Florida Network of Youth and Family Services
Quality Improvement Program Report

Review of Children's Home Society, West Palm Beach, FL
Residential Program

December 14-15, 2022

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	Limited

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

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	Satisfactory
3.06 Staffing and Youth Supervision	Limited

Percent of indicators rated Satisfactory: 50 %
Percent of indicators rated Limited: 50 %
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: 75 %
Percent of indicators rated Limited: 25 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Paula Friedrich - 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 September 1, 2022).

Persons Interviewed

	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed	X	Nurse – Part time
	Chief Operating Officer		Advocate		# Case Managers
X	Executive Director	X	Direct – Care Full time		# 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
X	Clinical Director		Volunteer		# Other (listed by title): ___
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records		# Health Records
X	Logbooks		Key Control Log	3	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	5	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	6	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	4	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

7	# of Youth	8	# of Direct Staff		# of Other		

Comments

Due to the systemic staffing issues which impact the availability for member agencies to participate in the QI Peer Review team review, this review was conducted using the Modified QI Review Tool.

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

Children's Home Society West Palm Beach (CHS West Palm) is a non-profit community-based corporation contracted with the Florida Network of Youth and Family Services (Florida Network) to operate Children in Need of Services/Families in Need of Services (CINS/FINS) Safe Harbor residential program and non-residential services to youth and families in South Palm Beach County. The program is located at 3335 Forest Hills Boulevard in West Palm Beach, Florida. 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 services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence and probation respite. Per the Director of Program Operations (DPO), CHS Safe Harbor is not contracted to provide intensive case management or FYRAC services.

CHS West Palm is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through June 30, 2025. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

Programmatic Updates

Staffing

Since the last audit, Lauren Fuentes was promoted as permanent Regional Executive Director, and Travelle Northern, Director of Program Operations will provide oversight of the CINS/FINS programs.

The program currently contracts with Bright Star Care of Palm Beach to provide credentialed and screened; Licensed Practical Nurses (LPNs) - Monday through Friday from 6:00pm to 8:00pm. The contracted LPNs have not yet received the nurse training offered through the Department of Juvenile Justice but per the shelter manager, training will be scheduled as soon as possible.

Staff vacancies reported during the annual QI visit was 2.5 FTE for Youth care Specialist, 1.0 FTE Residential Counselor, and 2.0 FTE for Community Counselors.

Program Updates

CHS West Palm Beach utilizes all service practice models for program activities. Most service activities are in person, depending on the service provider. Community counseling intakes are in person but individual family sessions are virtual if more conducive to meet the family's needs. The program currently uses paper files; however the agency began a work group to transition to electronic files in the near future.

The residential program has purchased a new van that includes several safety upgrades. The van is not yet delivered because it is unfortunately on back order.

CHS West Palm operates other non-CINS/FINS programs that complement the CINS program such as the federally funded Basic Center Services, Safe Place (Outreach), and a mentoring program.

Facility

During the onsite visit, the agency had begun renovations for one of its residential wings to expand its program in 2023, to double the number of beds available. Once completed, it will begin renovations to the CINS/FINS wing of the building.

The agency currently has a ten (10) year lease on the current facility, which became effective in May 2022. The Palm Beach administrative office has moved to the same location as the Safe Harbor Shelter- 3335 Forest Hill Blvd. West Palm Beach 33406

Funding/Finance

The agency received funding from Ballenisles Foundation to support its efforts with CINS/FINS program. In continuing fundraising efforts within the region, the agency will host its three large events (5K, Legacy Luncheon, and Ultimate Dinner party).

Governance and Community

CHS West Palm Beach is now part of the Palm beach County Homeless and Housing Alliance. It also has a Mental Health Agreement partnership with Palm Beach County School for co-located mental health counselors. The agency increased its board membership over the last year to 20 community people.

External Corrective Action Plans

CHS West Palm did not have any Corrective Action Plans through other funding agencies this year.

Narrative Summary

CHS West Palm Beach is under the leadership of a management team that consists of a Regional Executive Director, a Director of Program Operations, a Residential Program Manager, and a Community Counseling Supervisor. The program used one of the agency's licensed mental health counselor (LMHC) to review and approve supervision levels for youth placed on suicide risk probationary observation. It was observed during the case record review, there were no clinical case notes for nine days in one youth record (October 26 to November 2, 2022), despite the youth having met with the therapist and the counselor on 10/2/2022, and some progress notes in general did not document services provided to youth in greater detail.

The residential program is staffed by a residential counselor, two full-time residential Shift Leaders, and eight Youth Care Workers (YCW) positions, three of which were vacant during the annual visit. The community counseling component of the program includes three full-time counseling positions. The program utilizes two interns during the review period.

The overall findings for the modified QI Review for CHS West Palm Beach are summarized as follows:

Standard 1:

Three indicators were reviewed for this standard: 1.01 Background Screening of Employees/Volunteers, 1.04 Training Requirements, and 1.06 Client Transportation. All three indicators were rated Satisfactory but indicators 1.01 and 1.06 were found to have exceptions.

Standard 2:

One indicator was reviewed for Standard 2, indicator 2.03 Case/Service Plan. Indicator 2.03 received a Limited rating.

Standard 3:

Two indicators were reviewed for standard 3: 3.01 Shelter Environment, and 3.06 Staffing and Youth Supervision. Indicators 3.01 was rated Satisfactory with exceptions and indicator 3.06 received a Limited rating.

Standard 4:

There are 2 indicators that were reviewed for standard 4, indicators 4.02 Suicide Prevention, and 4.03 Medications. Both indicators 4.02 and 4.03 were rated Satisfactory with exceptions.

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

Standard 2:

Indicator 2.03 - Limited

1) Service plan goals are not individualized for all four applicable residential youth records reviewed.
2) Three residential records indicated on the service plan the parent could not sign the service plan due to being on the telephone; however, the case notes did not document the parent provided verbal approval of the plan as required by the indicator.
3) The service plans in two residential youth records reviewed did not include the supervisors signature.
4) The service plan in another youth record did not indicate the date the plan was initiated.
5) NIRVANA assessments in four of the nine applicable records were signed but backdated prior to the date the plans were actually printed, resulting in a finding of falsification and reporting of incident to the Central Communication Center.
6) There was no documentation in three youth records to validate the counselor discussed service plan goal progress with the parent and youth every 30 days in the first three months.

Standard 3:

Indicator 3.06 - Limited

1) Two relief staff from another CHS Program were consistently utilized by the program during the review period to work on shifts and supervise residential youth. The two staff did not have training documentation to support minimum CINS/FINS training requirements were completed prior to working independently with youth.
2) Late 15-minute bed checks were observed twice on the same shift where each check was completed one minute late on August 17, 2022 at 11:31pm and August 18, 2022 at 1:01am.

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			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: The agency has a policy CHS/7101 that was last reviewed and approved on November 1, 2022 by the Director of Program Operations.	
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 two new staff were hired since the last QI review. Both staff completed the Berke employee suitability prescreening assessment prior to hire. One of the two staff documented a passing score.	One of the new staff hired had a "low" score on the Berke assessment and no explanation or reason for hiring with a non-passing suitability score was provided by management.
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 four background screenings were reviewed for two new employees hired and two interns who were utilized since the last QI review. All four personnel had eligible background screenings completed prior to hire and/or intern start state.	
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**	The agency has not rehired any new staff during the QI period who had a break in service.	
Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	There was one applicable staff eligible for five-year re-screening during this review period. The re-screening was completed prior to the staff's retained fingerprints expiration date.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The provider submitted its Annual Affidavit of Compliance with Level 2 Screening Standards on December 5, 2022, prior to the January 31, 2022 deadline.	

Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Documentation supported E-Verify work authorizations were completed for the two new staff hired.	
Additional Comments: **There are no additional comments for this indicator.**			
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency has a policy CHS/7104 that was last reviewed and approved on November 1, 2022 by the Director of Program Operations.	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**No eligible items for review**	The program does not have any new staff hired on or after September 1, 2022, the effective date of this requirement.	
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)*	**Compliance**	Training files for the two staff hired since the last staff training files reviewed. Both staff completed the DOJ Civil Rights and Federal Funds training in the first thirty days 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**	One of the two new staff completed an excess of 80 training hours and the second staff is on target for completing 24 hours remaining in the next nine months of their first year of hire.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	Both staff completed all mandatory training required during the first 90 days 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.	**Compliance**	This requirement is applicable to one of the two new hires who is a case manager. The staff completed the NIRVANA and JJIS training required.	

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**	At the time of the onsite visit, there were no eligible clinical shelter training records to 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 in-service direct care training records were reviewed. All four training records had an excess of 40 hours of Florida Network, Skill Pro and job related mandatory/refresher training.	
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.	**Compliance**	The shelter manager is responsible for managing all employees' individual training files and completes routine reviews 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.	**Compliance**	All six training files reviewed confirm the program maintains an individual file for each staff which includes an annual employee training plan including a tracking form for hours completed and related documentation. It was observed all six staff had completed the Florida Network (FN) Bridge MAB training instead of a face-to-face training. Programs are encouraged to contact the FN when in need of MAB training so they can be informed of available resources or so a Live training can be scheduled.	
Additional Comments: **There are no additional comments for this indicator.**			
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 has a policy CHS/7106 that was last reviewed and approved on November 1, 2022 by the Director of Program Operations.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	All drivers are approved by administration to drive clients in agency vehicles per policy. Human Resources office performs annual motor vehicle checks. The program maintains a list of 14 approved drivers for FY 2022-2023 that was last revised 9/28/2022.	

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Per agency policy, all drivers who are approved by administration to drive clients in agency vehicles are covered under the agency's insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency's policy CHS/7106 prohibits transporting a client without maintaining at least one other passenger in the vehicle during the trip and includes exceptions when a 3rd party cannot be present.	
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**	Per shelter manager, evaluation of client's history, evaluation, and recent behavior are factors considered when approval for single client transport is given.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency policy reflects the 3rd party can be an approved volunteer, intern, agency staff, or other youth. These individuals were also observed on the transportation logs reviewed.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	Program has a 2016 Nissan NV 3500 van that is used to transport youth. A review of transportation logs for the 2016 Nissan van was conducted for the review period. A total of 25 single transports were reviewed. The supervisor was aware and provided prior approval for 21 of the 25 single transport. Supervisory approval for seven of the 21 single transports was documented in both the logbook and on the transportation log, 13 were documented only in the logbook, and one was a signed approval on the transportation log.	Four single transports were conducted without evidence of a supervisor's approval.
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**	All transportation logs reviewed include initials of the driver, date and time, mileage, number of passengers, reason for travel, and location.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has a policy CHS/7203 that was last reviewed and approved on November 1, 2022 by the Director of Program Operations.	

The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Exception**	Ten youth records were reviewed, five residential and five community counseling. All five community counseling records reviewed contained a service plan developed from information gathered at the initial screening, intake, suicide screening and NIRVANA; however, goals on the service plans for the residential youth records were identical.	Service plan goals are not individualized for all four applicable residential youth records reviewed. A standard template with identical goals is used as the service plan for all residential youth and is not updated after completion of the NIRVANA.
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Four of the five residential and five community counseling youth records had service plans developed within 7 days of completion of the NIRVANA. One residential youth service plan was not developed because the youth absconded and never returned.	
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**	The program's service plans use a standard template that includes all the following required elements: service type, frequency, location, person responsible, target date for completion, actual completion date, and signature of counselor and supervisor. All five community counseling records documented service plans that were consistent with the requirement.	Three residential records indicated on the service plan the parent could not sign the service plan due to being on the telephone; however, the case notes did not document the parent provided verbal approval of the plan as required by the indicator. The service plans in two residential youth records reviewed did not include the supervisors signature. The service plan in another youth record did not indicate the date the plan was initiated. NIRVANA assessments in four of the nine applicable records were signed but backdated prior to the date the plans were actually printed. This finding of falsification was reported by the program to the Central Communications Center (CCC) and assigned CCC case #202205512.
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	**Exception**	Service plan reviews were applicable to two residential and four community youth records. Three of the six records contained service plan reviews within the required 30, 60, and/or 90-day timeframes as required.	There was no documentation in three youth records to validate the counselor discussed service plan goal progress with the parent and youth every 30 days in the first three months.
Additional Comments: **There are no additional comments for this indicator.**			
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 has a policy CHS/7301 that was last reviewed and approved on November 1, 2022 by the Director of Program Operations.	

Facility Inspection	**Compliance**	The facility tour was conducted during the QI visit and the shelter was found to be clean and appealing. The grounds was well maintained and free of debris or hazardous material. All of the toilets and showers observed during the tour were clean and functional. The shelter is well lit throughout. No graffiti was found on the walls or furnishings. All agency and staff vehicles are locked and secure. One agency van used by the program, a 2016 Nissan NV3500, was inspected and found to be equipped with a first aid kit, fire extinguisher, flashlight, a glass breaker/air bag deflator and seat belt cutter. In and out access is limited to keys assigned to each staff. Egress plans are located throughout facility in hallways and common areas. Client rules, CCC, and abuse hotline phone numbers are posted on a board in the dorm hallway. Department of Children and Families Child Care License is displayed and the license is effective through 1/23/2023. The Council on Accreditation certificate is effective through 6/30/2025.	
Additional Facility Inspection Narrative (if applicable)	All interior areas are free of contraband and is free from hazardous unauthorized metal/foreign objects. All chemicals and Material Safety Data Sheets (MSDS) are located in locked closet in the dormitory and each item is inventoried at minimum once per week during the review period. MSDS is maintained on each chemical item in use. Two sets of washers and dryers are located in the laundry room on the wing. All six bedrooms are equipped beds covered with sheets, pillows, and comforters that match the theme for each bedroom. Each youth has an individual dresser for clothing. Other valuable items are stored securely for youth as needed.		The program currently inventories chemicals on a weekly basis; however, a perpetual inventory is not conducted as required. Vertical blinds in the bedrooms have cords/chains which can pose a safety issue for youth.
Fire and Safety Health Hazards	**Compliance**	Annual facility fire inspection was conducted 12/5/2022 by Palm Beach Fire Rescue and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. Fire extinguisher annual inspection was completed 4/13/2022 for 12 fire extinguishers by Life Safety Management Inc. Semi-annual Fire Suppression system inspection was conducted by Life Safety Management Inc on 4/13/2022 and 10/7/2022. At least one fire drill was observed to be completed in two minutes or less monthly. Mock drills were observed to be completed quarterly. Satisfactory Residential Group Care and Food Service inspections were completed by the Department of Health on September 23, 2022. Food menus are posted and were signed by licensed Dietician on 9/21/22. All cold food is properly stored marked as well as labeled. Dry storage and pantry area is clean and food properly stored. Refrigerators/freezers are clean and maintained at required temperatures. Fridge temperature showed a reading of 35 degrees Fahrenheit and two freezers showed temperature readings of minus 12 degrees Fahrenheit.	

Additional Fire and Safety Health Hazards Narrative (if applicable)	For the period June-November 2022, the agency completed a minimum of one fire drill per month on each shift within two minutes or less. Mock emergency drills were conducted monthly on each 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**	The agency has a formal grievance process that is reviewed with youth during orientation and is also posted on the wing. Grievance forms are accessible adjacent to the staff station on the dorm wing next to the grievance box which is mounted on the wall.	
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**	The residential manager has possession of the keys to the grievance box. Grievances are resolved within 72 hours in accordance with agency policy and practice and direct care staff do not handle the grievances.	
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**	A review of the daily schedule revealed youth are engaged in meaningful, structured activities seven days a week during awake hours and idle time is minimal. Youth are provided at least one hour of physical activity daily. Upon request youth may participate in faith-based activities. Youth are provided opportunities for homework and have access to a variety of books. Daily schedule is posted on the wing and is accessible to youth.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency has a policy CHS/7306 that was last reviewed and approved on November 1, 2022 by the Director of Program Operations.	
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 maintains the minimum staffing ratios as required by Florida Administrative Code and contract. Dates of staff schedule reviewed during the past six months are: 6/11-6/24, 7/30-8/5, 8/20-8/26, 9/3-9/16, 10/8-10/14, and 11/12-11/18.There is at least one staff to six youth ratio, during awake hours and community activities, and one staff to 12 youth during sleep hours.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Staff schedules reviewed demonstrate all shifts consistently maintained a minimum of two staff present.	
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	**Exception**	The program is utilizing staff from other CHS programs as relief staff to cover shifts due to vacant positions; however, the staff from other programs have not completed the minimum training requirements for working directly with shelter youth. All program staff included in staff to youth ratio are background screened.	Two relief staff from another CHS Program were consistently utilized by the program during the review period to work on shifts and supervise residential youth. The two staff did not have training documentation to support minimum CINS/FINS training requirements were completed prior to working independently with youth.
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	It was observed that the staff schedule is provided to staff and posted in the medication room.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	On-call staff is included on the staff schedule which is posted in the medical office, the residential staff leader's office, and sent by email to all staff.	
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**	In the residential wing there are four 2-bed bedrooms located on one side of the staff station and two 2-bed bedrooms located on the other. Youth are separated by gender on either side of the staff station. A review of bed checks was conducted for the following dates and times: July 16th, 12am-2am; August 7th, 2am-4am; September 14th, 4am-6am; October 21st, 1am-3am; and November 13th, 3am-5am.	Late 15-minute bed checks were observed twice on the same shift where each check was completed one minute late on August 17, 2022 at 11:31pm and August 18, 2022 at 1:01am.
Additional Comments: **There are no additional comments for this indicator.**			

4.02 - Suicide Prevention			Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has a policy CHS/7402 that was last reviewed and approved on November 1, 2022 by the Director of Program Operations.	
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.	**Exception**	Three closed residential youth records were reviewed. The community counseling supervisor stated the program did not have any applicable community counseling youth identified as a suicide risk during the review period. Suicide risk screening was completed on the day of admission during the initial intake and screening process for the three residential youth. One of the three youth did not score for suicide ideation at intake and was placed on precautionary observation (PO) five days later based on statements made by the youth.	One youth was not identified as a suicide risk at the time of intake on 10/21/2022; however, the youth's intake assessment was not signed by the supervisor. On 10/26/2022 at 9:14pm, the youth was placed on PO based upon statements made by the youth. Clinical case notes did not document the youth being placed on PO.
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The current Suicide Risk Assessment used by the program was approved by the Florida Network.	
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**	Two of three reviewed records were applicable for two youth placed on PO based on suicide screening at intake and one youth who was placed on PO due to statements five days later after intake.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	Two of the three applicable youth records reviewed contained supervision logs maintained for the duration the youth was placed on increased supervision. Each log documented youth behaviors at ten-minute intervals. There was one period on 10/26/2022, between 1:00pm-2:00pm, that the PO log and log book indicated the youth was meeting with the therapist and youth care staff resumed PO at 2:10pm. It was observed that although the youth met with the therapist and counselor on 10/27/2022, there were no clinical case notes documenting clinical services provided on 10/26/2022 - 10/27/2022.	

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**	The program used one of the agency's licensed mental health counselor (LMHC) to review and approve supervision levels for youth placed on PO. Supervision levels were not changed until further assessment was completed by the licensed professional for the three youth who were placed on PO.	
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.	**No eligible items for review**	There were no eligible community counseling suicide risk youth records during the review period.	
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.	**No eligible items for review**	There were no eligible community counseling suicide risk youth records during the review period.	
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.	**No eligible items for review**	There were no eligible community counseling suicide risk youth records during the review period.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	There were no eligible community counseling suicide risk youth records during the review period.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	There were no eligible community counseling suicide risk youth records during the review period.	
Additional Comments: **There are no additional comments for this indicator.**			

4.03 Medication			Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency has a policy CHS/7403 that was last reviewed and approved on November 1, 2022 by the Director of Program Operations.	
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**	The program contracts with Bright Star Care of Palm Beach to provide credentialed and screened; Licensed Practical Nurses- Monday through Friday from 6:00pm to 8:00pm.	
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 stores all medication in the Pyxis ES Med-Station Cabinet inaccessible to youth. The cart is stored inside the locked medication room in accordance with Florida Statute. The program stores oral medications in a separate drawer from the topical medications and injectors. Observations during the annual review verified the program has a small refrigerator used for the storage of medications; however, the program did not have any youth requiring refrigerated medications during the review period. The refrigerator was located within the locked medication room, and the temperature was maintained between 36-46 degrees. All controlled medications and narcotics are maintained within the secured Pyxis ES Station. An informal interview with one of the system managers confirmed this practice. The program is required to have three Med-Station keys in the event the Pyxis system malfunctions. Observations conducted confirmed all keys were accounted for and maintained in the medical office.	

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**	The program has a list of five "system managers" for the Med-Station. Only designated staff with proper user permissions have access to secured medications, and have limited access to controlled medications. The program uses a Medication Distribution Log to document all medication distributed by a non-licensed staff. Medication is only distributed by non-licensed staff when the nurse is off duty. The program policy clearly outlines a medication and delivery system aligned with Florida Network Policies. The program's policy stipulates epinephrine auto injectors are the only injectable medications accepted. The program maintains a list of staff trained and authorized to assist in medication distribution and the use of epinephrine auto injectors. The training of non-healthcare staff in the use of epi-pens was completed in the Relias portal from the Florida Network instead of by a registered nurse which was approved by the Network.	
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**	Documentation confirmed the program has a perpetual inventory with running balances that is maintained as well as shift-to shift counts for all prescribed medications. The shift-to-shift counts are completed by two staff members. Interview with the Residential Shift Leader reported over-the-counter medications are inventoried weekly and perpetually.	The program reported they do not maintain any medical sharps including syringes or razors. However, three pairs of medical scissors were observed in the lockable blue cart of drawers in the medication office and there were no weekly inventories maintained for the weekly inventory of sharps as required by the program's policy and procedures.

There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Pyxis reports are actually printed and reviewed daily.	
Medication discrepancies are cleared after each shift.	**Compliance**	The program reported not having any discrepancies in a "very long time" or during the review period.	
Additional Comments: **There are no additional comments for this indicator.**			