Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth and Family Alternatives, Inc.
New Beginnings Shelter

18377 Clinton Blvd.
Brooksville, FL 34601

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for YFA New Beginnings for the FY 2021-2022 at its program office located at 18377 Clinton Blvd., Brooksville, 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. YFA New Beginnings 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 YFA New Beginnings present for the entrance interview were: Mark Wickham, CEO; Jess Sternthal, VP of Prevention and Shelter; Amanda Killian, VP Quality Improvement; Isabel Dias, Program Manager; Kelly Scott, Community Counseling Program Director; The last onsite QI was conducted visit February 17-18, 2021.

In general, the Reviewer found that YFA New Beginnings is in compliance with specific contract requirements. **YFA New Beginnings 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 03-09-2021-2022

Agency Name: YFA New Beginnings	Monitor Name: Marcia Tavares, Lead Reviewer
Contract Type : CINS/FINS	Region/Office: 18377 Clinton Blvd., Brooksville, FL
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): March 9-10, 2022

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)
	Explain Rating						
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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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)
						$3,000,000 aggregate effective 7/01/21-7/01/22. Workers Compensation through Bridgefield Employers Ins 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 agencies policy and procedure manual. The policies are divided into ten sections with subsections in each one. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. Procedures are included for general ledger, bank	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						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 Procedure. The Petty Cash fund does not exceed the established minimum and is used for purchases of $25 or less. Petty cash is stored in a secure locked location in the building. The agency produced past documentation of monthly petty cash reconciliations. Petty cash is reconciled on a consistent basis (monthly/quarterly) by designated staff and reviewed by the Supervisor. Disbursements and invoices are approved by the Program Supervisor as required.	**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. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – Per the Executive Assistant, the agency has not purchased any property with FNYFS funds.	**No recommendation or Corrective Action.**

Agency Name: YFA New Beginnings						Monitor Name: Marcia Tavares, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 18377 Clinton Blvd., Brooksville, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): March 9-10, 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)**
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 Forefront LLC.	**No recommendation or Corrective Action.**

CONCLUSION

YFA New Beginnings has met the requirements for the CINS/FINS contract as a result of full compliance with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. One of the five indicators was not applicable because the provider does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit 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.

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. - New Beginnings
CINS/FINS Program

DATE: March 9-10, 2022

Compliance Monitoring Services Provided by

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	**Satisfactory**
2.04 Case Management & Service Delivery	**Not Applicable**

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

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	**Satisfactory**
3.06 Staffing and Youth Supervision	**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: 77.78 %
Percent of indicators rated Limited: 22.22 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

Rating	Definition
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
Tara Gilligan – Regional Monitor, Department of Juvenile Justice

Methodology

This modified review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused in particular areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (effective January 2022).

Persons Interviewed

	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate		# Case Managers
X	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
X	Program Director		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 by title): VP Quality
	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	4	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	14	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	4	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	2	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Surveys

6	# of Youth	9	# of Direct Staff		# of Other

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 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

Youth and Family Alternatives (YFA) Inc. operates three crisis shelters in the State of Florida that are contracted with Florida Network of Youth & Family Services, Inc. New Beginnings, located in Brooksville, Florida serves Hernando, Sumter, and Citrus 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 Community Counseling North Team of CINS/FINS also serves youth and families in the same counties and coordinates the delivery of community services to families and children in care. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are 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 8 CINS/FINS youth. YFA is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through October 31, 2024.

Since the last QI visit, the program has a new leadership team with the hiring of Jess Sternthal, Vice President of Prevention and Residential Shelters, and the promotion of Isabel Dias to Program Manager. Prior to her promotion in December 2021, Ms. Dias served as the Residential Supervisor for RAP House, another CINS/FINS program operated by the agency. In her new position, Ms. Dias has hired a Team Lead (internal promotion), a Residential Supervisor, an Office Specialist, and is in the process of hiring new youth care staff as well as the RN for the shelter.

The past year has been a challenging year for YFA New Beginnings regarding staffing. The agency has experienced critical staffing issues due to significant turnover between November 2021 and January 2022 including a program manager, a counselor, and ten youth care positions, four of which occurred in the month of December. Currently, there are five vacant positions: a residential supervisor, three part time youth care positions, and a nurse. The VP of Shelters indicated the agency has implemented a staff stabilization plan focused on recruiting staff and increasing staff capacity to 93% by the end of March 2022. As of the QI visit, the agency demonstrated progress toward achieving this goal and had experienced an increase in staffing capacity, up from 43% in February to 61% in March. 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

New Beginnings is under the leadership of a management team that consists of a VP of Prevention and Residential Shelters, a shelter Program Manager, a Community Counseling Program Director, and a Residential Supervisor, and a residential team lead. New Beginnings is currently staffed with a licensed counselor, an office specialist, an outreach coordinator, 3 shift leads, 5 full-time YDS, 1 part time YDS. There are 3 part-time YDS positions open as well as the nurse’s position. 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 New Beginnings are summarized as follows:

Standard 1:
Three indicators were reviewed for this standard. One of the three indicators 1.01 was rated satisfactory with exceptions. Indicators 1.04 and 1.06 received a limited rating due to training deficiencies observed for three first year staff and three in-service staff, and lack of supervisor's approval for single youth transports.

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. Both indicators were rated satisfactory with exceptions noted. The exceptions for indicator 3.01 were due to missing chemical inventories, a missing MSDS for one chemical, insufficient fire drills conducted during the past 6 months, and missing emergency drills. Indicator 3.06 was found to have exceptions resulting from inadequate staffing during the period November 2021 – January 2022.

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 or Failed Rating (If Applicable):

Standard 1
Indicator 1.04 – Limited
None of the three first year staff completed all mandatory trainings required in the first 90 days as follows: one staff was missing five mandatory trainings (DJJ SkillPro Information Security Awareness, EEO, PREA, Suicide Awareness, and Fire Safety Equipment); another staff was missing four required trainings (Behavior Management, valid CPR, valid First Aid, and DJJ SkillPro PREA training); and the third staff was missing Behavior Management training.

None of the three in-service staff completed all annual trainings required as follows: one staff was missing seven annual trainings (DJJ SkillPro: Suicide Prevention, Sexual Harassment, Human Trafficking, Child Abuse; FN Suicide Prevention; valid CPR; and valid First Aid training); a second staff is missing seven annual trainings (DJJ SkillPro: Suicide Prevention, PREA, Sexual Harassment, Human Trafficking, Child Abuse reporting; FN Suicide Prevention, and Fire Safety Equipment); and the third staff is missing FN Suicide Prevention training.

Indicator 1.06 – Limited
No evidence of approval was observed in the logbook or on the transportation log for four of the five single transports that occurred during the review period. Also, time of travel was not documented on the transportation logs reviewed for the Kia Sedona.

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: Agency has required policy and procedure RGC 1.01 that was reviewed 7/20/21 and approved by the CEO.	
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 uses the Criteria Basic Skills Test (CBST) pre-assessment tool to determine eligibility for employment that was implemented December 19, 2019. An eligible pass rate is a minimum raw score of 30. The tool was utilized to screen all eleven applicable new hires; however, one staff received a sub-score of 22 and the CBST was completed 2/28/2022 after the staff's 11/8/2021 hire date. The program manager indicated positive feedback of the staff's suitability based on observation of work performance was provided to HR to support job suitability despite the low score.	Exception One new staff was hired in November 2021 but did not complete the pre-screening CBST assessment prior to hire as required.

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**					A total of eleven new staff were hired since the last onsite QI visit. All eleven background screenings were initiated prior to DJJ hire dates with eligibility documented on the Clearinghouse results. No exemptions were applicable. There were no eligible volunteers in the program during the review period.	
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 eligible staff hired with a break in service for less than 90 days.	
Five-year re-screening completed every 5 years from initial date of hire		**X**				The program had three eligible staff who met the criteria for 5-year re-screening during the review period. Two of the three staff had active retained prints with the clearinghouse; however, the rescreening was still in process for the third staff whose rescreening was submitted 3/9/2022 during the QI review.	Exception The agency did not have a completed five year rescreening for one applicable staff whose results were still pending due to a request that was submitted 3/9/2022 during the 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 program had a signed and notarized Annual Affidavit of Compliance with Level 2 Screening Standards that was completed, notarized, and sent to the Background Screening Unit (BSU) on February 28, 2022 after the January 31st deadline.	Exception Annual Affidavit of Compliance with Level 2 Screening Standard was submitted to DJJ BSU on 2/28/2022 after the January 31st deadline.
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**X**					Proof of E-Verify work authorizations were maintained in all eleven new hire files.	

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 provider has a written policy and procedure RGC 1.04 that was reviewed on 2/11/2022 and approved by the CEO.

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 first year direct care staff files were reviewed. All three staff competed the USJDO 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				All three first year staff training records reviewed did not demonstrate staff had completed all mandatory trainings required during the first 90 days of hire.	Limited Exception None of the three first year staff completed all mandatory trainings required in the first 90 days as follows: one staff was missing five mandatory trainings (DJJ SkillPro Information Security Awareness, EEO, PREA,Suicide Awareness, and Fire Safety Equipment); another staff was missing four required trainings (Behavior Management, valid CPR, valid First Aid, and DJJ SkillPro PREA training); and the third staff was missing Behavior Management training.
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			Program has one new clinical shelter staff hired within the last year; however, staff is licensed.	
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			No eligible non-licensed 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				All three in-service staff training records reviewed did not demonstrate staff had completed all mandatory annual trainings required and one community counseling staff did not complete the 24 hours of training required.	Limited Exception None of the three in-service staff completed all annual trainings required as follows: one staff was missing seven annual trainings (DJJ SkillPro: Suicide Prevention, Sexual Harassment, Human Trafficking, Child Abuse; FN Suicide Prevention; valid CPR; and valid First Aid training); a second staff is missing seven annual trainings (DJJ SkillPro: Suicide Prevention, PREA, Sexual Harassment, Human Trafficking, Child Abuse reporting; FN Suicide Prevention, and Fire Safety Equipment); and the third staff is missing FN Suicide Prevention 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 program has training files for each staff that contain training hours tracking forms, certificates, sign-in sheets and other training material.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: The provider has a written policy and procedure RGC 1.06 that was reviewed on 10/5/2021 and approved by the CEO.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The program provided a list of sixteen approved drivers with current driver's licenses who are covered under the agency's insurance policy.	

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					The approved drivers' list indicates driver's license eligibility status for each of the sixteen eligible staff. A valid auto insurance policy was also submitted for review.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	X					The agency's transportation policy RGC 1.06 outlines the importance of avoiding single youth transports. It also specifies that in the event of a single transport, a supervisor's pre-approval is required, youth should be sitting in the back, and an open line should be maintained.	
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				Five single transports were reviewed for the review period. Only one of the five single transports indicated approval by supervisor on the transportation log.	Limited Exception No evidence of approval was observed in the logbook or on the transportation log for four of the five single transports that occurred during the review period.
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The program utilized staff and/or youth when available for transports completed with a third party.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.		X				The program had two vans for transporting youth up to 1/1/2022 when one of the vans was transferred to the RAP House location. The current van in use is a 2017 Kia Sedona.	Limited Exception Time of travel is not documented on the transportation logs reviewed for the Kia Sedona.
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 provider has a written policy and procedure RGC 1.06 that was reviewed on 10/5/2021 and approved by the CEO.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	The provider has a written policy and procedure RGC 2.03 that was reviewed last reviewed on 1/24/2022 and approved by the CEO.	

Case/Service plan is developed within 7 working days of NIRVANA	X					Three residential youth records (one open and two closed), and three community counseling youth records (one open and two closed) were reviewed. All six youth service plans were completed within seven days of admission.	
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				Individualized and prioritized needs and goals were identified in all six records . Similarly, service type, frequency, location, person responsible, and target dates for completion were included in all six records. All six plans had the date of initiation evidenced by signature of the youth, parent/guardian, and counselor. Five of the six plans were signed by the supervisor.	Exceptions 1) The service plan for one closed residential youth record was missing the signature of the supervisor. 2) A second closed residential youth record was missing the actual completion date for goals on the service plan.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	X					Three applicable plans were reviewed for progress and revised by the counselor every thirty days. Two of the plans were revised for the first three months, and the remaining plan was only open for two months.	
Standard Three – Shelter Care							
cy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: The provider has a written policy and procedure RGC 3.01 that was reviewed on 10/13/2021 and approved by the CEO.	
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 Program Manager. During the tour, the furnishing were observed to be in good condition with no rips or tears. All beds appeared sturdy and functional. No insect droppings or infestation was noticeable. The shelter is located on a large campus. The exterior areas are well maintained and free of debris/hazard. Attractive flowers adorn the entrance of the shelter. The campus has a large backyard with adequate separate recreational spaces for volleyball and basketball. 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 boys also have access to 2 full bathrooms. Each 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 some areas have lighting that is motion activated. The program uses a 2017 Kia Sedona minivan to transport youth. The van is equipped with a first aid kit, flashlights, fire extinguishers valid through July 2022, glass breaker, and seat belt cutter, air bag deflator, and emergency equipment. Working batteries were added to the flashlight in the van during the tour. The program has 5 sets of keys, one for program manager and four to be used by staff. Doors are kept locked throughout the residential areas and accessible only with a key. A key fob is used to enter the dorm areas.	Exceptions 1) Chemical inventories were only available from December 2021 through current as former inventories could not be located. Chemical inventory is done weekly but not maintained on a perpetual basis to accurately reflect reduction in count due to usage. 2) Material Safety Data Sheets (MSDS) were available for all but one chemical (Purefy Pro) used by the program. Per Residential Team Lead, the MSDS could not be located online and no available contact information is on the container label.

Additional Facility Inspection Narrative (if applicable)	Egress plans are located in each staff office, in common areas and in each youth bedroom. Abuse hotline information is posted on each dorm wing as well as in a red binder, including CCC number, located at the exits of the facility. Rights/responsibilities is posted in the lobby. Grievance box and forms are accessible to youth at the entrance to youth dorm. SOGIE signage was observed posted throughout the facility. Room searches are conducted randomly weekly. Youth has open shelfing area for personal clothing. No contraband was observed. There are 3 separate storage areas - laundry room, kitchen, and chemical closet. Inventories are available for each storage location from December through current only as former inventories could not be located. MSDS were available for all but one chemical (Purefy Pro) used by the program. Per Residential Team Lead, the product will be removed because the MSDS could not be located online and no available contact information is on the container label. The inventory is done weekly but not maintained on a perpetual basis to accurately reflect reduction in count due to usage. Program has one laundry room equipped with 2 washers and 2 dryers. All were observed to be in great condition as they were purchased in December 2021 and were clean and free of lint. During the tour, all beds had a pillow and was covered with bed sheets and a comforter. A locked box is available in the medication room and cabinet next to laundry room to secure youth belongings needing lock up. DCF license is posted in the lobby and is effective through August 9, 2022. COA accreditation is effective through 10/31/2024						
Fire and Safety Health Hazards	X					A successful annual fire inspection was conducted by Brooksville Fire Department on 7/23/2021. Four of the fire extinguishers in the facility and one in the van was inspected July 2021, valid one year. The most recent alarm and emergency equipment testing was completed 12/3/21 by Piper Fire Protection. Satisfactory combined Department of Health group care and food inspection was completed 2/14/22; one violation regarding date marking was found and corrected immediately by staff.	
Additional Fire and Safety Health Hazards Narrative (if applicable)	Only 3 fire drills, one each month, were reported for the review period (Dec 2021-Feb 2022).Only 2 emergency drills were reported for the review period, one on the 1st shift in Dec 2021 and one on the 3rd shift in March 2022. The pantry is located adjacent to kitchen behind a locked door. Sharps are kept in a locked box in the pantry; A first aid kit is also located behind the door in the pantry. Refrigerator temperature was observed to be 40 degrees Fahrenheit; freezer temperature was 0 degrees Fahrenheit.						Exceptions 1) Only 2 emergency drills were conducted during the review period, one on the 1st shift in December 2021 and one on the 3rd shift in March 2022, missing the required quarterly drills on each shift. 2) The program did not provide evidence of monthly fire drills for September - November 2021, only for December 2021-February 2022.
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					Program has an activity calendar as well as program schedule posted at entrance to dorm area 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 program schedule is posted at the entrance to dorm area with structured activities each day.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: The provider has a written policy and procedure RGC 3.06 that was reviewed on 11/17/21 and approved by the CEO.	
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	X					Reviewed staff schedules for the past 6 months. The program maintained the required ratio of 1 staff to 6 youth during awake hours and community activities and 1 staff to 12 youth during the sleep period.	

• 1 staff to 12 youth during the sleep period							
All shifts must always provide a minimum of two staff present		X				During the months of November 2021 to January 2022, the program has experienced significant staff turnover resulting in the loss of 2 youth care staff in November, 6 staff in December (program manager, counselor, and 4 youth care), and 2 youth care staff in January 2022. As a result of this external control factor, the agency was unable to maintain two staff on each shift during the months of January and February. A corrective action plan was implemented to focus effort on recruiting staff and stabilizing staffing. Since implementing this plan, the program has seen an increase in staffing capacity, up from 43% on 2/7/22 to 61% on 3/7/22. The goal is to achieve 93% capacity by 3/28/22.	Exception: The review of staff schedules revealed timeframes where the program was not able to meet the requirement of two staff per shift. There is evidence management implemented a corrective action plan with demonstrated improvement in staff recruitment and staffing. Consequently, the rating is satisfactory with the exceptions mentioned above, rather than a Limited rating.
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					Shelter staff included in the staff-to-youth ratio included only properly trained youth care workers. Youth care workers in training were identified on the staff schedule with an asterisk (*) and were not included in the staff to youth ratio.	
The staff schedule is provided to staff or posted in a place visible to staff	X					Residential supervisor maintains schedule in a binder, and schedule is posted on a wall adjacent to dorm entry door.	
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					Staffing challenges experienced by the program impacted availability and access to additional staff to create a holdover roster; however, team leads, counselors, and other trained agency staff are utilized to fill gaps.	

Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction		X				The facility has two separate wings, one for each gender. Five random overnight shifts during the past six months were reviewed for 15-minute bed checks as follows: 9/23/21, 10/10/21, 11/7/21, 12/16/21 (3am-5am) and 1/24/22 (4am-6am). On 9/23/21, 2 sequential bed checks were not documented in the log book at respective check time. Staff made an entry in the logbook to indicate they were done but did not write the checks at the appropriate times as they were cleaning the facility.	Exception On 10/10/21, five (5) bed checks were conducted beyond the 15-minute requirement.
Standard Four – Mental Health/Health Services							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES** If NO, explain here: The provider has a written policy and procedure RGC 4.02 that was reviewed on 2/8/22 and approved by the CEO.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Suicide Risk Screening and Approval							
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	X					Four applicable residential youth records were reviewed for two open and two closed records. All four youth had documentation suicide risk screening occurred during the initial intake and screening process. Suicide screening results were reviewed and signed by the supervisor and documented in the youth's case file.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	
Supervision of Youth with Suicide Risk							

Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	X					All four youth screenings indicated suicide risk as a result of the suicide risk screening, and the youth was placed on sight-and-sound supervision until assessed by a licensed professional. Three of the youth were assessed by a licensed professional in the morning of the first business day following the intake screening. The remaining youth entered the program on March 8, 2022 and had not been at the program long enough to be assessed by the licensed professional at the time of the review.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					All four youth were placed on the appropriate level of supervision based on the results of the suicide risk screening. Staff assigned to monitor the youth documented the youth's behavior at thirty minute or less intervals and included the time of day, behavioral observations, any warning signs observed and the observer's initials.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	X					The supervision level was not changed or reduced until a licensed professional completed a further suicide risk assessment on the three applicable youth.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES** If NO, explain here: Indicate policy number, authorized signee, date(s) of last review/revision/approval:	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**	The provider has a written policy and procedure RGC 4.03 that was reviewed on 2/8/22 and approved by the CEO.	
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)						All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth. The Pyxis machine in stored in accordance with guidelines in Florida Statute 499.0121 and policy section Medication Management. Medications requiring	

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**					refrigeration are stored in a secure refrigerator, located in a secure room, and the refrigerator is used only for this purpose. Temperatures are kept between 36 and 46 degrees for storage of medications.	
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						The agency maintains a minimum of two Super Users for the Med-Station. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances. A Medication Distribution Log is used for distribution of medication by non-licensed and licensed staff. The medication delivery process was consistent with the FNYFS medication management and distribution policy. At the time of the review, the nurse's position was vacant for six months. The agency does not accept youth currently prescribed injectable medications, except for epi-pens. Documentation was reviewed which	

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					pens. Documentation was reviewed which showed non-licensed staff have received training in the use of epi-pens provided by the registered nurse.	
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					Controlled substances prescribed have a perpetual inventory with running balances and shift-to-shift counts are verified by a witness and documented. The program does not provide over-the-counter medications. If a youth requires an over-the-counter medication, the youth's parent or guardian is contacted to bring the medication to the youth at the program. The youth can then be provided the single dosage of medication, and the parent or guardian is required to take the remaining medication home. Syringes and sharps are secured and counted at least weekly. Documentation of these inventories was reviewed and there were no discrepancies.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	
Medication discrepancies are cleared after each shift.	X					Medication discrepancies are cleared after each shift.	