Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Crosswinds Youth Services - Cocoa Beach
Residential Program

November 2-3, 2022

Compliance Monitoring Services Provided by

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Teresa Andersen –MQI Deputy Supervisor, Department of Juvenile Justice
Jennifer Tummino – 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

X	Chief Executive Officer		Case Manager		Nurse – Full time
X	Chief Financial Officer		Counselor Non-Licensed	X	Nurse – Part time
X	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	Direct – Care Full time		# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
X	Clinical Director		Volunteer		# Other (listed by title): ___
	Counselor Licensed		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	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	9	# 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		Vehicle Inspection Reports		

Observations During Review

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

Surveys

4	# of Youth	18	# 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

Crosswinds Youth Services, Inc. (Crosswinds) contracts with the Florida Network of Youth and Family Services, Inc. (FNYFS) to provide Children in Need of Services and Families in Need of Services (CINS/FINS) to youth under 18 years of age who are most at risk, including those who have run away, truant, and/or beyond parental control in Brevard County. Services are offered onsite in the short-term residential shelter as well as community-based at the facility, in the youth's school, or in their homes. The program is located at 1407 Dixon Boulevard in Cocoa, Florida. Since its accreditation in 2007 by the Council on Accreditation (COA), Crosswinds has maintained re-accreditation, effective through May 2023. In addition to CINS/FINS, other programs include transitional living program, Safe Place, street outreach for homeless youth to help get them off the streets, family counseling to reunite and strengthen families, help for youth aging out of the foster care system, and intervention for young offenders. Crosswinds is also a Stop Now and Plan (SNAP) provider, utilizing an evidence-based cognitive behavior model program that helps youth, six through 11 years, and their parents, learn effective ways to manage emotions and problems.

The following programmatic updates were provided by Crosswinds Youth Services:

Staffing

Crosswinds has promoted Pierre Bandoo from Compliance Administrator to Shelter Director. The position of Shelter Manager has been added to the shelter structure and the agency is currently seeking to fill that position. Crosswinds has also added Case Managers to the shelter to help with the implementation of the Florida Network Nirvana assessment. During the Quality Improvement (QI) review, the program reported five vacancies for Youth Specialists.

Program updates

- The program recently hired an additional registered nurse to enhance coverage. Both nurses work collaboratively on evenings and weekends to conduct medication processes during those times.
- Crosswinds has been using alternative scheduling to help recruit staff. There are now positions that have a four-day work week and weekend only shifts.
- Staff have taken part in several focus groups to help create a shelter program that addresses the needs of the youth, people served, and staff.
- A strategic planning session was held with staff and recommendations identified were communicated to the Board who is working with a consultant to create an agency Strategic Plan.

Facility

- The window alarms were replaced during the summer of 2022 because of numerous conversations with the Network on concerns that the current window alarm system does not alert staff.
- Wireless Access Control System – the agency is working with Representative Fine and Senator Wright on legislative request to fund a keyless system throughout Crosswinds. The cost for the upgrade is $250, 000 and a match of $100,000-$125,000 would be required. The wireless system would eliminate used of keys and improve security of the building. The proposal also includes additional upgrades to the alarm systems.
- HVAC-AHU-1 was replaced in February 2022. Replacement was needed due to the failure of the variable frequency drive which caused the unit to run excessively. The second unit needs to be replaced within the next year.
- A homeless encampment was discovered in the wooded area on the west side of campus near Building A. The area had to be cleaned of debris left by the homeless campers. The area has also been cleared of some of the underbrush.
- The wireless system in the shelter has been upgraded as there was none previously.

Funding/Finance

- All Department of Children and Family funded beds are at a minimum of $258 per night.
- United Way funding through the allocation process increased from $53K to $60K effective for fiscal year 2022-2023. The funding is a match for Health and Human Services and provides support for shelter and street outreach services.
- The signature fundraising event, Great Brevard Duck Race, continues to be held virtually. Crosswinds is also supported by the Rockledge Rotary Debry event. Both efforts support all of Crosswinds youth.
- There was no management letter issued by Whittaker-Cooper Financial Group for the single audit for FY 2020-2021. The audit for FY 2021-2022 is in process.
- Salaries for Youth Specialist have increased from $12.00 an hour to $15.00 an hour with some staff (based on education, experience, and seniority) making $16.00 an hour.

Governance and Community

- There were no major new community partnerships during the fiscal year.
- Board of Directors members have stayed the same. Nina Gadodia is Chair and Andrew Walters is the Treasurer.

External Corrective Action Plans

The agency does not currently have any corrective action plans with other funders.

Other

- The Florida Network's utilization contract continues to be financially challenging. DJJ and QA requirements remain in place even without guaranteed funding. Utilization has been down to the struggles of hiring staff based on the stringent requirements.
- Crosswinds is currently using the Berke Assessment Tool to determine the suitability of prospective candidates during its hiring process.
- Referrals have been a challenge, but the numbers have significantly increased over the past few months.

Narrative Summary

Crosswinds operates both the Robert E. Lehton Children's Shelter (residential) and Community Counseling CINS/FINS Program in Brevard County. The CINS/FINS program has a management team that is comprised of a Chief Operating Officer (COO), a Shelter Director, a Counseling Program Director, and a Clinical Supervisor. The COO oversees the activities of both the residential and the community counseling CINS/FINS Program. Crosswinds Youth Services participates with the National Safe Place Program, a network of voluntary community sites where youth in need of help can go for safe refuge and monitors more than 60 Safe Place sites throughout Brevard County. The Department of Children and Families has licensed Crosswinds Youth Services as a Residential Child Caring Agency for 20 beds effective through February 17,2023.

The overall findings for the modified QI Review for Crosswinds Youth Services are summarized as follows:

Standard 1:

Three indicators were reviewed for standard 1: 1.01 Background Screening of Employees/Volunteers, 1.04 Training Requirements, and 1.06 Client Transportation. Indicator 1.01 and 1.06 were rated Satisfactory but there were some exceptions for 1.06. Indicator 1.04 received a Limited rating.

Standard 2:

One indicator was reviewed for standard 2, Indicator 2.03 Case/Service Plan. Indicator 2.03 was rated Limited.

Standard 3:

Two indicators were reviewed for standard 3: 3.01 Shelter Environment, and 3.06 Staffing and Youth Supervision. Both Indicators were rated Satisfactory with exceptions.

Standard 4:

There are two 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 Limited.

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

Standard 1:

Indicator 1.04 - Limited

1) One of three new staff reviewed completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training 34 days late outside of the 30-days required timeframe.
2) One new staff completed the Medication Distribution for Non-Licensed Staff 77 days late beyond the 90-days of hire timeframe.
3) Two of the three in-service staff did not complete all annual required trainings. One of the staff was missing one course and the other was missing three courses due within the annual training year.

Standard 2:

Indicator 2.03- Limited

1) Two closed residential records reviewed did not include completion dates for goals listed on the service plans.
2) All four applicable shelter youth records did not have the parent signature on the service plan as the parents were not present and there was no indication the service plans were reviewed with the parents.
3) Four youth had service plans reviews completed late, for a total of five late reviews.

Standard 4:

Indicator 4.02- Limited

Precautionary observation (PO) times appeared to be pre-filled and not in real time on three separate occasions. It was determined the PO log for one residential youth was falsified and a call was made to the Central Communications Center. Additionally, assessment of suicide risks were not completed within 72 hours of intake for three residential youth records reviewed.

For one community counseling youth, there was no documentation indicating the parent was given a copy of the youth's Safety Plan nor any follow-up documentation. Another community counseling youth was assessed and determined in need of Baker Act; however, no status/ outcome information was documented. The chronological notes only documented a call was initiated to a Licensed Mental Health Counselor (LMHC) to authorize the Baker Act.

Indicator 4.03- Limited

There is no evidence shift-to-shift counts of controlled medication is being conducted by the program. The medical distribution log (MDR) includes a section for completing these counts but it is not being utilized.

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			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: Policy 1-4 was approved October 2022 by the Chief Operating Officer (COO).	
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.	**Compliance**	The agency uses the Berke prescreening assessment. Seven new employees were hired since the last QI visit; however, one of the seven is the nurse and was exempt from completing the prescreening assessment. The six applicable new employees completed the Berke assessment prior to hire and all six received passing scores.	
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**	The agency completed eligible Department of Juvenile Justice (DJJ) background screenings prior to hire dates of seven staff hired since the last QI review. There were no interns utilized by the program during the review period.	
Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.	**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**	Program employee roster shows two staff were eligible for five-year rescreening. The agency conducted timely five-year re-screenings and the clearinghouse roster shows effective retained prints for both staff.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The program emailed the Annual Affidavit of Compliance with Level 2 Screening to DJJ Background Screening Unit on January 11, 2022, prior to the January 31st 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 seven 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)			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: Policy 1-23 was approved October 2022 by the COO.	
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)*	**Exception**	Training records for three staff who completed their first year of hire were reviewed. Reviewed documentation confirmed two of the three staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	Exception One staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training 34 days late on 9/05/21,outside of the 30-days required timeframe, due by 8/02/21.
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**	Three staff training files were reviewed and each training file evidenced a minimum of 80 hours of training or more for the first full year of employment.	
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 during the first 90 days of employment from date of hire.	Exception One staff completed the Medication Distribution for Non-Licensed Staff 77 days late on 12/05/21, not within 90 days of hire, due by 9/19/21.
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**	Three staff training files were reviewed; however, none of the three reviewed 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).*	**Exception**	Three eligible staff training files were reviewed and each training file evidenced a minimum of 40 hours of mandatory refresher training annually during the calendar training year 1/1/21 - 12/31/21. One of the three staff completed all required annual trainings.	Exception Two of the three staff did not complete all annual required trainings. One staff did not complete the Human Trafficking Course in 2021, which is required annually. It was completed on 10/01/20 and later on 3/08/22. A second staff did not complete three annual required trainings: 1) Human Trafficking Course was not completed in 2021, which is required annually. It was completed on 7/28/20 and later on 9/19/22; 2) Child Abuse Recognition, Reporting and Prevention course was not completed in 2021, which is required annually. It was completed last on 7/30/20; and 3) Information Security Awareness course was not completed in 2021, which is required annually. It was completed on 7/28/20 and 9/06/22.
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 Director is the designated staff member responsible for managing all employees' individual training files. He also completes routine reviews of staff files 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.	

Additional Comments: There are no additional comments for this indicator.			
1.06: Client Transportation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**NO** If NO, explain here: Upon first review, P&P did not include evaluation of client's history, evaluation, and recent behavior when considering approval for single client transport; policy was updated and approved during the QI visit. Policy 5-12 was last revised February 2019 and approved by the COO October 2022.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	Policy 5-12 states Crosswinds will validate driver's licenses and driving records of staff who transport youth twice annually. A roster, effective October 19, 2022, of all agency staff valid driver's license was reviewed.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency provided supporting documentation of insurance and standard-appropriate valid drivers' licenses for all staff covered under its 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 does not specifically prohibit transporting a client without at least one other passenger in the vehicle. However, single transports require staff to alert the on-call or their supervisor to get permission. Staff will note name of client, who gave permission, and reason for transport in the logbook.	
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 Director, 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's policy states an approved volunteer, additional staff member or another youth can be included as a 3rd party for the purposes of transport.	
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 transportation logs and single transports during the past six months for two agency vehicles was conducted. A total of 41 single transports were conducted and six of the 41 did not demonstrate supervisor's approval was provided.	Exception Van #2 had 14 single transports during the six-month period, three of which did not include a supervisor's approval and seven were not documented in the logbook. Van #3 had 27 single transports during the six-month period; three of the 27 did not include a supervisor's approval and five were not documented in the logbook.

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**	Reviewed transportation logs include vehicle information, driver name, date, start and end time, mileage out/in, number of passengers and the destination as the purpose/location of travel.	
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: Policies, 2-03 NIRVANA and 2-04 Service Planning were approved by the COO October 2022	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	Ten youth records were reviewed, five from residential and five from community counseling. Three of the five for each program were closed records, while the remaining two were open records. Documentation for each record confirmed the case plan was developed based on the initial screening, intake assessments, suicide screenings and the NIRVANA, with the exception of one which was not applicable because the youth was not in the shelter long enough for a service plan to be developed. All screenings and assessments were in each youth record.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All nine applicable youth service plans were located in each youth record and were developed within seven days of the completion of the NIRVANA.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	All nine applicable youth service plans contained the required elements on each form. Four of six closed files documented the actual completion date for goals listed on the plan.	Exceptions Two closed residential records reviewed did not include completion dates for goals listed on the service plans. All four applicable shelter youth records did not have the parent signature on the service plan as the parents were not present and there was no indication the service plans were reviewed with the parents.

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**	The five shelter youth were not applicable for service plan reviews, as they were not in the shelter more than thirty days. The remaining five community counseling youth each had reviews completed.	Exception Four youth had service plans reviews completed late, for a total of five late reviews as follows: one youth had two reviews and one was completed nine days late; one youth had one review which was five days late; one youth had two reviews one being two days late and the other being eight days late; and one youth had two reviews and one was competed two days late.
Additional Comments: **There are no additional comments for this indicator.**			

3.01 - Shelter Environment		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01	**YES** If NO, explain here: The program has several policies relating to Shelter Environment as follows: policy 3-6 Daily Schedule, 3-7 Faith Based Opportunities, 3-9 Linens, 3-14 Shelter Environment, Cleanliness, and Maintenance, 3-15 Food Services, 3-30 Sleeping Rooms, and 4-1 Emergency Drills. The policies were approved October 2022 by the COO.	

Facility Inspection	**Exception**	The facility inspection was conducted via in-person tour during the onsite visit. During the tour, it was observed that the grounds were landscaped and well-maintained and the furnishings were in good repair. The tour of the shelter facility included the main lobby area, the common/living areas, male/female bedrooms, kitchen area, laundry room, staff offices, and exterior areas. Each dormitory has five bedrooms with two beds each and a bathroom equipped with two shower stalls, two toilets, and two sinks. Each youth has an individual bed that has clean sheets and pillows, a dresser for personal clothing, and access to lockers for personal items requiring lock up. Observation reveals the dorms were free of foul odors, leaks, and in good living order. The kitchen is also clean and has a food pantry area that is maintained at optimal temperature and free of insect droppings. There is a large commercial refrigerator and two freezers, one of which is located in the pantry. All cold storage and freezer temperatures were maintained at appropriate temperatures. Cold food is stored properly, marked and labeled. The program has two sets of keys that are used on each shift. Transfer between shifts is documented in the log book. A locked key box is located in the staff office for additional facility keys.	Exceptions 1) Chemical inventory was not accurate for three items observed during the tour. The count for glass cleaner was marked as four on the most recent inventory completed 11/2/2022, but only three were found in storage; Lysol wipes showed four but only two were observed and an additional two were for another brand; and Lysol spray showed five but only four were observed. Claire disinfectant spray, one can, was not listed separately on the inventory. 2) No perpetual inventory of chemicals is being conducted, only weekly inventory. 3) MSDS sheets were missing for four items being used: Staples glass cleaner, Fantastik, Tide and Car Wash.

Additional Facility Inspection Narrative (if applicable)	No evidence of graffiti on walls, windows, or doors was observed. There is sufficient light to complete tasks performed. The dumpster is kept locked and is located in the rear of the building. There were two 2019 Honda Odyssey minivans used by the program to transport youth that were inspected during the tour. Both vehicles were equipped with all the required safety equipment. The abuse hotline, egress maps for the facility, DJJ Incident Reporting #, SOGIE signage, and general client rules are visibly posted in common areas in the facility. In addition, the DCF Child Care License and COA documents are posted inside the entrance door in the lobby area. The DCF Child Care License certificate was issued for 20 beds on 2/18/2022 and the COA certificate is valid through May 2023. The MSDS binder and chemical inventory is located in a locked chemical storage cabinet in the janitor room which is kept locked. Reviewed documentation and informal interview with Shelter Director revealed a perpetual inventory is not maintained, some of the chemical listed on the inventory were not present in the cabinet, and chemicals. MSDS sheets were missing for some items in use. Three washers and three dryers were observed to be functional.		
Fire and Safety Health Hazards	**Exception**	Reviewed documentation confirmed the program had their annual fire safety inspection completed by Cocoa Fire Department on 1/26/2022 and cleared re-inspections on 1/31/2022 due to violations of emergency lighting not maintained on the boy's corridor and privilege room. The program completed an annual fire extinguisher inspection on 11/9/2021 for nine fire extinguishers located throughout the facility. The Department of Health completed a satisfactory combined food and group care inspection on 1/21/2022.	Exception Monthly fire drills were not conducted on the overnight (3rd) shift in the months of September and October 2022.
Additional Fire and Safety Health Hazards Narrative (if applicable)	During the past six months, the program completed fire drills at least once a month within two minutes or less on the first and second shift and quarterly mock emergency drills on all three shifts.		

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 grievance box is located next to the staff station adjacent to the dayroom. Grievance forms were kept next to the grievance box. The grievance procedures are included in the youth handbook and reviewed with youth during program orientation.	
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	Reviewed grievance forms confirmed the management or a designated supervisor reviewed the grievance within 72 hours as required. A mock grievance deposited by the lead reviewer was responded to by the shelter director with two days of the onsite visit.	
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	Compliance	The daily schedule reveals youth are engaged in meaningful, structured activities seven days a week. The schedule also provides for at least one hour of physical activity. Youth are given the opportunity to participate in faith based activities with non-punitive activities offered for those who choose not to participate. Youth are given the time to do homework and read appropriate program approved books. The daily schedule is publicly posted and accessible to staff and youth.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: Policy 3-19 was approved October 2022 by the COO.	
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**	A review of staff schedules for April 11, 2022 - October 22, 2022 plus the current schedule posted October 30, 2022 - November 5, 2022, confirmed the minimum staff ratios for each day was met.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	A review of staff training records and staff schedules for April 11, 2022 - October 22, 2022 plus the current schedule posted October 30, 2022 - November 5, 2022, confirmed a minimum of two staff were present for each shift and the staff working on each shift met all training requirements.	
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**	A review of background screening documentation, staff training records, and the staff schedules for April 11, 2022 - October 22, 2022 plus the current schedule posted October 30, 2022 - November 5, 2022, confirmed the staff working on each shift were all background screened and properly trained.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	Through observation it was determined the staff schedule is posted in the staff's common area/staff office.	
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**	Through observation it was determined the staff holdover schedule, with a list of staff and their telephone numbers is posted in the staff's common area/staff office.	
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**	A review logbooks of six different days and times as follows: May 13, 2022: 12am-2am; June 8, 2022: 2am-4am; July 3, 2022: 4am-6am; August 20, 2022: 1am-3am; September 12, 2022: 3am - 5am; and October 14, 2022: 12am - 2am. Observation confirmed staff were completing bed checks every fifteen minutes with four exceptions.	Exceptions June 8, 2022: 2am-4am - one set of four youth was observed at 1:31am then the next observation was 2:04am. July 3, 2022: 4am-6am - one youth was observed at 5:00am - then the next observation was at 5:29am August 20, 2022: 1am-3am - 3am-5am - two sets of youth: one set of youth was observed at 3:44am then the next observation was at 4:05am; next set of youth were observed at 3:45am then the next observation was at 4:04am
Additional Comments: **There are no additional comments for this indicator.**			

4.02 - Suicide Prevention			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: Policy 4--12 was approved October 2022 by the COO.	
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**	A review of five closed records confirmed each suicide risk screening was completed during the initial intake and screening process. Three of the youth were shelter youth and two were community counseling youth.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services.	

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**	A review of three closed shelter records confirmed each youth was placed on the appropriate level of supervision. Each youth had a suicide risk; therefore, was placed on precautionary observation/sight and sound.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Exception**	There was a staff assigned to observe each youth while they were on precautionary observation (PO) and each check was documented every thirty minutes. However, PO times appeared to be pre-filled and not in real time on three separate occasions. Additionally, assessment of suicide risks were not completed within 72 hours for three youth records reviewed. It was determined the PO log for one youth was falsified and a call was made to the Central Communications Center.	Exceptions The observation checks were documented consistently on the half hour for each check, not making it clear if they were actually done in real time. There were three instances of the staff pre-filling out the document; two of the logs only had the times pre-filled for the remainder of their shift, with each youth being placed on standard supervision prior to the shift ending. The remaining log documented with times, orientations and staff initials for an additional twelve hours after the youth was placed on standard supervision. One youth's Suicide Screening was on Monday, July 11, 2022. Youth was not assessed by licensed professional until Friday, July 15, 2022. Youth remained on PO entire time. Required Actions were not noted on Suicide-Self Harm Form (Intake). One youth's Suicide Screening was on Wednesday, May 4, 2022 at 7:30pm. Youth was assessed by licensed professional on Friday, May 6, 2022 at 2pm. The next follow-up was not until Tuesday, May 10, 2022 at 1:58pm. Youth remained on PO entire time. For the third youth, the youth's Suicide Screening was on Thursday, September 1, 2022 at 3:05pm. Youth was assessed by licensed professional on Friday, September 2, 2022 at 5:45pm. Youth PO log shows youth remained on PO until Saturday, September 3, 2022 at 5:45am; however, the logbook indicates the youth was removed from PO on September 2, 2022 at 5:47pm. In addition, the program's Youth Location Chart indicates the youth was removed from PO on September 2, 2022 between 5pm and 5:30pm. The logbook further states on September 2 at 6:22pm the youth went on an outing. It was determined the PO log was falsified and a call was made to the Central Communications Center. Required Actions and youth name was not noted on Suicide-Self Harm Form (Intake).

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**	A review of three closed records confirmed each youth's level was not changed or reduced until a further assessment was completed by a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional.	
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.	**Compliance**	Two of the five youth were participating in community counseling and applicable. Both youth were 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.	

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**	Neither of the two youth needed to be referred as appropriate agency licensed staff were present for both and completed the assessment of risk assessment.	
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.	**Exception**	Two closed records were reviewed. The Safety Plan documents resources for the youth and family. For one youth, there was no documentation indicating the parent was given a copy of the youth's Safety Plan nor any follow-up documentation. There is a box to check on the Safety Plan indicating a copy was provided to the parent/guardian and this box was not checked. There were no notes in the chronological notes indicating this information was provided. The youth's name was not noted on Suicide-Self Harm Form (Intake). The remaining youth was assessed and determined in need of Baker Act; however, no status/ outcome information was documented. The chronological notes only documented a call was initiated to a LMHC to authorize the Baker Act.	Exceptions For one youth, there was no documentation indicating the parent was given a copy of the youth's Safety Plan nor any follow-up documentation. There is a box to check on the Safety Plan indicating a copy was provided to the parent/guardian and this box was not checked. There were no notes in the chronological notes indicating this information was provided. The youth's name was not noted on Suicide-Self Harm Form (Intake). The remaining youth was assessed and determined in need of Baker Act; however, no status/ outcome information was documented. The chronological notes only documented a call was initiated to a LMHC to authorize the Baker Act.
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	Parents were contacted for youth records reviewed.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	None of the two screenings were conducted on school property.	

Additional Comments: **There are no additional comments for this indicator.**

4.03 - Medications			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: Policy 4-7, Medication Storage, Access, Inventories, and Disposal, and Policy 4-8, Medication Supervision and Monitoring were approved October 2022 by the CEO.	
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 has two registered nurses (RN)with verified credentials who conduct medication processes during the evenings and weekends.	
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**	An in-person tour of the medication room was conducted. The Pyxis ES medication cabinet is located in a locked room in the staff office area of the building, inaccessible to youth. Medications were stored in the Pyxis cabinet as required. Oral medications were stored separately from injectable and topical medications. Controlled medication is also maintained in the Pyxis cabinet. The program maintains a locked refrigerator solely for medications requiring refrigeration but there was no current medication needing refrigeration present. Documentation supported the temperature of the refrigerator is checked on a regular basis. The Pyxis keys are labeled and kept at the back of the cabinet so they can be accessed by the shift leads in the event there is a malfunction with the med-station.	

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 shelter has two System Managers for the Pyxis ES station. A list of staff who are trained and authorized to access medication is maintained by the program. A medication distribution log is used to document all medications distributed to youth while at the shelter. The program verifies medication by contacting the issuing pharmacy which is one of the approved methods listed in the FNYFS operations manual. Delivery of medication also adheres to the FNYFS policy using the six rights, ensuring the correct medication, dosage, and method of delivery is provided to the right youth. Youth currently prescribed injectable medications are not accepted by the program. Training documentation supported all staff on the staff medication approval list were trained in the use of epi-pens.	
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**	The program had one youth taking controlled substances during the review period; however, shift-to-shift counts were not being done for controlled medication. Over-the-counter (OTC) medication inventories were reviewed and documented. OTC's are inventoried perpetually and weekly by the staff. The Sharps inventory was reviewed. The inventory was completed on a weekly basis during the review period.	Exception There is no evidence shift-to-shift counts of controlled medication is being conducted by the program. The MDR includes a section for completing these counts but it is not being utilized.

There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The Shelter Director runs three monthly reports using the Pyxis machine to monitor medication practices: Discrepancy Report, User Report, and All Profile Report. Copies of the reports are maintained in a binder and information is reviewed with staff regarding corrective action as needed.	
Medication discrepancies are cleared after each shift.	**Compliance**	Evidence of clearing discrepancies on the occurring shift was observed on reports run by the Shelter Director that shows discovery user to be the same as resolver user.	
Additional Comments: **There are no additional comments for this indicator.**			