Florida Network of Youth and Family Services
Quality Improvement Program Report

Review of CCYS - Tallahassee
CINS/FINS Program

November 2-3, 2022

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	**Satisfactory**
2.04 Case Management and 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: 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
Ken Phillips – Regional Monitor, Department of Juvenile Justice

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the 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 August 1, 2021).

Persons Interviewed

X	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
X	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	Direct – Care Full time	2	# 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
X	Clinical Director		Volunteer		# Other (listed by title): ___
X	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	X	Grievance Process/Records		# Health Records
X	Logbooks	X	Key Control Log	6	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	19	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	10	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	5	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	7	# Youth Records (Open)
X	Fire Inspection Report	X	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	X	Tool Inventory and Storage	X	Facility and Grounds
X	Recreation	X	Toxic Item Inventory & Storage	X	First Aid Kit(s)
X	Searches		Discharge	X	Group
X	Security Video Tapes		Treatment Team Meetings	X	Meals
X	Social Skill Modeling by Staff	X	Youth Movement and Counts	X	Signage that all youth welcome
X	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

2	# of Youth	15	# of Direct Staff		# of Other		

Comments

Due to COVID-19, this review was conducted onsite/hybrid/virtually.

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

Someplace Else Shelter

The agency is experiencing staff member vacancies in counseling positions and reports there is a very competitive market for individuals with clinical licenses. At the time of this quality improvement (QI) program review, the agency staff includes master-level residential and non-residential counselors. There are four counselors in community counseling and two in residential. A residential counselor is currently the acting clinical director.

The agency is licensed by the Department of Children and Families (DCF) for 18 residents. The agency has established limiting the number of youth it can effectively serve. The agency has capped the census at a 12-resident capacity for the last year. Last month in October, the youth census was up to and at times over 12 in the last year and a half. At the time of this QI program review there were eight youth which included six CINS/FINS and two DCF.

The agency implemented Florida Network of Youth and Family Services (FNYFS) NIRVANA assessment instrument in January 2022. The agency certified two staff members in Managing Aggressive Behavior (MAB). The agency received two federal grants for housing for their Transitional Living Program (TLP) and Street program. The agency is also collaborating with Career Source to inform and secure older CINS and DCF youth 16 years of age and up for job opportunities.

The agency reported since October 2021, daily operations have been relatively steady. The Someplace Else (SPE) has continued to work with Junior League, Elder Care Services and a developed new relationship with Second Harvest (created to receive fresh fruit and vegetables for the youth). The Junior League of Tallahassee has also worked extensively with SPE to assist in decorating for the holidays. The Junior League participated in 30 Days of Giving, in which they provided CCYS staff members with small gifts during the holiday season. The shelter bedrooms have gone through a "facelift" with new paint, carpet, and artwork. In April 2022, CCYS reached a milestone 29 years of service to the community and celebrated with various events throughout the week to show case appreciation. The celebration events included participation of both staff and shelter youth.

The agency's leadership reported requests for services have picked up with the community opening back up in the last several months. The agency reported with the amount of youth needing services, it has been a struggle trying to serve them all. During this time, the agency reported staff member turnover continued to be high and creating shifts for the employees to work and serve the youth has been challenging. The agency reports it has been able to do the best of its abilities to make things work. Since last year the agency has had six staff members leave to advance their careers and were able in return to hire seven direct care staff (including a Registered Nurse) to help.

The holiday time is a special time of the year and not all of the youth are able to spend time with the people they want to

spend it with. During Thanksgiving time, the agency prepared meals for the youth, had a turkey drive, and enjoyed the company of the staff and youth. There was an ugly Christmas party with the youth and a door decoration contest during December. The summer months were filled with outside activities. In August, the agency had their 3rd annual book back drive to give back to the community. The shelter youth were able to benefit from this drive.

Staff Recruiting Challenges

There are a lot of referrals not applicable or the experience does not match up when recruiting staff through Indeed and other job platforms. Major channel utilized by the agency to recruit and advertise job openings is word of mouth, Indeed online platform, job fairs at local universities, employees and general endorsement. The suitability assessment utilized by the agency is called Berke – HighMatch; based on a low, moderate or strong match job candidate. The agency reports that it provides prompts to help them further assess the candidate prior to hiring.

Stakeholders

Additionally, the agency reported working extensively with the State Attorney's Office and Public Defender's Office to ensure the best outcomes for youth and families who are utilizing the youth shelter for domestic violence respite services. The SPE shelter manager and clinical director met with the State Attorney's Office Juvenile Division Chief to ensure successful outcomes for both the youth and family when addressing violence against family members in the home. The agency reported due to the COVID-19 pandemic, domestic violence has become an increasingly prevalent issue. The agency Chief Executive Officer (CEO) also met with the State Attorney, Jack Campbell, to discuss challenges and opportunities for better collaboration.

The agency reported it has been able to provide youth different outings including bowling, movies and have created a working relationship with Tallahassee Fire Department. The Tallahassee Fire Department has participated in CCYS's Field Day with bringing the fire truck and allowing the youth to look and be informed about the features of the fire truck.

SNAP Program

The agency reported some barriers in operating the SNAP program including family withdrawal rates this year were higher in comparison to previous years. Specifically, families attended intakes and orientations, but then would not attend groups. The participant withdrawals places the program in a more challenging position because the agency tries to find replacements which are not always available. The agency reports it will continue to increase its efforts to offer parents incentives to increase program engagement.

This past year, the agency reported it did not receive as many group-ready referrals for its program. Some of the referrals received were youth who were too old. Additionally, some of the referrals received were for youth who needed more than what SNAP could offer. Once a family gets services from one program, the family sometimes does not want to transfer to another program, or their child is doing better and no longer requires SNAP. The program also did not receive as many referrals as usual. The agency reports it is dealing with COVID and has experienced challenges in being able to do its usual outreach and recruitment of youth with the appropriate profile and needs. The agency reported it will implement efforts to increase the presence of the SNAP program across the city and attend outreach events; as well as using SNAP in Schools as a hot bed for referrals.

The agency reported not being able to facilitate a girls' group this year due to the lack of referrals. The agency has experienced receiving fewer referrals. The families either had conflicts or denied the program needs. The agency has

facilitators available to conduct a girls' group, but it does not have girls to place in the group. The agency plans on trying to use its SNAP in School classes to identify girls who can benefit from the program.

Site Activity and Performance

- Facilitated multiple boys' cycles with siblings and not having any issues.
- Facilitated a parent's group with divorced parents with no issues.
- Got agency staff member SNAP Facilitator trained
- No staff turnover
- Successful data entry/uploads
- Established a new working relationship with a Gadsden County school & Jefferson County schools
- Met all SNAP in Schools numbers.
- Continued school partnership with Hartsfield, Sabal Palm and Governors Charter (3 years and counting)

Family Place Community Counseling Program

The past year has been one of significant turnover with all new current Leon County counselors since the last QI program review. There is one counselor (in nearby rural Wakulla County) who has been with the agency more than a year. This staff member acquired the position after completing an internship with CCYS.

In addition to counselors, the clinical director also departed CCYS earlier this year. Specifically, the agency reported that it has seen many counselors leave the agency once they become licensed. A former clinical director, who was a licensed mental health counselor, relocated to the Washington DC area for a career advancement. The residential clinical director transferred into the community counseling director role, though she has actually been performing in both roles as her previous position remains vacant.

The agency reported numbers have remained low and that is thought to be remnants of COVID, particularly the schools not being as organized with their staff and making referrals. The program has been in several schools, however, providing groups in some cases and individual counseling at others.

Most recently, the Family Place Program has started receiving an increase in referrals from Leon County for cases in which they have already filed Truancy Petitions. The agency reported that it is working with the DJJ attorney to navigate this change and bolster the Case Staffing Committee.

Narrative Summary

The CCYS is under the leadership of the Chief Executive Officer/President, Chief Operations Officer, Outreach and Development Director, Shelter Program Manager, Residential Services Clinical Director, Residential Supervisor, Registered Nurse, Non-Residential Services Clinical Director, Street Outreach Supervisor, Stop Now and Plan Coordinator, Human Resource Coordinator, with five full-time and eight part-time Youth Care Specialists, two Residential Youth and Family Care Counselors, four Non-Residential Youth and Family Care Counselors; and the Residential Shelter Support Specialist is vacant. There is one Residential Service Intern and one Non-Residential Services Intern. The CCYS agency provides residential and non-residential services to youth ages six to seventeen. The Some Place Else (SPE) Youth Shelter facility is located in Tallahassee, Florida. The non-residential program provides Children In Need of Services and Families In Need of Services (CINS/FINS) services to the following counties: Franklin, Gadsden, Jefferson, Leon, Liberty, Madison,

Taylor and Wakulla. Additionally, CCYS provides services to special populations who meet the criteria for Domestic Violence Respite (DV); Staff Secure shelter; Domestic Minor Sex Trafficking (DMST); youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family and Youth Respite Aftercare services (FYRAC); and Stop Now and Plan (SNAP). CCYS is not contracted to provide Intensive Case Management services.

The agency has increased both in the number of full-time and part-time staff members. Since the last review in September 2021, the shelter has increased the youth care roster from 7 to 14 and as of the QI program review. The Registered Nurse position is now filled. The agency secured a new person for the position on June 14, 2022, after the position was vacant for an extended period of time.

The overall findings for the QI Review for CCYS are summarized as follows:

Standard 1: Standard 1 has a total of three indicators regarding management accountability. Two of the three indicators in Standard 1 were rated Satisfactory with exceptions (1.01 Background Screening of Employees/Volunteers and 1.06 Client Transportation). One of the three indicators was rated Limited (1.04 Training Requirements).
Standard 2: Standard 2 has a total of one indicator that is related to intervention and case management. The indicator 2.03 Case/Service Plan was rated Satisfactory with exceptions.
Standard 3: Standard 3 has a total of two indicators regarding shelter care. Two of the two indicators were rated Satisfactory with exceptions (3.01 Shelter Environment and 3.06 Staffing and Youth Supervision).
Standard 4: Standard 4 has a total of two indicators regarding mental health and health services. One of the two indicators was rated Satisfactory with no exceptions (4.02 Suicide Prevention) and one indicator was rated Satisfactory with exceptions (4.03 Medications).

Summary of Deficiencies resulting in Limited or Failed Rating:

Standard 1: Indicator 1.04 Training Requirements – Limited
One first year staff member failed to produce evidence training documents indicating completion of multiple training topics within the first 30 and 90 days of employment. One in-service staff member failed to produce evidence indicating completion of required training topics (CPR, First Aid, Fire Safety). One in-service staff members failed to complete the forty-hour annual training requirement.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator		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			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: The agency policy number is 1.01, Background Screening. This policy content addresses all requirements for this indicator. The policy was reviewed and approved by the Chief Executive Officer in September 2022.	
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.	**Exception**	A total of twelve employees and six interns were applicable and reviewed for the initial background screening requirements. All twelve employees and six interns had evidence of an eligible background screening completed prior to their start date with the program. Each of the twelve employees also had evidence of a completed pre-employment assessment tool done prior to their hire date. None of the eighteen total staff reviewed indicated a break in service. The program utilizes the Burke Job Fit Report as their employment assessment tool.	Exception: A youth care specialist (YCS) had a hire date of July 19, 2022 and a pre-employment assessment tool completed August 2, 2022. It is noteworthy to mention according to the Human Resources Coordinator, this staff was originally hired as an intern prior to a YCS; therefore, did not require the pre-employment assessment tool to be completed until after their original hire date as an intern.
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	**Compliance**	A total of twelve employees and six interns were applicable and reviewed for the initial background screening requirements. All twelve employees and six interns had evidence of an eligible background screening completed prior to their start date with the program.	

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.	**No eligible items for review**	No staff reviewed were eligible for having a break in service.	
Five-year re-screening completed every 5 years from initial date of hire	**No eligible items for review**	There were no staff who were observed requiring a five-year re-screening.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	An Annual Affidavit of Compliance with Level 2 Screening Standards was completed and submitted to the Background Screening Unit on January 10, 2022.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Each staff had proof the E-Verify was obtained from 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)			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency policy number is 1.04, Training. This policy content addresses all requirements for this indicator. The policy was reviewed and approved by the Chief Executive Officer in September 2022.	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	A review of four first year staff member training records were conducted to assess the agency's adherence to the requirements of this indicator. There is documentation in each staff member's training record to verify all new hire pre-service training requirements for safety and supervision have been met.	

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)*	**Exception**	Training records for four staff members who completed their first year were reviewed. Reviewed training documentation confirmed of three of the four staff members completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	Exception: One the four staff members does not have evidence of completing the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	Four randomly selected staff member training records were reviewed and each training record contained evidence of completing 80 hours of training or more for the first full year of employment. Four of four staff members have evidence of completing necessary training hours to date. None of the randomly selected staff members have completed their first year of employment. Staff members are still within their first year to meet annual new hire required training topics.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Two of three staff completed all mandatory training topics during the first 90 days of employment from date of hire.	Exception: One of four staff members does not have documented evidence of completing all mandatory training hours during the first 90 days of employment from date of hire.
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**No eligible items for review**	Four staff member training records were reviewed for adherence to the requirements of this indicator. None of the four eviewed staff roles were responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS).	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	The program has not hired any applicable non-licensed mental health clinical shelter staff since the last QI review.	
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).*	**Compliance**	Four staff member training records were reviewed for adherence to the requirements of this indicator. Three of four staff members contained documented evidence of completing the required minimum of 40 hours for residential training. One of the four staff members contained evidence of completing the required 24 hours for non-residential training hours.	
Required Training Documentation			
The agency has a designated staff member responsible for managing all employee's individual training files and completes routine reviews of staff files to ensure compliance.	**Exception**	At the time of this on-site program review, the agency has designated the Human Resources Coordinator as primarily repsonsible for managing all employee's individual training records. An interview with the agency's Chief Operations Officer and Human Resources Coordinator regarding the current status of maintaining training records was conducted.	Exceptions: The agency did not have staffing to consistently monitor training records to ensure that training courses are completed by staff members. Current training course completion slips used by the agency are not being entered in to staff member training logs in a timely manner. The agency does not contain organized individual staff member training records in order to conduct routine reviews of completed trainings to ensure compliance.
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Exception**	The program currently maintains tracking of completed training through training completion slips. At the time of this program review, staff member training records were not in separate training files for each of the staff members. Staff training records include training completion sheets that document the completed training(s) and includes the training topic, hours and date the training was completed. Training certificates, sign-in sheets and other training-related documents were present for staff members.	Exceptions: The agency does not have consistent comprehensive training files that organize and total up training hours for each staff member. Current training course completion slips used by the agency are scattered and not organized. Further, training completion slips are not being entered into the individual staff member training logs.
1.06: Client Transportation			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency policy number is 1.06, Transportation. This policy content addresses all requirements for this indicator. The policy was reviewed and approved by the Chief Executive Officer in September 2022.	

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency provided a list of drivers approved by administrative staff to drive youth in approved agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Documentation was provided indicating the list of the agency's approved drivers. According to an interview with the program's Human Resources Coordinator, the insurance provider, Hub International, provides the program a list of staff members approved based on receipt of their driver licenses. All current staff members are listed and approved to conduct transport events for the program.	
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	**Compliance**	The program has a written policy and applicable procedures which prohibits transporting a youth without maintaining at least one other passenger in the vehicle during all transportation events.	
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	**Compliance**	The agency's policy and procedures includes staff requirement in the event a third party cannot be obtained for transporting a youth. The policy indicates the youth's history, evaluation, and recent behavior are items taken into consideration when approving single transports.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency's policy and procedures requires the third party rider for youth transportation events be an approved volunteer, intern, agency staff, or other youth.	

The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	A review of Vehicle and Transportation Logs provided for the scope of the annual compliance review was conducted. A total of 258 transports were observed documented as facilitated for the scope, which included a total of 96 single youth transport events, each of which a single staff facilitated the transport. Approval from supervisory staff for single transport events was documented with the corresponding Vehicle and Transportation Log.	Exception: One single transport event occurring October 18, 2022 was unable to be determined whether supervisory approval was obtained prior to the transport based on documentation. The time the transport initiated was documented for 8:35AM, and the supervisor approval was documented for 9:38AM. There were a total of seven of the 96 single transports where the transport staff was the supervisor, and prior approval was not obtained.
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.	**Compliance**	The program has Vehicle Transport Logs which capture all required documentation to include name and number of passengers and driver, mileage, destination and purpose, supervisory approval (if applicable), and time in and out.	
2.03 - Case/Service Plan			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency policy number is 2.03, Case/Service Plan Screening. This policy content addresses all requirements for this indicator. The policy was reviewed and approved by the Chief Executive Officer in September 2022.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	Eight randomly selected client files served in the last six months from April 2022 to October 2022 were assessed to determine their adherence to the requirements of this indicator. Four of the clients are Community Counseling files (two open files and two closed files) and four client files are residential client files (two open files and two closed files). Eight of the eight client files contained an initial case plan based on presenting problems obtained during the initial screening, intake and NIRVANA assessment process.	

Case/Service plan is developed within 7 working days of NIRVANA	**Exception**	Eight randomly selected client files served in the last six months were reviewed. The reviewer identified the date of assessment in six client case files to determine their adherence to the case plan being developed. Six of the eight client files contained evidence that the initial plan was developed within the seven working days of NIRVANA process.	Exception: Two of the eight client files did not contain evidence that the initial plan was developed within the seven working days of NIRVANA process.
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	**Exception**	Eight randomly selected client records served in the last six months from April 2022 to October 2022 were reviewed to assess the status of case plan services provided by the agency. Eight of the eight client records were reviewed and found to have individualized case plan which addressed the goals identified during the screening, intake and in the NIRVANA assessment. Eight of eight client records contained evidence of each record documenting the service type, frequency, and location associated with addressing each client's goals in their respective service plans. Eight of eight client records contained evidence of the designated person responsible for completing each goal documented in each file. Eight of eight client records contained evidence documenting the scheduled target dates. Three of the six eligible client files contained evidence of the actual date of completion of goals. At the time of this on-site program review, two of eight client records were open ongoing cases and were not yet due to be completed. Eight of the eight client records contained evidence of client signatures documented in each file. Seven of the eight client records contained evidence of parent/guardian signatures documented in each file. Eight of eight client records contained evidence of the supervisor's signature documented in each file.	Exceptions: Three of the six client records reviewed did not have evidence of documenting the actual completion dates. One out of eight client records did not contain evidence of the parent's signatures.

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	**Compliance**	Eight randomly selected client files served in the last six months from April 2022 to October 2022 were reviewed to assess the status of case plan services provided by the agency. Four of the eight client files were eligible to be reviewed for adherence to the requirements of this indicator. Four of the four eligible client files contained evidence of case plans which were reviewed for progress by counselor and parent/guardian every 30 days.	
3.01 - Shelter Environment			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency policy number is 3.01, Shelter Environment. This policy content addresses all requirements for this indicator. The policy was reviewed and approved by the Chief Executive Officer in September 2022.	

Facility Inspection	**Exception**	The agency has a Florida Department of Children and Families (DCF) license. The current license is in effect through December 20, 2022. A full tour of the residential youth shelter was conducted during the onsite program review. The tour was guided by the Residential Director. The facility is well furnished and all furnishings were in good order with no visible damage. The youth shelter includes an entryway with a foyer that limits access to visitors. The facility is an open layout and has a main day room, youth reading area, computer room, eat in kitchen, resident bedrooms, resident and staff members' bathrooms, youth care work station, medication room, utility/janitor closet, pantry, laundry and storage room, and supervisor and counseling offices. The resident bedrooms are outfitted with all required bedding items including pillows, fitted sheets, spread and comforters. Each bedroom is clean and no graffiti was observed in any of the sleeping rooms. All rooms do not contain contraband and do not have evidence of hazardous unauthorized metal/foreign objects including cords, rope or metal shower rings. Each bed has a designated storage shelf. All bathrooms are clean and operational. Both washers and both dryers are operational. The lint collector in the dryer is clean. The food menu is posted and up-to-date. All cold food stored in the refrigerator and freezers are marked as required. The dry food storage area in the pantry is clean. All lighting is operational except one lighting fixture in the dayroom. All agency vehicles and personal staff vehicles were found to be locked.	Exceptions: One resident bathroom has a leaking shower head. One lighting fixture is not working in the day room. The agency did not have a perpetual inventory for chemicals on-site at the time of the annual QI program review. A perpetual inventory was developed; however, during the review and according to the center's supervisory and administrative staff, will be maintained according to the requirements of the indicator.

Fire and Safety Health Hazards	**Exception**	Fire drill documentation was provided for the previous six months. Drill documentation included the names of staff and youth involved, date and time, location of the mock fire situation, and time of drill initiation and time of completion/evacuation. The program operates on three shifts. Drill documentation was found for each of the months reviewed and on each shift. All drill times between the time of drill initiation and time of evacuation were noted as being at two minutes or within as required, with the following exceptions: Drills on third shift for the months of August, September, and October were documented as three minutes. One drill on first shift in June was documented as five minutes. An annual fire inspection was conducted on October 11, 2022 by the Tallahassee Fire Department, which noted no violations. Annual fire extinguisher and fire safety equipment received an annual inspection on August 31, 2022 by Fotia Services, LLC. No issues were observed identified. In addition, the State of Florida Health Department was on-site February 3, 2022, based on documentation reviewed, to conduct an annual safety and health inspection. No violations were noted or identified.	Exceptions: Drill conducted in June showed a period of three minutes timespan between the time initiated and time of evacuation during the first shift. Drills for August, September and October 2022 indicated a timespan of three minutes between the time initiated and time of evacuation.
Additional Fire and Safety Health Hazards Narrative (if applicable)	Fire drills conducted on the First Shift: 12:00AM - 8:00AM. Drill documentation provided for the past six months. Drills observed documented as conducted for fire drills once a month on first shift. Second shift: 8:00AM - 4:00PM. Documentation indicated drills done monthly on second shift. As applicable, third shift: 4:00PM - 12:00AM. Drills documented monthly on third shift.		
Grievance			

There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	A locked drop box marked for grievances was observed located on the direct care staff station desk within the large common area. The box was visible and accessible to youth. Grievance procedures were observed posted on the box along with blank grievances for youth. Grievance instructions were posted on the box. Instructions provided also included language requiring staff to assist youth in completing a grievance in the event the youth needs help filling out the form.	
There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook. All grievances are resolved within 72 hours and documented by program director.	**Compliance**	During the annual compliance review week, observations were made of the shelter manager assigned unlocking and checking the contents of the grievance box. The checks were observed documented in the logbook and highlighted in purple. Completed grievances were maintained for the year by program administration. Grievances for the scope of the annual compliance review were reviewed. A total of six grievances were received. Each were addressed by staff on the Resolution of Grievance section of the form. Resolution date signature was at or within seventy-two hours for each grievance from the date the grievance was initiated.	
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.	**Compliance**	The agency has a detailed daily activity schedule posted on the bulletin board in the dayroom and in each hallway in the youth shelter. The program conducts a daily activities schedule that includes caring for all general needs and a broad range of daily activities. Specifically, the daily activities include 6:00am wake up, hygiene, room clean up/chores, morning motivation/card conference, breakfast, school, lunch, return to/from school, afternoon snacks, individual counseling sessions, structured in-house activities, outdoor activities, re-orientation jeopardy, dinner, group, structured activity, pm chores, showers, snack time, card conferences, bedtime and lights out at 9:30pm. The program schedule provides for daily physical activity and weekly faith-based activities. The shelter environment is abuse free and does extend the opportunity for non-punitive activities to those youth who do not participate in faith-based activities. The agency has a behavior management system (BMS) that each direct care staff member is trained to use when providing care and other shelter services to residents during their shelter stay.	
3.06 - Staffing and Youth Supervision			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency policy number is 3.06, Staffing and Youth Supervision. This policy content addresses all requirements for this indicator. The policy was reviewed and approved by the Chief Executive Officer in September 2022.	

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	**Compliance**	The program has a written policy and procedures which denotes the minimum staff to youth ratio requirement of 1:6 for daytime activities and a ratio of 1:12 during periods of sleep. The shift schedule was observed posted and visible for all staff members to review.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Logbooks and staffing schedules were provided which cover the scope of the annual compliance review. One day for each month of the review scope was reviewed for compliance with staff to youth supervision and ratio. A total of six days were reviewed and found evidence there were at least two staff for each of the three shifts reviewed. An interview with the Chief Operations Officer and direct care supervisor revealed in the event an additional staff may be needed to assist in supervision, a supervisor, counselor, or administrative staff may assist in this capacity, given they are working only at the time in direct supervision of youth and not in their role as staff supervisor or counselor.	
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	**Compliance**	All staff training records, including volunteers and interns, reviewed indicated each had an eligible background screening completed prior to their hire date.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	Staff schedule was observed posted behind the staff station desk in the dayroom area. The schedule is made available for all staff members.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	Staff names and phone numbers are documented on the weekly staff work schedule. An interview with staff and shift supervisor revealed in the event the shift is short a staff person, the supervisor and designated on-call staff person will be notified.	

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	**Exception**	Youth rooms are separated into double and triple occupancy. Youth are assigned to rooms based on age. The rooms are located along a hallway within the staff station and dayroom area. Cameras are located in the dayroom and hall areas and capture video surveillance of youth and staff activities 24 hours a day, seven days a week. The camera stores video footage from the previous 30 days. Five separate evenings were randomly selected to review for fidelity of the room checks by staff during sleeping hours. The following evenings of the last 30 days were reviewed: November 3, 2022; October 30, 2022; October 26, 2022; October 12, 2022 and October 31, 2022. Each evening had at least two staff members present as required. Staff members were observed opening youth room doors and looking in to perform the checks. Room checks were observed being done within fifteen minute time periods with some exceptions noted as follows: On October 30, 2022, checks were observed during the times between 12:11AM and 1:03AM. A check was observed on camera done at 12:11, 12:21, 12:32, and 1:03AM. However, it is noted the camera system appeared to jump in time from these gaps indicated. Corresponding Ten-Minute Bed Check Logs were obtained and had documentation checks were completed during this timeframe at required intervals. According to the supervisor assisting with this	Exceptions: Room checks were observed being done within fifteen minute time periods with some exceptions noted as follows: On October 30, 2022, checks were observed during the times between 12:11AM and 1:03AM. A check was observed on camera done at 12:11, 12:21, 12:32, and 1:03AM. However, it is noted the camera system appeared to jump in time from these gaps indicated.
Additional Staffing and Youth Supervision Narrative	video monitoring, the camera system has a history of skipping times and leaving gaps in the system. In addition, there is a noted delay in time from one camera video shown to another camera during the same time periods when viewed. According to the administrative staff, the program has been approved to receive a new camera surveillance system installed, which is planned to be completed this week. The administrative staff further stated, the plan is for the new system to have improved playback and to add additional camera views for the program.		
4.02 - Suicide Prevention			**Satisfactory**
	YES		

Provider has a written policy and procedure that meets the requirement for Indicator 4.02		If NO, explain here: The agency policy number is 4.02, Suicide Prevention. This policy content addresses all requirements for this indicator. The policy was reviewed and approved by the Chief Executive Officer in September 2022.	
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
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.	**Compliance**	Six randomly selected client records served in the last six months from April 2022 to October 2022 were assessed to determine their adherence to the requirements of this indicator. Six of the six client records contained documented evidence of the client indicating a 'Yes' response to at least one of the five suicide questions. Each direct care staff member is trained and screen all residential clients with the five suicide risk screening questions during the intake process. All six client files answered 'Yes' to a minimum of one or more suicide risk screening questions. Each of the six client records reviewed contained evidence of the supervisor's signature confirming the review of the screening results.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Six of the six client records contained documented evidence of a completed screening form in the file indicating the youth being placed on sight and sound supervision status. A review of the program logbook found that all six clients were documented in the logbook as being placed on the appropriate level of elevated supervision. All six client records contained a 'Yes' response on the suicide risk form which required that the resident be immediately placed on sight and sound status until an assessment is completed by a clinician or a counselor under the direct consultation and supervision of a clinician.	

Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	All direct care staff members are required to document the status of the client every 15 minutes or less while on elevated supervision status. Six of the six client records contained documented evidence of the client's status being observed on sight and sound observation sheets every 15 minutes or less by direct care staff across all three work shifts. All six clients observations were documented as required and the client was not removed from the elevated supervision status until receiving orders from the clinician to remove them from sight and sound status. Sight and sound status entails ten minute observation checks. Sight and sound also requires that the resident be on constant watch. The resident is also housed in a bed in the multi-purpose room close to youth care work station.	
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	**Compliance**	Six of the six client records contained documented evidence of the client's sight and sound status not being changed unless given directions by the licensed clinician to keep them on or remove them from the sight and sound status. All sight and sound observations are consistently documented by direct care staff members without interruption unless ordered by the licensed clinician to remove them from the sight and sound status. Each of the six client records reviewed had documented evidence in the program logbook, as well as the observation sheets indicating the clients were removed from the sight and sound status by order of the licensed clinician.	
Youth with Suicide Risk *(Community Counseling Only)*			

Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**Not Applicable**	This section of the indicator is only applicable to Community Counseling service providers.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**Not Applicable**	This section of the indicator is only applicable to Community Counseling service providers.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**Not Applicable**	This section of the indicator is only applicable to Community Counseling service providers.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Not Applicable**	This section of the indicator is only applicable to Community Counseling service providers.	

When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	This section of the indicator is only applicable to Community Counseling service providers.	
4.03 - Medications			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency policy number is 4.03, Medications. This policy content addresses all requirements for this indicator. The policy was reviewed and approved by the Chief Executive Officer in September 2022.	
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	During the time of this review, the agency had secured a Registered Nurse (RN). Prior to April 2022, the agency had not had a RN for more than a year. Per an interview with the RN, the RN is currently overseeing the daily duties of medication security and assisting with the delivery of medications to all clients with prescribed medications. The RN also provides all training to staff members during their onboarding process and as needed.	
Medication Storage			

a. All medications are stored in a Pyxis ES 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 Pyxis ES 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	**Compliance**	The program requires all medication to be stored in the Pyxis ES Station Medication Cabinet. This Pyxis ES Station is inaccessible to youth and stored in a small medication room equipped with a half-door and prohibited for youth to access. At the time of the on-site QI program review, all oral and topical medications are stored separately from injectable epi-pens. Each medication is assigned and stored in a separate cubed pocket in one of four trays of the Pyxis ES Station. The refrigerator used for storing medication was observed at the required temperature, but no youth currently has any medication requiring refrigeration. The RN was interviewed and demonstrated where all narcotics and controlled substances are stored in the Pyxis ES Station. The program does have youth that are required to receive prescription medication during their shelter stay. One reviewer observed the direct care staff assist in the delivery of the AM medication to one youth on day two of the program review. The Pyxis ES Station keys are stored in the desk accessible to staff in the event they need to access medication if there is a medication Pyxis ES Station malfunction or power outage.	
Medication Distribution			

a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES 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 three methods listed in the FNYFS Policies & Procedures 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	**Compliance**	During the time of this review, medication pass was observed on the AM workshift on day two of the program review. The distribution session was conducted properly by the direct care staff member with no exceptions observed. The prescribed medication was separated from the oral medication, topical medication and cream. A review of the Medication Log displayed each time a medication for the identified youth used was properly documented. The program maintains a minimum of 11 System Managers for the Pyxis ES Station. Specifically, the program has only designated certain staff permissions to have access to secured medications, with limited access to controlled substances. The program utilizes a medication distribution log for distribution of medication by a non-licensed and licensed staff member. The agency verifies medication using one of the three methods listed in the Florida Network of Youth and Family Services (FNYFS) policy and procedure document. The delivery process is consistent with the FNYFS medication management and distribution policy. The program does not accept youth who are prescribed injectable medications, excluding epi-pens. When on duty, the RN is the primary staff member assisting with the delivery of medications to clients. The RN also conducts a follow up review on all health records of clients admitted to the program when she is not on duty.	
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	**Exception**	A review of the agency's current practice regarding medication inventory was conducted. During this program review, sharps are secured, counted, and documented on a weekly basis. Over-the-counter medications are inventoried weekly and documented in the inventory log. All controlled substances accessed regularly were maintained, in which a shift-to-shift count of the medication is verified by the RN or designated staff who have access in User Permissions. All medications are also inventoried perpetually when distributed to clients. At the time of this program review, the program did not have any narcotics on site.	Exception: One (open case) client on controlled medications did not have documented evidence of one shift to shift medication count on a 8am-4pm work shift.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Exception**	The RN reported the agency only produces on an as needed basis.	Exception: The agency is not producing Pyxis ES Station medication cabinet reports consistently on a monthly basis.
Medication discrepancies are cleared after each shift.	**Compliance**	An interview was conducted with the RN. The RN reported all discrepancies are required to be cleared prior to the close of each work shift. The agency's policy also includes procedures that require discrepancies to be identified and cleared each work shift. At the time of this program review, there were no discrepancies reflected in the Pyxis ES Station.	