FLORIDA NETWORK
of youth and family services

Florida Network for Youth and Family Services
Compliance Monitoring Report for

SMA Beach House
3875 Tiger Bay Road
Daytona Beach, FL 32124

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for SMA Beach House for the FY 2021-2022 at its program office located at 3875 Tiger Bay Road Daytona Beach, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. SMA Beach House is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 2021 through June 30, 2022.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC, and Peer Reviewer(s). Agency representatives from SMA Beach House present for the entrance interview were Pam Palmer, Director of Residential Adolescent Services; Melissa Alton, Clinical Director; Kimberly Craft, Clinical Compliance Manager; Charlotte Robinson, Clinical Review Specialist; Kim Stone, Operations Supervisor; and Andrea Wilson, Administrative Assistant. The last QI visit was conducted December 2-3, 2020.

In general, the Reviewer found that SMA Beach House is in compliance with specific contract requirements. **SMA Beach House 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 02-23-2021-2022

Agency Name: SMA Beach House	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 3875 Tiger Bay Road, Daytona Beach, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): February 23 - 24, 2022**

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

Agency Name: SMA Beach House	Monitor Name: Marcia Tavares, Lead Reviewer
Contract Type: CINS/FINS	Region/Office: 3875 Tiger Bay Road, Daytona Beach, FL
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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		
						$1,000,000 each/$2,000,000 aggregate effective 6/30/2021-6/30/2022. 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 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 May 2019.	**No recommendation or Corrective Action.**
b. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: No change in practice was reported for the agency since the last site program review in December 2020. Reviewed petty cash Policy and Procedure FS0305. The Petty Cash fund does not exceed the established minimum of $250. Petty cash is stored in a secure locked location in the building. Petty cash is reconciled on a consistent basis (monthly/quarterly) by	**No recommendation or Corrective Action.**

Agency Name: SMA Beach House						Monitor Name: Marcia Tavares, Lead Reviewer	
Contract Type: CINS/FINS						Region/Office: 3875 Tiger Bay Road, Daytona Beach, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): February 23 - 24, 2022	
	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)
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						designated Administrative Assistant and reviewed by the Supervisor. Disbursements and invoices are approved by the Program Supervisor as required.	
c. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
d. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2021, and 2020 was completed by James Moore, C.P.A. and Consultants and dated December 1, 2021. Per the audit report, a separate Management Letter requiring a Corrective Action Plan is not required and was not issued by the auditor. A copy of the audit was submitted to the FNYFS.	**No recommendation or Corrective Action.**

CONCLUSION

SMA Beach House 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, t**he overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the 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 review.

If required, the provider must submit a corrective action plan to address corrective actions cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of SMA Healthcare, Inc.
CINS/FINS Program

February 23-24, 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	**Satisfactory**

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

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	**Satisfactory**

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

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	**Satisfactory**
3.06 Staffing and Youth Supervision	**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: 87.5 %
Percent of indicators rated Limited: 12.5 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Baldwin Davis - Consultant-Forefront LLC/Florida Network of Youth and Family Services
Kristine Harshaw - 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	X	Direct – Care Full time	1	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
X	Clinical Director		Volunteer		# Other (listed by title): ___
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports		Grievance Process/Records		# Health Records
X	Logbooks		Key Control Log	5	# 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	5	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	4	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

Comments

Due to COVID-19, this review was conducted onsite using the modified QI Review plan.

Monitoring Purpose:

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

Strengths and Innovative Approaches

The past year has been a difficult year for SMA Beach House regarding staffing. The agency has experienced critical staffing issues due to the lack of applicants for its Behavior Health Technicians (BHT) positions in Beach House and its Residential Adolescent program. On average the program has been down 4 BHT full-time positions, a part-time position and 1 Operations Supervisor position for the past year. Currently, the vacancy is for 6 full-time BHT positions, 1 part-time position and the Operations Supervisor position. The director reported having 3 candidates in the screening process which will take approximately 2 weeks at minimum before onboarding at Beach house. The program also lost its Case Manager and Outreach Specialist for Beach House. The case manager accepted another position within the agency and the Outreach Specialist returned to a BHT III position at Beach House.

It's been a challenge recruiting staff for the BHT positions as the asking salary is $18/hour. Steps taken by the program to manage the current crisis includes offering double-time salary rate as an incentive for staff to cover overtime. The agency also recently approved a career ladder for shift supervisor's position to incentivize staff.

In September 2021, the agency hired a new Clinical Director, Melissa Alton to replace Jessica Szymcyzk who moved to an Outpatient counselor position in October 2021. It also hired an Operations Supervisor, Colin Ventrella for the RAP program who has been providing oversight to Beach House until filling the vacant Operations Supervisor position.

The Basic center grant ended September 30th, 2021 and the agency did not apply for the grant for 2022.

Beach House received a grant from Jeep Beach in December 2021 to purchase some furniture for the Beach House group room. The chairs and activity table have been ordered and will be delivered in the near future.

Narrative Summary

SMA Beach House is contracted by the Florida Network of Youth and Family Services to provide CINS/FINS services to youth and families in need. The program provides residential, community counseling, and case management services over two counties -- Volusia, and Flagler, across Circuit 7. The program is managed by a Director of Adolescent Services who oversees a Manager of Operations. The youth shelter operates 24 hours a day, 365 days a year and is licensed for up to ten CINS/FINS shelter beds.

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

The overall findings for the modified QI Review for SMA Healthcare are summarized as follows:

Standard 1
Three indicators were reviewed for this standard. Indicator 1.01 was rated satisfactory with exceptions and indicator and 1.06 was rated satisfactory with no exceptions. Indicator 1.04 received a limited rating due to training deficiencies observed for three first year staff and three in-service staff.

Standard 2
One indicator was reviewed for standard 2. Indicator 2.03 was rated satisfactory with exceptions.

Standard 3
Two indicators were reviewed for standard 3, indicators 3.01 and 3.06. Indicator 3.06 was rated satisfactory with no exceptions. However, there were exceptions noted for indicator 3.01 that were observed during the facility tour as follows: 1) No airbag deflator was located in the Chevy Trax; 2) DJJ Incident Reporting number was not posted in the facility; 3) No grievance box was observed to be accessible to youth; 4) Chemicals (8 different types) located in the staff office are not secured behind a locked door. A bottle of bleach was observed to be stored in the cleaning closet but was not included on the inventory; 5) Annual Fire Inspection has not yet been completed by Volusia County Fire Prevention Bureau. Last inspection was 1/27/21; and 6) No fire drills were completed during the review period by the program.

Standard 4
There are 2 indicators that are reviewed for standard 4, 4.02 and 4.03. Both indicators were rated satisfactory with no exceptions.

Summary of Deficiencies resulting in Limited Rating:

Standard 1:
Indicator 1.04 – Limited

Training records for three first year staff revealed none of the three completed all mandatory trainings required in the first 90 days of hire. All three staff were missing three or more required trainings. The majority of trainings completed were not received on time. Two of the three new hires did not complete the DOJ Civil Rights training within 30 days of hire. Similarly, one of the in-service staff (case manager) was missing one (1) annual training. The remaining two in-service youth care staff were missing five (5) and eight (8) annual training topics, respectively. None of the in-service staff completed the required annual 40 hours of training. Additionally, the HR office is responsible for maintenance of training records; however, it does not track and monitor staff training activities and there are no individual training files for each staff which includes employee training hours tracking form and related documentation such as certificates, sign-in sheets and agendas for each training attended. HR only maintains a list of training completed by each staff and certificates/supporting documentation had to be requested.

The program received a Limited rating for this indicator during the last QI review in December 2020. During the current onsite visit, the director stated the program has experienced critical staffing issues and, on average, has been down four fulltime and one part-time youth care position, and one operation supervisor position. This staffing challenge has impacted the ability of current staff to stay abreast with current training requirements.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	Satisfactory (S)	Non-compliant (E)	No Eligible Items for Review (N)	No Practice (NP)	Not Applicable (N/A)	Review Based Upon Document Source	Notes
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 titled Employee Eligibility Background Check. The policy was last reviewed on 01/28/2022 by the Director of Adolescent Services.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.		X				The agency hired five new staff since the last QI Review and has implemented use of a new pre-employment suitability assessment called Impact Assessment Tool that includes a pass rate and/or score. The assessment was completed for three of the five new staff hired.	Exception: Pre-employment screening assessment was not completed for two of the five new staff hired.
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					All five new staff were background screened prior to hire. One of the five staff was a rehire who was separated for more than 90 days. The program did not utilize any interns/volunteers since the last on-site 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			None of the new staff hired had a break in service for less than 90 days.	

Five-year re-screening completed every 5 years from initial date of hire			X			The organization had no staff who required a five year re-screen since the last QI Review.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					The agency submitted the Annual Affidavit of Compliance with Level 2 Screening via email to the Background Screening Unit on 01/27/2022.	
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 five 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 titled Training Requirements. The policy was last reviewed 01/28/22 by the Director of Adolescent Services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*		X				Three new staff training files were reviewed for Civil Rights Training completion within the first 30 days as required of employment. One of the three staff training files reviewed completed the DOJ Civil Rights training within 30 days of hire.	Limited Exception: Two of the three new hires did not complete the DOJ 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				Three new staff files were reviewed for completion of mandatory training during the first 90 days of hire. All three staff were hired between January and August 2021 and were missing some of the mandatory trainings as of the date of the QI review or did not complete other trainings on time. The program received a Limited rating for this indicator during the last QI review in December 2020. During the current onsite visit, the director stated the program has experienced critical staffing issues and, on average, has been down four fulltime and one part-time youth care position, and one operation supervisor position.	Limited Exception: None of the three staff completed all mandatory training during the required 90 day timeframe. All three staff were missing three or more required training. The majority of trainings completed were not received on time.
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training			X			There were no applicable staff within this review cycle.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).			X			There were no applicable staff during this review cycle.	
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 training records were reviewed for two residential direct care staff and a community counseling case manager. All three staff did not complete the ten required annual training topics.	Limited Exception; One of the in-service staff (case manager) was missing one (1) annual training. The remaining two in-service youth care staff were missing 5 and 8 annual training topics, respectively. None of the in-service staff completed the required annual 40 hours of training.
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.		X				The agency's human resource (HR) office is responsible for collecting and maintaining employee training. The program provided a printout of trainings completed for each staff that lists topics and dates completed. Certificates and corresponding supporting documentation are sent electronically to HR but are not maintained in an individual training file for each staff. HR does not track and monitor staff training activities and so there is no methodology to identify and report missing trainings or hours for each staff.	Limited Exception: The organization does not track and monitor staff training activities as there are no individual training file for each staff which includes employee training hours tracking form and related documentation such as certificates, sign-in sheets and agendas for each training attended.
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: The agency has a policy titled Transporting Clients. The policy was last reviewed and approved 2/2/2022 by the Director of Adolescent Services.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The agency maintains a list of staff approved to transport clients.	

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					All approved drivers have a valid Florida driver's license and are covered under the company vehicle 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					Reviewed policy titled Transporting Clients.	
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			Review of transportation logs and logbook indicates that the program had no single client transports since the last QI review.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					All transports reviewed included a 3rd party that was either another agency staff or 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					Mileage logs were reviewed for the last six months for the stated two vehicles used for the program. All logs were filled out in their entirety and included the date, the name of the driver, the destination/purpose, mileage, time in, time out, total passengers, vehicle performance comments, and staff initials.	
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 titled Case/Service Plans. The policy was last reviewed and approved 2/2/2022 by the Director of Adolescent Residential Services.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case/Service plan is developed within 7 working days of NIRVANA	X					Seven youth files were reviewed for service plan development. All seven files contained a service plan created within seven days.	
Case plan service Plan includes:						All seven plans reviewed contained individualized and	Exception:

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				prioritized need and goals including the service type, frequency, location, and the date the plan was initiated. Each listed the person responsible and target completion dates. Only one file had an actual completion date for the youth's goals. In three files, the parent/guardian signatures were not included, but noted by the service manager that consent was given over the phone. In two of the seven files the youth signature was not included, but also noted by the service manager that consent was given over the phone. One youth file was not signed due to the youth being removed from the program as a Baker Act.	Three of the closed files did not contain an actual completion date for plan goals. The goals on service plan have due dates for a past date with no completion indicated.
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					There were three community counseling service plans applicable for 30-day reviews. All three documented all reviews were completed timely as required and contained progress notes for monthly follow ups. The length of stay for residential youth at this facility is twenty-one days. Residential youth are not on site for thirty-day plan reviews.	
Standard Three – Shelter Care							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: Agency has policy for Shelter Environment that was reviewed and approved 2/2/2022 by the Director of Adolescent Residential Services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Facility Inspection		X				A tour of the facility was conducted with the Director of Adolescent Residential Services. During the tour, the following items were observed: Furnishings were in good condition with no rips or tears. All beds appeared sturdy and functional. No insect droppings or infestation was noticeable. The shelter cottage sits on a large 10 acre campus. All exterior areas are well maintained and free of debris/hazard. Maintenance was observed cleaning the inside and outside areas during visit. A large oversized dumpster is located at the rear of the facility and was observed to be covered during the visit. All bathroom facilities were clean and functional. Girls have access to 2 full bathrooms and a half bathroom. Boys have access to 2 full bathrooms. Each full bathroom has a toilet, sink, and one shower. Walls appeared clean and void of soil, stains, or graffiti. The facility is well lit throughout and bathroom lighting is motion activated. Program uses two vehicles to transport youth, a Chevy Trax and a Ford Escape. Both vehicles are equipped with first aid kits, flashlights, fire extinguishers, glass breaker, and seat belt cutter. The Ford Escape also has an airbag deflator. The fire extinguishers equipped in the vehicles did not have inspection tags; however, they were observed to be marked "full". Doors are secure with key access required. Program has shadow boxes located on the girls' and boys' wings as well as in the main hallway and group room. Postings in the shadow boxes include: Egress plans, abuse hotline information, rights/responsibilities, grievance procedures, SOGIE signage and program schedules.	Exceptions: 1) No airbag deflator was located in the Chevy Trax. 2) DJJ Incident Reporting number was not observed in mounted shadow-box postings or other posting in the facility. 3) No grievance box was observed to be mounted or accessible to youth. Per Operations Supervisor, youth typically hand grievances to the supervisor.

Additional Facility Inspection Narrative (if applicable)	DCF license posted in lobby expired 2019; however, the program provided a copy of the current DCF license effective through 7/11/2022. Program has two laundry rooms, one on each wing. The laundry room is equipped with 2 washers with automatic detergent/fabric softener dispensers and 2 dryers. All were observed to be clean. During the tour, all beds occupied by youth had a pillow and was covered with bed sheets and a comforter. The program has labeled lockers located near the entrance of the shelter and are assigned to each youth to store belongings.						4) Chemicals (8 different types) located in the staff office are not secured behind a locked door. A bottle of bleach was observed to be stored in the cleaning closet but was not included on the inventory.
Fire and Safety Health Hazards		**X**				The most recent annual facility fire inspection was completed by Volusia County Fire Prevention Bureau on 1/27/21.	Exception: Current annual fire inspection is overdue and was last completed by Volusia County Fire Prevention Bureau on 1/27/21.
Additional Fire and Safety Health Hazards Narrative (if applicable)	In the past 6 months, the program conducted 3 emergency drills per month on each shift except for January 2022 where it was only conducted by the 1st shift; however, this supersedes the requirement to conduct drills quarterly on each shift. The program has not completed any fire drills during the review period. Food is prepared offsite and dining room/cafe is not equipped with a kitchen, just a dining room with hot and cold storage appliances. The hot food is stored in a warmer and food is labeled and dated. Refrigerator temperature is 38 degrees Fahrenheit. No freezer is used in the cafe. All fire extinguishers in the facility were inspected April 2021, valid one year through 4/2022. Alarm and emergency equipment testing was completed 2/10/21 by Signal 21 Security Systems Inc. DOH Sanitation Certificate is valid through 9/30/2022. Agency is CARF certified effective through 4/30/23. Satisfactory DOH Group Care inspection was completed 3/9/21 and a satisfactory DOH Food inspection was completed 9/28/21 with no violations found.						Exception: No fire drills were completed during the review period by the program.
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.						Program has a weekday, weekend, and holiday schedule with structured activities each day. Physical activity is scheduled for at least 1 hour daily. Youth are provided an opportunity to attend religious/faith based activities on the weekend and alternative activities are available to youth who do not choose to participate. Youth are given the time and opportunity to do homework and read. The program has a library with a variety of books for the youth to read. The daily schedule is posted in the shadow boxes mounted	

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					throughout the facility.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: Agency has policy for Staffing and Youth Supervision that was reviewed and approved 2/2/2022 by the Director of Adolescent Residential Services.	
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					Staff schedules for the past 6 months were reviewed. The program maintained the required ratio by staffing each shift with a minimum of 2 staff for contracted 12 beds. There was only one recent instance 2/14-2/17/2022 where the program had a staffing emergency (one staff with a medical emergency and second staff was terminated), that resulted in the overnight shift having one person for 4 hours of the shift for 4 days.	
All shifts must always provide a minimum of two staff present	X					Each shift is staffed with a minimum of two staff on duty, a supervisor and a behavior health technician.	

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 included on the staff schedule have been background screened and receive training prior to providing youth supervision.	
The staff schedule is provided to staff or posted in a place visible to staff	X					Schedule is posted on the door of the medication room and is accessible to staff.	
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					Due to the current staffing crisis and vacancy for five direct care staff, the program is not able to maintain a hold-over roster; however, staff are required to stay overtime for at least one day per week if the subsequent shift does not have full coverage and management is used as a backup in the event direct care staff is not available to cover a shift.	
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					Bed checks are documented on observation logs maintained for each youth. Six youth files were observed for fifteen minute checks during sleeping hours. Each of the six files contained client observation forms with documented checks during the hours the youth were sleeping. Times are documented in real time with staff initialing each entry. The facility has two separate wings, one for each gender. There are four bedrooms on each wing. Three of the rooms on the girl's wing have 3 beds and one (flex room) has two beds. All four bedrooms on the boy's wing have 2 beds.	
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: Agency has policy for Suicide Prevention that was reviewed and approved 2/2/2022 by the Director of Adolescent Residential Services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible**	**No Practice**	**Not Applicable**		

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					Five youth files were reviewed for suicide screening. All five youth were screened for suicide risk during intake and each was reviewed and signed by the supervisor. Four of the five youth were removed from suicide precautions following intake by the program supervisor. One youth was assessed post intake and put on suicide precautions until removed from the program by Baker Act.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The program's suicide risk assessment was 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					All five youth were placed on the appropriate level of supervision following the suicide risk assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					One youth required close monitoring after being placed on precautionary observation. Documentation was completed every thirty minutes, as required.	
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					Supervision levels were not changed until the licensed mental health professional completed a follow up assessment or in one case, the youth was removed from the program by Baker Act.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES** If NO, explain here: Agency has policy for Medications that was reviewed and approved 2/2/2022 by the Director of Adolescent Residential Services.	
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					Observations of the medical office and medication cart were made. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth. The Pyxis machine is stored in accordance with state guidelines and policy. Oral medication are stored separately from injectable epi-pens and topical medication. The medical office has a refrigerator for medications requiring refrigeration. The program does not have any refrigerated medications at this time. Narcotics and controlled medications are kept in a separate drawer in the med-station. Pyxis keys are accessible to staff in the event of a Pyxis malfunction.	
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station						The agency currently has three super-users for the med-station, the two nursing staff and the program director. Only designated staff have access to	

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					secured medications, with limited access to controlled substances. The medication distribution log is used for distribution of medication by trained, unlicensed staff. The staff verify medication using one of the four methods listed in the manual. The nursing staff conduct all medication distribution and medical issues while they are on-site. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy. The program does not accept youth who are currently prescribed injectable medications, with the exception of epi-pens. Non-licensed staff have received training on the use of Epi-pens, provided by the program's registered nurses. Registered nurses conduct medication pass training for non-medical staff.	
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 program keeps a perpetual inventory for all controlled substances, with a running balance and a shift-to-shift count that is witnessed and documented. Over-the-counter medications are inventoried weekly by the nursing staff maintaining a perpetual inventory. Sharps are secured in a locked cabinet and inventoried weekly.	

There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					Monthly reviews of medication management practice is being done by the nurse who runs and observe the Pyxis Med-Station knowledge portal reports.	
Medication discrepancies are cleared after each shift.	X					Any medication discrepancies are cleared up prior to the end of each shift, when necessary.	