additional staff until all positions are filled, they currently have three positions to be filled.
Community Counseling currently accommodates telehealth and in-person counseling sessions, based on family requests/needs. The program continues to conduct outreach in the community and working with partners to establish and maintain referral relationships.
The agency's SNAP program was chosen by the Florida Network to pilot the SNAP for Youth Program for youth ages 12-17 and our team recently completed required training. The team are currently implementing this pilot.
SafePlace2B-Shelter, in October 2021 the agency was awarded a 3-year Basic Center Grant from the Department of Health and Human Services. This funding allows the agency to enhance the services it provides through additional specialized shelter staff training, including youth engagement that enhances services to runaway and homeless youth as required by that federal grant.
The agency is in the process of making improvements to its facility's security and is currently installing security-controlled locks on all their internal and external doors.

Narrative Summary

Family Resources, Inc. is managed by the Chief Executive Officer whom oversees, the Chief Operations Officer and the Vice President of Impact, two newly created positions. Family Resources Clearwater provides residential and non-residential counseling and case management services across a single Pinellas County, which is located within DJJ Circuit 6. Day-to-day activities at Family Resources Clearwater youth shelter, are managed by a Shelter Supervisor. The community counseling program is managed by the Director of Client Success.

8 staff surveys were completed for this review. For question, "In the past year, how have the working conditions been in your program?" 1 residential staff reported 'good' working conditions, 1 staff reported 'fair' and another staff stated 'poor'. 1 staff stated they have worked at the agency less than a year. With regards to the shelter environment, one respondent said "yes" to hearing staff use profanity when speaking to a youth and "yes" to observed a co-worker using threats, intimidation, or humiliation when interacting with the youth. There were 6 youth surveys completed and all 6 gave favorable feedback. All 6 youth surveys denied hearing adults use curse words and felt adults were respectful when speaking to youth. Additionally one respondent stated, " There is a lack of communication within shelter as well as little follow through with any issues or concerns staff relays to supervisors". There was no unfavorable feedback noted for non-res staff survey results.

The overall findings for the QI Review for the agency are summarized as follows:
Standard 1
Three indicators were reviewed for this standard. One of the three indicators of standards 1, 1.01 was rated satisfactory and indicators 1.04 and 1.06 was rated limited.

Standard 2
Only one indicator was reviewed for standard 2. Indicator 2.03 was rated as limited. Exceptions were noted for missing service plans and two of three community cases reviewed did not have 30-day reviews completed.

Standard 3
Two indicators were reviewed for standard 3, indicators 3.01 and 3.06. Indicator 3.01 was rated satisfactory with no exceptions; however, there was a exception noted for indicator 3.06 that were observed during the facility tour as follows: A review of staff schedules revealed a significant number of single staff cover over a six-month period going back to October 2021.

Standard 4
There are two indicators that are reviewed for standard 4, 4.02 and 4.03. Indicator 4.02 was rated satisfactory with no exceptions. However, indicator 4.03 was rated satisfactory with an exception as the agency does not conduct monthly reviews of medication management practices but reports that they do check for med errors on a weekly basis.

Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable):
Standard 1:
Indicator 1.04 - Limited
Indicator 1.04 indicated that one of three staff missed completing the required DJJ Civil rights training within 30 days; additionally all three staff did not complete all their mandatory training within the 90-day period of hire.

Indicator 1.06 – Limited
Indicator 1.06 revealed inconsistency in practice of one-on-one transportation of youth that indicated no supervisor authorization during the six month period of reviewed documentation.
Reviewing the agency log book was reviewed with shelter supervisor for single transport it was noted that supervisor approval was not given in all five randomly chosen instances of single youth transportation on 02/14/22; 2/22/22; 1/24/22; 1/25/22; 12/ 28/21.

Standard 2:
Indicator 2.03 – Limited

Two of the five records reviewed did not include service plans; where 30 day service plan reviews were required for two community counseling cases, they were not completed.

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* *E.g. 4 out of 4 files reviewed contained "....." or 2 out of 4 files had a completed needs assessment.*	**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: The agency has a policy in place titled 1.01 Background of Employees and Volunteers. The policy was last reviewed in January 2022 by the Chief Operations Officer.	**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**					A total of ten new staff were hired since the last onsite QI review. All ten staff met the criteria for a pre screening assessment. The agency uses the Berke Assessment Tool and completed the screening prior to hire for the ten staff reviewed. One of the ten staff had a low score on the Berke Assessment, however the agency provided documentation via email communication between HR and COO regarding explanation as to why the staff was hired with the low score.	
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**					The agency had a total of ten new staff members who were hired since the last on-site QI review. All ten staff were background screened prior to hire. There were no volunteers, interns, or contractors used since the last QI review.	

Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.			X			Agency has no evidence of any employees who have had a break in service and who are in good standing and reemployed with the agency without an additional suitability assessment or background screening if the break is less than 90 days.	
Five-year re-screening completed every 5 years from initial date of hire	X					The agency had five staff presented for review who were eligible for five years rescreen based on their hire date. One staff rescreen was not applicable to be reviewed based on the date listed for the retained prints expiration date.	
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 presented a completed form of the Annual Affidavit of Compliance with Level 2 Screening which was sent via email to the Background Screening Unit on the date 01/10/2022. Confirmation email to CEO from BGSU confirmed receipt 1/11/2022.	
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 ten new staff hired.	

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 in place titled 1.04 Training Requirements. The policy was last reviewed in January 2022 by the Chief Operations Officer.	**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				There were a total of three staff files that were reviewed to capture 90 days of hire training as required. All staff were hired before January 1st and two of these staff had the DOJ Civil Rights and Federal Funds training completed within 30 days of hire.	Exception: One of the three staff did not complete the DJJ Civil Rights training within 30 days of hire.
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				There were three staff training files reviewed for the 90 day training requirements. While staff completed some training, all three staff did not document as having all the required training completed within the required 90 days. Training completed by all three staff included CINS/FINS Core; Sign and Symptoms of MHSA; Child Abuse Reporting; CPR; First Aid; Universal Precautions; (Skills Pro - Child Abuse; Information Security; EEO; PREA; Sexual Harassment; TIC; Human Trafficking) Fire Safety; In-Service component and Cultural Humility.	Exception: One staff did not complete DJJ Civil Rights, Youth Dev., MI, PAT, Confidentiality, Serving LGBTQ. Other staff did not complete Suicide Prevention, Confidentiality, Medication Distribution, Serving LGBTQ and the third staff did not complete Medication Distribution, Nirvana, BM, Youth Development, and Program Orientation. Two of three staff reviewed completed training outside of 90 day requirement.
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							

Non-licensed mental health clinical shelter staff did complete the Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training		X				There were two non-license clinical staff files that were reviewed. Only one staff completed the non-licensed assessment.	Exception: One staff did not complete the Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training.
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	X					One of the two non-license clinical staff training files was reviewed and it was documented that the staff completed the non-licensed assessments.	
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 were reviewed for this training requirement. One staff did not complete all the required annual training but still two months with which to have these completed.	
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					All training files reviewed contained a spreadsheet documenting all trainings, date completed, and hours. Also, training files included related documentation such as training certificates, sign-in sheets, and training worksheets, these were not tracked and tabulated to indicate the hours of training completed.	
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 in place titled 1.06 Agency Vehicle. The policy was last reviewed September 21 by the Chief Operations Officer.	**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 program provided a list of staff approved to transport youth.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					There was documentation provided to show that all drivers had a valid Florida driver's license and are covered under the agency'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					The agency's policy prohibits transporting a youth without another passenger in the vehicle. There are provisions in place in case a 3rd party is not present in the vehicle. The policy notes they can have an open call system which is where 1:1 transport is conducted, the driver will call the on-site staff and leave the phone open for the duration of the journey.	
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 has policy that covers 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. However, reviewing the agency log book for single transport with the shelter supervisor it was noted that supervisor approval was not given in all randomly selected instances. Staff reported that there is an informal system in place to use open call which must be documented in log book but that was also not documented.	Exception: Reviewing agency log book for single transport it was noted with the help of the shelter supervisor that supervisor approval was not given in all randomly chosen instances over the past six months. The randomly selected dates reviewed for these single transports were on 02/14/22; 2/22/22; 1/24/22; 1/25/22; 12/ 28/21
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The 3rd party presence on transports, reviewed for the last six months, was either an agency staff member or another youth.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	X					Transportation Logs were reviewed for the last six months and documented the date, time, mileage, number of passengers, destination and drivers' initials. All Transportation Logs were filled out completely.	
Standard Two – Intervention and Case Management							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** If NO, explain here: The agency has a policy in place titled 2.03 Case/Service Plans. The policy was last reviewed in September 2021 by the Chief Operations Officer.	**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				3 out of 5 files reviewed contained service plans completed within 7 working days of the NIRVANA assessment.	Exception: Two of the five records did not contain service plans. One of the youth attended a community counseling intake and never returned for another session to complete their service plan. The youth has since been discharged. The other youth attended a community counseling intake on February 22, 2022. The service plan is due within seven working days, which would be March 3, 2022. The youth was scheduled for a session on March 12, 2022 and did not show up. The case notes indicate the youth rescheduled an appointment for March 21, 2022 and the service plan will be completed at that time.
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				Three of five reviewed records included completed service plans. All three completed service plans included individualized and prioritized needs and goals identified by the NIRVANA, service type, frequency, and location, person(s) responsible, target dates for completion and actual completion dates, signature of youth, counselor, and supervisor, and the date the plan was initiated. Only two of the plans were signed by the parent/guardian.	Exception: Two community counseling records did not include service plans. One youth's parent/guardian signature line was not completed which indicates the guardian was not present but the guardian was updated on the youth's service plan.

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				Two of the plans were applicable for thirty-day reviews, and neither of the thirty-day reviews were done as required. The third plan was not applicable for a thirty-day review, as youth was discharged prior to thirty days.	Exception: Two records did not include service plans. One youth's thirty-day review was due on March 10, 2022 and there was no documentation of a review being done. The other youth's thirty-day review was due on January 29, 2022. The review log dated March 15, 2022 indicates the plan was reviewed on January 30, 2022,but the counselor/case manager forgot to sign the document. The youth and parent sections state they were unavailable but they were informed of the thirty-day review. The youth was discharged on February 9, 2022. The supervisor signed off on the review on March 15, 2022.
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES** **NO (explain below)** If NO, explain here: Indicate policy number, authorized signee, date(s) of last review/revision/approval:	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Counselor/Case Manager is assigned					X	This indicator was not applicable for the modified QI review.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs						This indicator was not applicable for the modified QI review.	

2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit					X		
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process					x	This indicator was not applicable for the modified QI review.	
Standard Three – Shelter Care							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: The agency has a policy in place titled 3.01 Shelter Environment. The policy was last reviewed in January 2022 by the Chief Operations Officer.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Facility Inspection	X					An on-site tour of the facility confirmed that furnishings, fixtures, and fittings were in good repair as well as the program being free of insect infestation. The grounds were adequately landscaped and maintained. All exterior areas were free of debris and the grounds were free of hazards with the dumpster and garbage cans covered. All bathrooms were noted to be clean and functional. There was no graffiti observed, lighting was adequate throughout. Doors are secure with key access required. Egress plans were posted in several locations as well as the client rules, abuse hotline information, and DJJ incident reporting information are posted in the staff area/youth group room. Blank grievance forms are available on the wall of the youth group room underneath the locked grievance mailbox. The program has one twelve-person passenger van which is equipped with all the major safety equipment as required. The keyring has a seat belt cutter and a window punch which also serves as an airbag deflator. Interior areas did not contain contraband and were free of hazardous items. Chemicals were stored behind locks and inventories and MSDS were adequately maintained. The washers and dryers were operational and clean of lint. Current DCF license and accreditation credentials are displayed. Each youth has their own individual bed with clean, covered mattress, pillow, and sufficient linens. The program has lockers in a closet that can be locked and serve as a safe place for youth to keep their personal belongings.	
Additional Facility Inspection Narrative (if applicable)							
Fire and Safety Health Hazards	X					Date of fire inspection(s) reviewed: Fire Inspection reviewed on September 27, 2021.	
Additional Fire and Safety Health Hazards Narrative (if applicable)	The annual fire inspection was completed on September 27, 2021, successfully. Fire safety equipment inspections were completed on April, 4, 2021 and the fire suppression on November 3, 2021 documenting satisfactory compliance. At least one fire drill was completed monthly on each shift since October 2021. Mock emergency drills were completed at least monthly since September,2021 and noted that all evacuations were completed under two minutes. Residential Group Care and Food Service inspection were successfully completed on September 30, 2021, there being no violations. Menus were posted and signed by an approved and licensed dietician, these menus were last reviewed on August 12, 2021. Cold food is properly stored, marked, and labeled and dry storage/pantry areas are clean. Refrigerators/freezers are clean and appropriate temperatures are maintained.						
Youth Engagement							

a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	X					The program has an activity schedule for weekdays and weekends. Each weekday youth are engaged in activity from 5:40 a.m. to 10:00 p.m. and from 8:30 am to 11:00 p.m. on weekends. The schedule indicates one hour of recreation/physical activity is provided daily and non-punitive activities are available if youth do not want to participate in a faith-based activity. The schedule includes over an hour of time for youth to complete homework or read approved books. The daily schedule is posted in the program's main group/living area.	
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 3.06 Staffing and Youth Supervision . The policy was last reviewed in September 2021 by the Chief Operations Officer.	**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					Logbooks were reviewed for a random sample of two days a month from October 2021 to March 2022. Video was reviewed from March 1, 2022 from 10pm-11pm, March 9, 2022 from 1am-2am, and March 12, 2022 from 4am-5am. A review of the logbooks and video surveillance found staffing ratios were maintained for awake and sleeping hours.	

All shifts must always provide a minimum of two staff present		X				Staff schedules were reviewed from October 2021 through March 2022. As a result of mainly Covid related staff losses and deficiencies, this unusual circumstance impacted the agency's ability to cover shifts with two persons as required by the standard and so one person was covering shifts for a significant time period. The agency has since corrected this deficiency at the time of the review and resumed the practice of having two staff minimum present on all shifts, per current log book notations.	Exception: A review of staff schedules found 317 of 543 shifts since October 2021 only had one staff scheduled. The agency indicated they would not be in compliance, as they have had staffing issues; however, at the time of the review they do now ensure they are in ratio at all times.
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 that were included in staff-to-youth ratios had an eligible background screening completed and had been appropriately trained.	
The staff schedule is provided to staff or posted in a place visible to staff	X					The staff schedule is posted in the youth shelter on staff cabinets and is also sent to staff via email.	
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 indicated they maintain a list of staff's personal phone numbers in their Shift Exchange Log.	Exception: The agency does not have an overtime rotation roster. The agency indicated if they have to hold anyone over they would holdover the person/people from the previous shift depending on ratio.
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					A review of video surveillance from March 1, 2022 from 10pm-11pm, March 9, 2022 from 1am-2am, and March 12, 2022 from 4am-5am found consistent fifteen-minute checks were conducted by staff. Fifteen-minute check observation forms found observations were documented in real time and matched with video. No inconsistencies noted. Physical layout of sleeping arrangements: Four bedrooms with up to three youth per room.	
Standard Four – Mental Health/Health Services							

Provider has a written policy and procedure that meets the requirement for Indicator 4.02						YES If NO, explain here: The agency has a policy in place titled 4.02B Comprehensive Master Plan for Suicide Prevention and Response- Pinellas. The policy was last reviewed in October 2021 by the Chief Operations Officer.	Add any exceptions below:
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Suicide Risk Screening and Approval							
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	X					Four closed shelter records were reviewed. Each record included a suicide risk screening which was completed during the initial intake and screening process. Each suicide risk screening was signed by a supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The agency's suicide risk assessment tool was reviewed, and it was reported it had been previously approved by the Florida Network.	
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					All four reviewed youth were placed on sight-and-sound supervision upon completion of their suicide risk screening. Each youth remained on sight-and-sound until an assessment of suicide risk was completed by a licensed professional or non-licensed professional under direct supervision of a licensed professional determining they could be stepped down to standard supervision.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Each youth was monitored by staff every fifteen minutes while on sight and sound supervision. Monitoring was documented on a Sight and Sound Observation Log. There is a place on the observation logs which indicates if any additional behavior observations or warning signs were observed they will be documented in shift notes.	
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 remained on sight-and-sound until an assessment of suicide risk was completed by a licensed professional or non-licensed professional under direct supervision of a licensed professional determining they could be stepped down to standard supervision.	

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 in place titled 4.03 Medication. The policy was last reviewed in October 2021 by the Chief Operations Officer. The agency also has policies in place titled 4.03A & 4.03B Medication Management and Distribution and Medication Disposal which were last reviewed in September 2021 by the Chief Operations Officer.	**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	**X**					A tour of the medication office was conducted. The agency has a Pyxis Med-Station located in the locked office, which is inaccessible to youth. All oral medications are stored separately from any topical medications, and the program does not have any injectable medications. The agency has a refrigerator that is used only for medications and was 42 degrees Fahrenheit at the time of the tour. The agency does not currently have any narcotics or controlled medications; however, they indicated it would be kept in the med-station if they did. The agency has Pyxis keys with the labels of "top cover", "back panel- left tall cabinet lock- left", and "back panel- right tall cabinet lock right", which are in a drawer in the medical office and accessible to staff.	

f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT							
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	**X**					The agency currently has three super users for the med-station. Only staff trained in medication administration assistance have access to the secured medications in the med-station. A Medication Distribution Log is utilized for the distribution of all medications and documents the staff who provided the medication and the youth's initials. The agency verifies medication utilizing one of four methods listed in the FNYFS Operations Manuel. The agency completes a Consent for Self-Administration of Medication and Verification of Prescription Medication form where they contact the pharmacist to verify the medication. When the nurse is on duty medication processes are conducted by the nurse. The delivery process of medications in consistent with the FNYFS Medication Management and Distribution policy. The agency indicated a verification of a list of each youth's medication is completed at the beginning of each shift including what medication they receive. The program maintains a sheet for each youth who takes medications including a photograph, the youth's name, the medications they take, and what time they take them. The youth then comes up to the window of the medical office and is given their medication and water. A mouth check is done, at the time they received the medication and medication count is documented, and the youth and staff initial. The agency indicated they do not accept youth currently prescribed injectable medications. The agency indicated non-licensed staff received training in the use of epi-pens during their first-aid training.	
Medication Inventory							

a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	X					The agency did not have any controlled substances at the time of the review and stated they have not had any during the review period. The agency indicated they utilize their Medication Distribution Log as a perpetual inventory and to keep their count. There is also a spot to document a shift-to-shift count with a spot for staff and a witness to initial. All over the counter medications are inventoried utilizing a perpetual inventory on the Medication Distribution Log. There is also a running inventory of over the counter medications on the med-station. The agency does not current have any syringes. They keep their sharps in a locked box inside a locked cabinet in the shelter. An inventory is conducted of the sharps each shift.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.		X				Nursing staff was contacted by phone to inquire about monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports and confirmed none was done. The agency reports they check weekly for med errors only.	Exception: The agency indicated there was no monthly reviews of medication management practice done via Knowledge Portal or Pyxis Med-Station Reports.
Medication discrepancies are cleared after each shift.	X					The agency reported all discrepancies are cleared out at the end of shift. A binder was provided including discrepancy reports which have been printed out.	