Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth and Family Alternatives, Inc.
George W. Harris Shelter
1060 US Hwy 17 South
Bartow, FL 33830

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 Youth and Family Alternatives, Inc. (YFA) George W. Harris for the FY 2021-2022 at its program office located at 1060 US Hwy 17 South, Bartow, Florida 33830. Forefront LLC (Forefront) is an independent compliance monitoring firm contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. YFA George W. Harris is contracted with FNYFS to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 1, 2021 through30, 2022.

The review was conducted by Keith Carr, Consultant for Forefront LLC and Peer Reviewer, Heather Gibson, DJJ Regional Monitor. Agency representatives from YFA George W. Harris present for the entrance interview were Jess Sternthal, Vice President (VP) of Prevention and Residential; Amanda Killian, VP Quality Improvement; Roderick Jefferson, Program Manager; Jovia Dukes, Residential Supervisor; Kelley Scott, Community Counseling Program Director; and Michelle Almand, YDS Office Specialist II. The last QI program review was conducted April 21-22, 2021 (hybrid program review format).

The Reviewer found YFA George W. Harris is in compliance with specific contract requirements. **YFA George W. Harris received an overall compliance rating of 100% for achieving full compliance** with all four applicable indicators of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit.

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 05-18-19-2021-2022

Agency Name: YFA George W. Harris	**Monitor Name: Keith D. Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1060 US Hwy 17 South, Bartow, FL 33830**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 18-19, 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, effective 7/01/21-7/01/22. Automobile insurance through Alliance of Nonprofits for Insurance for combined limits of liability/property damage for $1,000,000. Policy effective for 7/01/21-7/01/22. Abuse/Molestation coverage through Alliance of Nonprofits for Insurance for limits of coverage of $1,000,000 each $2,000,000 aggregate effective 7/01/21-7/01/22. Professional Liability through Alliance of Nonprofits for insurance for limits of coverage of $1,000,000 each	**No recommendation or Corrective Action.**

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	Explain Rating						
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
						$3,000,000 aggregate effective 7/01/21-7/01/22. Workers Compensation through Bridgefield Employers Insurance Co for limits of coverage of $1,000,000 each accident effective 7/01/21-7/01/22. Umbrella Liability Insurance through Alliance of Nonprofit for insurance for limits of coverage of $3,000,000 each/aggregate effective 6/1/2021-6/1/2022. 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 under "Financial Management" in the agency's policy and procedure manual. The policies are divided into ten sections with subsections in each one. The fiscal procedures reviewed appear to be consistent with generally accepted accounting principles (GAAP) and	**No recommendation or Corrective Action.**

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Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): May 18-19, 2022	
	Explain Rating						
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						provide for sound internal controls. Procedures are included for general ledger, bank reconciliations, purchasing, invoicing, payroll, petty cash, computer backup, and other relevant financial processes. Policies last revised and approved March 2019.	
c. 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: Reviewed petty cash Policy and Procedures. The Petty Cash fund does not exceed the established minimum total amount of $500 and is used for purchases of $25 or less. Petty cash is stored by the Residential Supervisor in a secure locked location in the building. The agency produced past documentation of monthly petty cash reconciliations for November 2021-March 2022. Petty cash is reconciled on a consistent basis (monthly) by designated staff and reviewed by the Supervisor. Disbursements and invoices are approved by the Program Manager and Residential Supervisor.	**No recommendation or Corrective Action.**
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag.	☐	☐	☐	☐	☒	N/A – Per YFA Contract Manager and the George W. Harris YDS Office Specialist II, the agency does not	**No recommendation or Corrective Action.**

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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)
In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**						utilize FNYFS funds for asset purchases and has not purchased any property with FNYFS funds in fiscal year 2021-2022.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2021 was completed by Reeder & Associates, PA November 30, 2021. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor. A copy of the audit is on file with the FNYFS.	**No recommendation or Corrective Action.**

CONCLUSION

YFA George W. Harris 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. A fifth indicator was not applicable because the provider does not have any current inventory purchased with DJJ/FN funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing Satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Youth and Family Alternatives, Inc. - George W. Harris
CINS/FINS Program

May 18-19, 2022

Compliance Monitoring Services Provided by

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CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of Indicators rated Satisfactory: 100 %
Percent of Indicators rated Limited: 0 %
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: 100 %
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: 88.89 %
Percent of indicators rated Limited: 11.11 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

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

Methodology

This modified review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused in particular areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (Effective January 2022).

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks	X	Key Control Log	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	9	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	9	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	8	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	4	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

5	# of Youth	10	# of Direct Staff		# of Other	

Comments

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

Monitoring Purpose

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

Strengths and Innovative Approaches

Youth and Family Alternatives (YFA) Inc. operates three crisis shelters in the State of Florida that are contracted with the Florida Network of Youth & Family Services, Inc. The George W. Harris youth shelter is located in Bartow, Florida and serves judicial circuit ten, which includes Hardee, Highlands, and Polk Counties. The shelter is licensed for 18 beds and offers 24-hour availability, youth supervision, food and clothing, life skills education, crisis counseling, individual and family counseling, recreation and leisure activities, and case management services. Educational services are provided by the local school district, in the county in which the shelter is located. The YFA Children in Need of Services/ Families in Need of Services (CINS/FINS) Community Counseling team serves youth and families in the aforementioned services counties and coordinates the delivery of community services to families and children in care in these areas. CINS/FINS provides the ability to serve both male and female youth ages from six to seventeen year old for community counseling services and ten to seventeen year old for residential services for youth locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides specialized services to youth who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). The youth census during the QI visit was seven CINS/FINS residents. YFA is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through October 31, 2024.

Since the last Quality Improvements (QI) visit, the program has a new leadership team with the hiring of a Chief Operations Officer and Vice President of Prevention, as well as residential and non-residential staff members.

The past year has been a challenging year for YFA George W. Harris program regarding staffing. The agency has experienced critical staffing issues due to significant turnover between November 2021 and January 2022. The program manager at the George W. Harris youth shelter reported since July of 2021, there has been a high turnover rate in the counselor and other direct care positions. The program manager reports that when he initially came on board in his current position, there were two counselors. Unfortunately, both counselors departed in August and September of 2021, respectively. The George W. Harris shelter was without a counselor on staff to service the Hardee, Highlands and Polk Counties service region. The YFA agency has provided assistance to the George W. Harris youth shelter location by the allowing counseling staff from New Beginnings and Rap House locations to provide support services on a temporary basis. The counselors conducted onsite counseling services, as well as providing virtual visits to program participants via Microsoft Teams virtual sessions. The program manager also carries a case load of shelter residents to ensure all clients received all services. In December 2021, a direct care staff member was promoted to a counselor position and a new staff member was hired. The newly hired staff resigned and recently promoted staff was placed on leave.

The program manager has taken over the counselor duties with assistance provided by other staff members from New Beginnings and Rap House. At the time of this onsite program review, the George W. Harris program currently has a counselor in the onboarding process that is scheduled to start at the end of May 2022. Unfortunately, the second counselor vacant position is not able to be filled at this time. The agency also has position vacancies that include a full time counselor and full time and part time youth care positions. The agency has implemented an agency-wide staff stabilization plan focused on recruiting staff and increasing staff capacity across all residential and non-residential programs. As of the date of this QI visit, the agency demonstrated progress toward achieving this goal and had experienced an increase in staffing capacity which is up from the first quarter. The agency also increased its youth care salaries to $14/hour to assist with recruitment and retention efforts.

In October 2021, the agency adopted Solarity, an electronic records system that converts its youth records into properly formatted and indexed records. The agency is continuing to work with the vendor to improve the automation, usefulness, and efficiency of the system.

Narrative Summary

The YFA George W. Harris CINS/FINS program that serves Hardee, Highlands and Polk Counties is under the leadership of a management team that consists of a Chief Executive Officer, Chief Operations Officer, Vice President of Prevention and Residential Shelter staffed by a Program Manager, Residential Supervisor, Office Specialist, Counselor, and Part Time Registered Nurse. The George W. Harris program is also staffed with 5 Youth Development Specialist (YDS) Shift Leads, 5 full-time YDS and YDS Cook. There is one full time YDS Team Lead, two Part Time YDS, and YDS Cook positions vacant. The program has not reported any critical incidents, administrative review, or current external investigation.

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 QI Review for YFA George W. Harris are summarized as follows:

Standard 1:

Three indicators were reviewed for Standard 1. All three indicators, 1.01 Background Screening, 1.04 Training Requirements and 1.06 Transportation were rated Satisfactory with exceptions. The exceptions for indicator 1.01 Background Screening was due to a Level 2 Screening and suitability assessment completed late. Exceptions for 1.04 Training Requirement was due to missing trainings; and exceptions for 1.06 Transportation was due to the agency direct care staff not obtaining supervisor's prior approval for single youth transports.

Standard 2:

One indicator was reviewed for Standard 2. Indicator 2.03 was rated a Limited. The explanations are provided below.

Standard 3:

Two indicators were reviewed for Standard 3, indicators 3.01 and 3.06. Indicator 3.01 was rated Satisfactory with exceptions noted. The exceptions for Indicator 3.01 were due to food in the refrigerator not being dated properly. Indicator 3.06 was rated Satisfactory with no exceptions.

Standard 4:

There are 2 indicators that are reviewed for Standard 4, 4.02 and 4.03. Indicator 4.02 Suicide Prevention was rated Satisfactory with exceptions. Indicator 4.03 Medications was rated Satisfactory with no exceptions. The exceptions for Indicator 4.02 Suicide Prevention were due to client files not having evidence documented in the agency's logbook regarding the youth placed on sight and sound status.

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

Standard 2 Intervention and Case Management

Indicator 2.03 – Case/Service Plan

No evidence in service plan for one client file to address presenting problems. One service plan was not developed within 7 working days from NIRVANA as required. Two of the six client files did not have evidence of target dates for completion and completion dates. Two of the six client files did not contain signatures from parents/guardians in service plans. Two of the six client files did not contain signatures from youth in service plans. One of the seven client files did not contain a signature from the supervisor in the service plan. In 2 client file cases, one of the three assigned goals is not clear and not focused on the addressing original presenting problems. One of the two community counseling client files do not have evidence of completing case plan reviews with all signatures at each 30-day plan review session.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators: Add an "**X**" in the applicable column *Satisfactory* *Non- Compliant (E.g. Exceptions)* ***No Eligible Items for Review*** ***No Practice*** ***Not Applicable***	Satisfactory (S)	Non-compliant (E)	No Eligible Items for Review (N)	No Practice (NP)	Not Applicable (N/A)	**Review Based Upon Document Source** *For example: Interview/Surveys, Observation, and/or Type of Documentation*	**Notes** **Explain any items that have any deficiencies, exceptions or are not applicable.**
Standard One – Management Accountability							
1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						**YES** If NO, explain here: N/A RGC 1.01 Background Screening of Employees/Volunteers/Interns/Interns/Contracted Providers was approved by the President/CEO and former COO (chief operating officer) on October 27, 2021.	**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**					All three new employee records reviewed had employment suitability prescreening documenting the staff person was hired prior to the date of hire.	
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 employee records reviewed had an eligible background screening indicating a clear background screen and an eligible rating given prior to the date of hire.	
Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.			**X**			There were no applicable employee records for this annual compliance review period. There was only one re-hire. However, the break in service was more than ninety days.	
Five-year re-screening completed every 5 years from initial date of hire	**X**					The program had one employee record applicable for a five-year rescreening and it was completed within the required time frame.	

Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?		X				The program provided a copy of the Affidavit of Annual Compliance with Level 2 Screening, as well as the email to establish when the signed document was submitted to the Department of Juvenile Justice (DJJ). The document was submitted twenty-eight days past the date required.	Exception: Affidavit for Annual Compliance with Level 2 Screening was 28 days late (2/28/2022).
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					A review of all six employee records utilized for this indicator were reviewed for proof of E-verify. All six records contained the required verification with the Department of Homeland Security.	
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: N/A RGC 1.04 Training was approved by the President/CEO and former COO on February 11, 2022.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*	X					All five new employee records reviewed had the required United States Department of Justice Civil Rights and Federal Funds training completed within thirty days of being hired.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				Three of five new employee records had all of the required training completed within ninety days. One new employee record had trainings completed outside of the ninety days. The employee was a re-hire just outside of the ninety day window which would have given an exemption to this requirement. The remaining employee record had training outside of the ninety day requirement as a result of staff turnover. Due to the program losing two employees, they were not able to conduct the NIRVANA assessment training.	Exceptions: One first year staff person's EIDS training was not completed due to timing of training and staffing shortages. Other missing trainings included Motivational Interviewing, NIRVANA trainings (administering and data entry). The second first year staff person's training was completed late after re-hire (after 90-days). These trainings included Managing Aggressive Behavior, FL Network Suicide Prevention, CINS/FINS CORE, and Universal Precautions.

Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training			X			The program does not have any applicable staff.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).			X			The program does not have any applicable staff.	
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				Two of four in-service employee records reviewed had the required forty hours of in-service training. The remaining in-service employee records contained an incomplete training records. Three of four training files documented the required refresher training was completed annually. One staff person currently on FMLA is missing documentation of three required trainings. These training courses include Fl Network Suicide Prevention, DJJ-Human Trafficking 101 and DJJ-Child Abuse Recognition, Reporting and Prevention.	Exception: One of four training files lacked the required 40 hours of training. One staff file that had 2 training hours in total, was not counted towards this exception due to the staff being on FMLA. The other staff file had 29 hours and was missing 11 hours of the annual required training hours.
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					The program maintains individual training records for each staff with all required elements. The individual training records includes training log, training topic, hours, and certificates.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**NO** If NO, explain here: YFA policy titled Client Transportation was last approved on January 24, 2022 by the President/CEO and former COO on February 11, 2022.	Exception: The current policy did not have evidence of notification and approval prior to the transportation event if a 3rd party cannot be obtained for transport.

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The program provided travel logs dated from July 2021 for two mini vans. The agency transport vehicles include 2017 and 2018 Kia vans. The agency provided Florida Commercial Auto Insurance identification cards for both vehicles coverage from July 1, 2021 through July 1, 2022.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					The agency provided an updated document outlining an approved list of staff members who are authorized to drive agency vehicles. There were sixteen staff members on the list dated May 11, 2022. An interview with the agency's Program Manager was conducted. The Program Manager informed the reviewer all staff on this list provided have a valid Florida Driver's license and are covered under the agency's commercial insurance coverage.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	X					The agency policy requires approved staff members have an approved third party person (staff, youth, volunteers or interns) in the vehicle on all transportation events that involve youth when possible.	
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 policy requires that approved staff members have an approved third party person (staff, youth volunteers or interns) in the vehicle on all transportation events that involve youth whenever possible. The policy does indicate the Program Manager or supervisor must be aware of the event and document approval of all single party transportation events. The agency has a practice that reviews the screening, intake and assessment information of each client regarding any current behavior related to all single transport events.	Exceptions: The current policy does not include that the Program Manager and/or designee must be notified and approve PRIOR to the transportation event if a 3rd party cannot be obtained for transport.
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The agency requires a third party to be present in all transportation events when possible. A review of the agency's single party transportation practice was conducted.	

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				A review of all client transportation events over the last six months from October 30, 2021 to May 19, 2022 were conducted. The agency provided a binder that included all records related to single-party transportation events. The agency's single party transport document lists date, client name, transporter's signature, reason for trip/destination, time of departure from shelter, time of arrival to destination, time of arrival back to shelter and mileage at start and end of stop. The transport document also includes a space for comments, notes, re-fuel and any applicable toll fees. A total of nine single party transport events occurred in the last six months. Eight of the nine events contained evidence documenting supervisor approval prior to the transportation event.	Exception: The travel log for the agency's 2017 vehicle has inconsistent documentation of departure times and return times in the van log associated with transportation events. Of the nine single party transportation events, one single party transport event did not have evidence of supervisor approval prior to the event occurring documented correctly. Further, this entry in the transportation log failed to include documentation of date and time as required by the agency's policy.

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: YFA Policy RGC 2.03 Service Plan Development and Service Monitoring was approved by President/CEO on February 8, 2022 and COO on February 3, 2022.	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case/Service plan is developed within 7 working days of NIRVANA		X				A review of seven randomly selected residential and non-residential client files from October 2021 to May 2022, was conducted by the reviewer to assess the agency's adherence to the requirements of this indicator. Of these cases, five were residential (3 open and 2 closed) and two were non-residential (1 open and 1 closed) client files. Two of three client files (2 open and 1 closed) opened after January 1, 2022, contain evidence of the service plan developed within seven days. The remaining four did not meet this requirement.	Exception: One of the three applicable cases opened after January 1, 2022, but did not have evidence that the service plan was developed within 7 working days of NIRVANA.

Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated		X				A review of seven client files contained evidence of service plans in six of the seven client files. A date that indicates when the plan was initiated is documented in six of the seven client files. Each of the six files contained individualized goals based on the NIRVANA assessment tool. All six client files have documented evidence of the service plan goals that include type of service, frequency and location where goals are designated to be addressed. Four of the six client files have evidence of target dates for completion and completion dates. Four of the six client files contained signatures from parents/guardians in service plans. Four of the six client files contained signatures from youth in service plans. Six of the seven client files contained signatures from the supervisor in service plans. Four client file cases, have two to three assigned goals focused on the addressing initial presenting problems identified during the screening and intake process. There are documented dates of completing plan 30-Day reviews in 1 of 2 Community Counseling files.	Exceptions: No evidence of a service plan in one client file to address presenting problems. Two of the six client files did not have evidence of target dates for completion and completion dates. Two of the six client files did not contain signatures from parents/guardians in service plans. Two of the six client files did not contain signatures from youth in service plans. One of the seven client files did not contain a signature from the supervisor in the service plan. In two client file cases, one of the three assigned goals is not clear and not focused on addressing the original presenting problems. There are no documented dates of completing plan 30-Day reviews in one of two Community Counseling files.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after		X				One of the two community counseling client files contained documentation of verified completion of case plan reviews with all signatures at each 30-day plan review meeting.	Exception: One of the two community counseling client files does not have evidence of completing case plan reviews with all signatures at each 30-day plan review session.

Standard Three – Shelter Care							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: YFA Policy RGC 3.01 Residential Group Care Environment was approved by the President/CEO on February 8, 2022 and former COO on February 23, 2022.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection		X				A full tour of the youth shelter interior and exterior areas of the physical plant and transportation vehicles was conducted following the entrance interview. The facility is clean and the furnishings in the dayroom girls and boys areas were found in good condition. The girls and boys dorm sleeping rooms contained adequate and clean bedding. The program recently received new donated beds from community stakeholders. There is no visible evidence of graffiti in the building. The facility did not have any visible signs of insect or rodent infestation in both the interior and exterior areas. The agency uses two vendors to address all issues pertaining to pest control on a quarterly basis. Terminix services provides interior pest control on a quarterly basis to interior areas. Truly Nolan provides exterior and attic rodent infestation prevention and trapping boxes. At the time of this onsite program review, the exterior grounds and landscaping were cut and well landscaped. The agency also maintains two first aid kits (kitchen pantry & nurse station) that are stocked and up to date. The facility posted several egress maps with illustrations of all rooms, fire extinguisher locations and exit points. The facility contains a grievance box located in the dayroom. Forms for residents to submit grievances are located adjacent to the box. All bathrooms and shower areas were found to be clean. The hot water in one of the boys bathroom was not working on day 1 of the program review. The agency issued a maintenance request. The Program Director reported the hot water issue was completed and was now in proper working order.	Exceptions: A container of grated cheese found in the refrigerator did not have a date. Hot water in one bathroom in the boy's dorm area was not working properly on Day 1 of the facility's QI review. The agency's food menus signed by a Dietician were observed to be out of compliance as the date signed was 10/30/19 and it is required to be done annually.
Additional Facility Inspection Narrative (if applicable)	All interior lighting was operational. All exterior lighting is operational and functioning s required. The shift-to-shift pass down of keys is completed and an update on the previous work shift is given to the Shift Lead. The agency has two transportation vehicles (2 Vans). Emergency equipment in each van includes a fire extinguisher, first aid kit, seat belt cutter and flashlight stored in a secure box. The Disaster plan was updated July 2021 for the 2020-2021 fiscal year. An inspection of the kitchen was conducted. The chemicals are counted weekly. All chemicals have a Material Safety Data Sheet. The chemical inventory counts are tracking weekly usage by the program. Staff report depleted supplies to the Residential Supervisor and maintenance.						
Fire and Safety Health Hazards	X					The annual facility fire inspection was completed on October 14, 2021 by the Bartow Fire Department-Fire Prevention/Inspection representative. The report indicated the facility passed inspection and no violations were noted. As of the date of this onsite program review, Piper Fire Protection has confirmed and scheduled fire safety equipment onsite inspection on June 6, 2022 that included all sprinklers, kitchen suppression system, emergency and exit lights and fire extinguishers.	

Additional Fire and Safety Health Hazards Narrative (if applicable)	The agency has a Department of Children and Families (DCF) License that is in effect. The current Child Care Licensing Facility license was granted on December 19, 2021, through December 18, 2022. The facility alarm inspection was conducted on February 4, 2022, sprinklers inspection on October 13, 2021, and the overhead hood inspection was last completed December 7, 2021.						
Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**X**					The agency's program schedule includes a broad range of activities that are provided to residents on a daily basis. The agency's approach to providing structured activities to participants is intended to build responsibility, accountability, reflection, care, trustworthiness, relatability, teaching and responsibility characteristics. The agency aims to have outcomes related to the services that it provides in its daily schedule that result in self awareness, autonomy and responsibility, physical health, intellectual ability, employability, civic/social ability and cultural ability. The specific activities include wake up, personal hygiene, breakfast, chores, school or related activities, physical exercise and record rush recreation and leisure time, group life skills and/or individual counseling, personal time, homework, reading, youth development meetings, hygiene, quiet time, spirit of time, reading, and bedtime. The agency also provides religious or faith-based activities as an option for residents. The agency provides a minimum of one hour for physical activity to all residents in the program every day during their residential stay. The agency's program daily schedule is posted in the dayroom on a bulletin board of the youth shelter along with other important program-related documents. The agency has a covered recreation area adjacent to the day room for group meetings, free time, reading, or games.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: N/A RGC 3.06 Staffing and Youth Supervision policy was approved by the President/CEO and former COO on February 3, 2022.	**Add any exceptions below:**

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	X					A review of video and on-site observations indicated the program met the prescribed supervision ratio of one staff to six youth during awake hours and one staff to twelve youth during sleep hours.	
All shifts must always provide a minimum of two staff present	X					A review of past and present approved schedules, video observations, and logbooks indicated the program met the required minimum staff member count of two staff per shift.	
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 in the supervision ratio are properly screened and trained.	
The staff schedule is provided to staff or posted in a place visible to staff	X					Staff member work schedules are kept in a marked binder. The binder contains past approved schedules, current week's schedule and two weeks of approved advanced schedules. The current schedule is also posted next to the computer used to sign on and off of the work shift, which is located in the copy room.	
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 program maintains a list of all staff members and contact information on the lead staff clipboard for use when staff members are needed to work outside of their schedule for coverage.	
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 documented bed checks was conducted to determine the presence of inconsistencies in documentation of bed checks. Five one-hour observations were observed for fifteen-minute bed checks: 4/22/2022 1:00 a.m. -2:00 a.m., 4/24/2022 11:00 p.m.-12:00 a.m., 5/3/2022 2:00 a.m.-3:00 a.m., 5/12/2022 3:00 a.m.-4:00a.m., and 5/15/2022 12:15 a.m.-1:15 a.m. Logbook documentation times coordinate with video observation bed check times. The physical layout of sleeping arrangements was assessed. There is a male and female set of hallways with a main desk where staff sit with views of all four hallways. The residents sleep two per room, unless individual housing is needed. Each bed is on an opposite wall within the room. The program recently received new donated beds from community stakeholders.	

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: YFA Policy RGC 4.02 Residential Group Care Suicide Prevention was approved by the President/CEO on February 8, 2022 and the former COO on February 23, 2022.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Suicide Risk Screening and Approval							
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.		X				A total of five youth records were reviewed and each youth received a suicide risk screening during their initial intake. Each of the five screenings and the associated suicide screening results were completed by a licensed clinical staff member. One client was discharged from the program but returned the following day and no suicide risk screening was found in their case file.	Exception: One client did not have evidence of documentation indicating the client was properly screened upon readmittance to the program after being discharged the previous day.
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The agency's suicide risk screening practice included the standardized risk screening questions required by the Florida Network of Youth and Family Services policy.	
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					Each of the five reviewed client files case were placed on the appropriate level of supervision based on the results of their initial suicide screening and subsequent assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Each of the five client file cases were placed on sight and sound status immediately and maintained on suicide precautionary status after the screening until the assessment could be conducted. Behavior checks were conducted and documented at least every thirty minutes as required. Suicide observation checks were documented on an observation form that staff members use to document the observation status of each youth on elevated supervision.	

Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement		X				A review of five client file cases included evidence that the supervision level was not changed unless a licensed professional or a non-licensed professional clinician was consulted prior to sustaining or removing the youth from elevated supervision status. There was no evidence in the logbook regarding clients being placed on or stepped down from sight and sound status in program logbook on a consistent basis. Following consultation with the licensed professional, two of the five client files did contain evidence documented in the agency's logbook regarding these youth being placed on sight and sound observation status.	Exception: Following consultation with the licensed professional, three of the five client files did not have evidence documented in the agency's logbook regarding these youth being placed on sight and sound observation status.
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES** If NO, explain here: RGC 4.03 Medication Control and Management was approved by the President/CEO and the former COO on February 8, 2022.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med-Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK-LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	X					The Pyxis machine was not operable prior to review. The program was able to have it repaired during the on-site review. The Pyxis machine was stored within the medical area, and in accordance with guidelines and policy, inaccessible to youth. Controlled medications are stored in the Med-Station. Oral medications are stored separate from the only injectable medication approved to be on-site, epi-pen, and other topical medications. The refrigerated medications, if on-site, are stored in a locked medication refrigerator, which temperature was read at 46 degrees Fahrenheit. At the time of the review, the program did not have any refrigerated medications. The keys to the medication locks are with the lead staff during each shift and the Pyxis keys are labelled as required.	

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					There are four super users and a list of approved, trained staff to administer medications is maintained. The program has been without a nurse on staff for several months. However, the position was recently filled (part-time Friday-Sunday). When a nurse is on-site, the nurse will administer all medications. The program utilizes the Prescription Medication Verification form (company form) to verify all medications received and contacts the pharmacy where the prescription was filled to verify all information. This method is one of the four approved medication verification methods listed in the Florida Network of Youth and Family Services (FNYFS) Operations Manual. The program has a separate binder for over-the-counter (OTC) medications with individual logs for each youth and each medication. All youth must have a Consent for Emergency form signed by the parent/guardian, or a DCF 53-39 form, in order to administer OTC medications. Perpetual inventory of prescription medication is maintained on the Medication Distribution Log. Medication Distribution Log is maintained for each medication taken by each youth. The program does not administer injectable medications, with the exception of Epi pens. Staff approved to assist in the delivery of medications have documented training by a licensed medical professional and a record is maintained in the staff training file.	
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					Perpetual inventory of prescription medication is maintained on the Medication Distribution Log. Medication Distribution Log is maintained for each medication taken by each youth. The medical room contains only one item on a sharps list, razors for personal hygiene. There was a sharps container observed in the medical room with used razors. The sign-out log has a perpetual inventory maintained on it.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					When the program has a nurse on staff, the nurse generates the Pyxis report at least monthly.	
Medication discrepancies are cleared after each shift.	X					Any discrepancy must be cleared by the person associated with the alert. This is completed for each shift daily, if required, during the medication count.	