Florida Network for Youth and Family Services
Compliance Monitoring Report for

Lutheran Services Florida Southeast - Lippman Youth Shelter

221 NW 43rd Court
Oakland Park, Florida 33309

January 18-19, 2023

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Lutheran Services Florida Southeast (LSF Southeast), for the FY 2022-2023. The agency has two program locations: 1) Lippman Youth Shelter located at 221 NW 43rd Court, Oakland Park, Florida, and 2) Administrative and Community Counseling office located at 2700 W. Cypress Creek Road, Suite D131, Fort Lauderdale Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. LSF Southeast is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 1, 2022 through June 30, 2023.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC, and Department of Juvenile Justice Peer Reviewer, Rondarrell George. Agency representatives from LSF Southeast present for the entrance interview were Raymond Ballinger, Regional Director; Scoundrel Oliver, Shelter Manager; Guillermo Arauz, Clinical Director; Laura Saldana, Director of Compliance; and Ivonne Fusco, Executive Administrative Assistant. The last onsite QI visit was conducted April 6, 2022.

In general, the Reviewer found that LSF Southeast is in compliance with specific contract requirements. **LSF Southeast received an overall compliance rating of 100% for achieving full compliance** with all five applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. There were no corrective actions as a result of the monitoring visit and no recommendation was made.

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

2022-2023 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 01-18-2022-2023

Agency Name: Lutheran Services Florida Southeast	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 221 NW 43 Ct., Oakland Park, FL 33309**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): January 18-19, 2023**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation – Certificate of Insurance. General Liability through Markel Global Reinsurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, and medical expense for $10,000, effective 6/01/2022 – 6/01/2023. Automobile insurance through Florida Insurance Trust for combined single limits for $1,000,000 each accident, effective 6/01/2022 – 6/01/2023. Workers Compensation through Accident Fund Insurance Company of America with limits of $1,000,000 each/aggregate, effective 6/01/2022 – 6/01/2023. Umbrella liability through Century Surety Company with limits of $1,000,000 each/aggregate, effective 6/01/2022 – 6/01/2023.	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						Professional Liability/Abuse Molestation through Markel Global Reinsurance Company for $1,000,000 each and $3,000,000 aggregate, effective 6/01/2022 – 6/01/2023. Florida Network is listed as certificate holder.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Agency maintains an Accounting Procedures Manual that is consistent with GAAP and provide for limited internal controls. The fiscal manual is updated as necessary with revised policies showing a revision/approval date. The most current approval date is October 5,2022. Policies are approved by the Chief Financial Officer.	**No recommendation or Corrective Action.**
b. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: Reviewed petty cash Policy and Procedure 4.32 included in section 4 of the Fiscal Manual that was last approved October 5, 2022. LSF SE has a petty cash fund for $1000 that is used for the shelter. The shelter manager is the custodian of the petty cash which is maintained in a locked safe in the	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						manager's office. The petty cash fund was reviewed with the shelter manager to reconcile onsite and documentation support accurate reconciliation with $592.30 total in receipts and $407.70 cash on hand.	
c. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation Provider maintains an inventory for computer and periphery equipment purchased from 12/2002. However, the items were noted as broken and no additional items were purchased with FN funds within the last year.	**No recommendation or Corrective Action.**
d. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: The provider submitted a copy of the Financial audit conducted for year ending June 30, 2022 and 2021. The audit was completed December 22, 2022 by RSM US, LLP. Per the audit, there was no management letter issued as there were no matters required to be reported and no corrective action is present because there were no findings required to be reported under the Federal Single Audit Act.	**No recommendation or Corrective Action.**

CONCLUSION

Lutherans Services Florida Southeast has met the requirements for the CINS/FINS contract as a result of full compliance with all five applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Lutheran Services Florida - Southeast
Residential Program

January 18-19, 2023

Compliance Monitoring Services Provided by

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	Satisfactory

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

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory

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

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 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:

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
Rondarrell George – 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		Nurse – Part time
	Chief Operating Officer		Advocate		# Case Managers
X	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
	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
	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	12	# Personnel /Volunteer Records
	Contract Monitoring Reports		Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	7	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	5	# Youth Records (Open)
X	Fire Inspection Report	X	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		Staff Interactions with Youth	X	Census Board

Surveys

1	# of Youth	9	# 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

Lutheran Services Florida (LSF) is a statewide, non-profit, human services agency with its headquarters located in Tampa, Florida. LSF Southeast (LSF SE) contracts 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) residential and community counseling services to youth and families in Broward County. The program operates out of two locations: 1) Lippman Youth Shelter, located in the City of Oakland Park, Florida, and 2) its administrative office and community counseling program (also known as Broward Family Center), located at 2700 W. Cypress Creek Rd., Suite D131, Fort Lauderdale, 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, truant, homeless, abused, neglected, or at-risk. The agency provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking (DMST), and youth referred by the Juvenile Justice Court System for domestic violence (DV) respite, probation (PR) respite, as well as DV and PR Family and Youth Respite Aftercare services (FYRAC). The census during the Quality Improvement (QI) visit was 12 CINS/FINS youth. Lippman is licensed to serve twenty (20) youth and the program's license was renewed by the Department of Children and Families (DCF) on June 28, 2022 and is valid until June 27, 2023. In March of 2022, the agency was informed that the Council on Accreditation (COA) approved the accreditation of LSF through February 2026. LSF SE programs were monitored during the visit for accreditation and met the standards set forth by COA.

The agency provided the following programmatic updates:

Staffing

During the current review period, the executive management structure for LSF SE remains intact and stable with no change in key leadership positions such as the Executive Administrative Assistant, Residential Manager, Youth Care Supervisor, and part time registered nurse. In May of 2022, former residential counselor, Guillermo Arauz, rejoined the LSF SE team in the role of clinical director. Guillermo is a Licensed Mental Health Counselor (LMHC) and provides clinical oversight for LSF SE residential and community counseling programs. Additionally, Guillermo is a Qualified Supervisor and oversees the region's internship program. Two new counseling staff were hired since the last QI review for the residential program and community counseling program. At the time of the onsite visit, the program had five vacant positions for three youth care specialists (YCS), a residential counselor, and a community counseling counselor.

Program Updates

Led by Diana Davila, the program continues to partner with Feeding South Florida to provide a food pantry for CINS/FINS families from the administrative office on Saturday mornings. Diana Davila has also led the program's efforts to provide parenting classes for CINS/FINS families through a partnership with Boys Town.

Over the last three years, the agency has been committed to improving facilities to provide the youth served at Lippman Youth Shelter a better living environment. In 2020 a capital campaign commenced with the goal of raising $250K. The global pandemic created some challenges and subsequent delays with fundraising. The campaign raised a significant amount of capital; however, it fell short of the stated goal. The agency remained steadfast in its commitment to make improvements to Lippman Youth Shelter. The agency's Grants Development Manager began exploring local and federal opportunities for assistance to support renovations at LYS. In December of 2022, the program got notice that it was awarded funds from Broward County Emergency Solutions Grant Coronavirus ESG-CV funds that the county received through the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The program received $450k in funding to support the renovations at Lippman Youth Shelter. The funds must be exhausted by June 2023.

Facility

Renovations at the Lippman Youth Shelter were underway during the QI review. New lighting was installed throughout the facility and hurricane windows were being installed during the review. The program does not anticipate any disruption in services. However, there may be times throughout the renovation process in which the residential census may be reduced to accommodate repairs to the bedrooms.

Funding/Finance

The program continues to receive CINS/FINS, Basic Center, and funds on a fee-for-service basis for care days provided to Department of Children and Families youth. Additionally, as previously mentioned, in December of 2022, the program was awarded funds from Broward County Emergency Solutions Grant Coronavirus ESG-CV funds to support renovations of the shelter.

Major Challenges

During the current review period, the program has experienced some challenges in successfully recruiting community and residential counselors. Additionally, there have been some challenges with gaining access to the schools in Broward County which has reduced the number of youths served in the community counseling program. The program has also encountered an influx of homeless youth and families due in part to another local provider no longer serving youth under the age of 18. As a result, there has been an increase in the length of stay for youth served in the residential program.

Narrative Summary

LSF SE is under the leadership of a management team, including a regional director, a shelter services manager, a licensed clinical director, a director of compliance, and a senior administrative assistant. The residential program is staffed by a youth care specialist supervisor, a part-time registered nurse, three YCS II, and 11 YCS I. In addition to the clinical director, the residential clinical component includes one master's level counselor position and the community counseling program is serviced by four bachelor's level staff. The program has not reported any major challenges, incidents, administrative review, or current external investigations.

The overall findings for the modified QI Review for LSF SE 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. Indicator 1.01 was rated Satisfactory but indicators 1.04 and 1.06 received a Limited rating.

Standard 2:
One indicator was reviewed for Standard 2, indicator 2.03 Case/Service Plan. Indicator 2.03 was rated Satisfactory.

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. Indicator 4.02 was rated Satisfactory and 4.03 was rated Satisfactory with exceptions.

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

Standard 1:

Indicator 1.04 - Limited

One of the three pre-service direct care staff did not complete two mandatory trainings, Universal Precaution and Fire Safety training; upon notification, the staff completed Universal Precaution on 1/18/2023 during the review.
A second pre-service direct care staff completed the following six trainings after the 90-day requirement: SOGIE/LGBTQ, Universal Precaution, CPR, First Aid, Adolescent Development, and Cultural Humility.
The third pre-service residential counseling staff had not completed the Behavior Management and Medication Distribution training due within 90 days of hire and completed CPR/First Aid after the 90-day deadline.

One of the three in-service staff only completed 19.7 annual training hours, less than 40 hours required.
The same staff did not complete four annual mandatory trainings as follows: MAB (expired 9/21/21), PREA Part 2 (expired 6/22/22), Fire Safety (expired 7/3/22), and Florida Network Suicide Prevention (expired 2/17/22). A second in-service staff did not complete the annual SkillPro Suicide Awareness training which expired on 2/2/22.

Indicator 1.06 - Limited

There is no evidence or documentation to support the supervisor's approval was provided prior to 37 of the 39 single transport conducted during the review period.

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: The agency has the required policy and procedure # 1.01 in place that was approved January 13, 2023 by the regional director.	
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 Predictive Index (PI) pre-employment assessment that was implemented July 2018. The tool was administered prior to the hiring of seven youth care staff during the review period. All seven employees obtained passing scores (greater than five) on a scale of 1-10. Two additional new hires were licensed and/or master's level clinicians and were not required to complete the suitability assessment per the agency's policy.	
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 nine staff were hired since the last onsite Quality Improvement (QI) visit. The program also utilized three interns during the review period. All twelve background screenings were initiated prior to hire/start dates with eligibility documented on the Clearinghouse results. There were no exemptions required.	
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**	None of the new hires were prior employees with a break in service for 90 days or less.	
Five-year re-screening completed every 5 years from initial date of hire	**No eligible items for review**	The program did not have any eligible five year re-screenings since the last QI visit.	

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 its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit on January 6, 2023 prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of employment authorization from the Department of Homeland Security was obtained through E-verify and maintained on file for all eight new hires.	
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: The agency has the required policy and procedure # 1.04 in place that was approved January 13, 2023 by the regional director.	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	A review of three pre-service staff training records were reviewed. All three staff were currently within the first year of hire. One of the three staff was hired after September 1, 2022, the effective date of this requirement. As of the date of the QI visit, the staff completed all new hire training requirements.	
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**	A review of three pre-service training records verified each staff completed the United States Department of Justice Civil Rights and Federal Funds training within the required 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**	Two of the three pre-service staff completed an excess of 80 training hours and the third staff is on target for completing the remaining 8.5 hours due within the next seven months.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	A review of three pre-service training records revealed none of the three staff completed all mandatory training due within the first 90 days of employment. One of the staff was late completing Motivational Interviewing training because the only training offered after her hire date of 8/2/2022 was cancelled in September due to Hurricane Ian. An email regarding the cancellation was submitted to the reviewer.	As of the date of the QI visit, one of the three pre-service direct care staff did not complete two mandatory trainings, Universal Precaution and Fire Safety training; upon notification, the staff completed Universal Precaution on 1/18/2023 during the review. A second pre-service direct care staff completed the following six trainings after the 90-day requirement: SOGIE/LGBTQ, Universal Precaution, CPR, First Aid, Adolescent Development, and Cultural Humility. The third pre-service residential counseling staff had not completed the Behavior Management and Medication Distribution training due within 90 days of hire and completed CPR/First Aid after the 90-day deadline.
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**	One applicable residential counselor 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).	**Compliance**	One applicable residential counselor completed the required Assessment of Suicide Risk training with supporting documentation confirmed by the licensed clinical supervisor.	

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 in-service direct care training records were reviewed. Two of the three training records had an excess of 40 hours (residential staff) and 24 hours (community counseling staff) of Florida Network, Skill Pro and job related mandatory/refresher training. One of the three staff completed all mandatory annual training.	One of the three in-service staff only completed 19.7 annual training hours, less than 40 hours required. The same staff did not complete four annual mandatory trainings as follows: MAB (expired 9/21/21), PREA Part 2 (expired 6/22/22), Fire Safety (expired 7/3/22), and Florida Network Suicide Prevention (expired 2/17/22). A second in-service staff did not complete the annual SkillPro Suicide Awareness training which expired 2/2/22.
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 Director of Compliance is responsible for managing all employees' individual training files and conducts periodic reviews to monitor and maintain the training records.	
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**	The program maintains individual training records for each staff. Each of the training records contained an annual training tracking form indicating the name of the training, date it was taken, and the number of training hours received. Further review of the files contained sign-in sheets, certificates and agendas of the training received.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency has the required policy and procedure # 1.06 in place that was approved January 13, 2023 by the regional director.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The shelter manager provided a list of 17 staff who are approved by agency administration to drive clients in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	All drivers named on the approved driver's list have current driver's licenses and are covered under the agency's insurance policy. The agency's auto insurance policy reviewed is effective through June 1, 2023.	

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 transportation policy 1.06 prohibits transporting a client without maintaining at least one other passenger in the vehicle during the trip and includes exceptions when a third 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**	The agency's policy outlines the importance of avoiding single youth transports. In the event of a single transport of youth, per the policy, approval is required by the Residential Supervisor who considers the client's history, evaluation, and recent behavior.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	Transportation logs were reviewed two agency vans for the review period July 2022 through the review date. With the exception of single transports, third party present in vehicles were typically agency staff or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	During the review period, a total of 39 single transports were identified from the review of transportation logs for the two agency vans. Supervisory approval was documented for each single transport on the transportation logs; however, the time of transport was not noted on the logs to discern if approval was given prior to single transports as required. Additionally, logbook entries of transports did not reference supervisory approvals for 37 of the 39 single transports.	There is no evidence or documentation to support supervisor's approval was provided prior to 37 of the 39 single transport conducted during the review period.
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**	Transportation logs include the driver's name, names of youth, beginning and ending odometer, time out/in, and purpose, and destination.	

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

2.03 - Case/Service Plan			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has the required policy and procedure # 2.03 in place that was approved January 13, 2023 by the regional director.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	Ten youth records were reviewed for five residential (two open and three closed) and five community counseling (three open and two closed) youth records. All ten records included individualized case plans based on information gathered during the screening, intake, and Network Inventory of Risks, Victories, and Needs Assessment (NIRVANA).	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All ten records reviewed contained case service plans that were completed with 7 days 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	**Compliance**	All ten records reviewed contained case service plans that included individualized and prioritized need(s) and goal(s) identified by the NIRVANA; service type, frequency, and location of services; person(s) responsible; target and completed date(s) for completion of goals; and date the plans were initiated. All required signatures of youth, parent/guardian, counselor, and supervisor were evident in six of the ten records. For the remaining four records, the progress notes indicated reasons for missing signatures where the youth refused to sign in one record, the parent was unavailable in another record, and parental consent was provided via Zoom virtual meetings in two records.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	All ten youth records contained progress notes by the counselor/case manager every thirty days for the first three months. None of the records were applicable for progress notes after 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 the required policy and procedure # 3.01 in place that was approved January 13, 2023 by the regional director.	
Facility Inspection	Compliance	A tour of the facility was conducted with the shelter supervisor. The facility was under construction with the installation of new windows and necessary repairs to bedrooms. During the tour, the furnishings were observed to be in fair condition with no rips, tears, or stains and will be replaced once the renovation is complete. All beds appeared sturdy and were covered with bed sheets, a comforter, and included a pillow. No insect droppings or infestation was observed. The exterior areas are well-maintained and free of hazards. The facility has a large backyard with adequate recreational space, including a basketball court. Large trash receptacles are located on the west side of the facility and were observed to be covered during the visit. During the construction, some bedrooms were not in use as they are being repaired. Bedrooms occupied were as follows: bedrooms 4, 5, and 7 (each has three beds) and bedrooms 2, 3, 6, and 10 had two beds each. Bedrooms are equipped with closets for clothing and personal belongings. A locked storage area is available to secure youth belongings needing to be locked up. The shelter has one laundry room equipped with two new washers and two dryers. All were observed to be in great condition and were clean and free of lint.	
Additional Facility Inspection Narrative (if applicable)	The walls appeared clean and void of soil, stains, or graffiti. The facility had new lighting and was well-lit throughout. The program uses two vans to transport youth. Each van is equipped with a first aid kit, flashlight, fire extinguisher, glass breaker, and seat belt cutter. The program has three master sets of keys used by management staff and each staff has a set of keys for entry into the shelter and access to all rooms. Egress plans are located in hallways, in common areas, and in each youth's bedroom. Abuse hotline and CCC information are posted in each bedroom and on a wall in the dayroom along with the posting of rights/responsibilities. The grievance box and forms are accessible to youth at the entrance to the dayroom. SOGIE signage was observed posted throughout the facility. No contraband was observed. Chemicals are stored in two locked large storage containers on the back deck. Inventories are conducted weekly and were found to be accurate during the review. MSDS were available for all chemicals. DCF license is posted in the lobby and is effective through June 27, 2022.		

Fire and Safety Health Hazards	**Exception**	All fire and safety inspections were found to be current during the review. An annual fire inspection was conducted by the city of Oakland Park on 1/9/2023. Fire extinguishers in the facility had valid inspections effective through February 2023. Range hood inspection was conducted by AB Fire on 9/30/22. Wiginton conducted a fire sprinkler inspection on 4/15/22. EAS fire services conducted an annual fire alarm test on 9/20/22. Department of Health completed a satisfactory food and group care inspection on 10/13/2022 and 11/20/22, respectively. The refrigerator temperature was observed to be 40 degrees Fahrenheit, and the freezer temperature was -4 degrees Fahrenheit. During the past six months, monthly fire drills were not conducted monthly on each shift as required. Mock emergency drills were also not conducted quarterly on each shift.	Monthly fire drills were missing for two of the six months in September and November on the first shift, four months on the second shift (July, October, November, and December), and five months on the third shift (July-November). Mock emergency drills were not conducted during the last two quarters on the second and third shifts during the past six months.
Additional Fire and Safety Health Hazards Narrative (if applicable)			
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 in each room. Grievance forms are accessible and are available next to the grievance box which is mounted on the wall at entry of the dayroom.	
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 and supervisor have possession of the keys to the grievance box. The grievance box was checked during the review and was found to be empty. The shelter manager maintains a Grievance Tracking Log which shows six grievances filed since July 2022. All six grievances were resolved by the shelter manager within 72 hours.	

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**	Youth are engaged in meaningful, structured activities seven days a week during wake hours. Some of the activities include but are not limited: educational, recreational, life, counseling, and social skill training. Idle time is minimal. Daily schedules reflect at least one hour of physical activity is provided daily and notated in the logbook. Youth are provided the opportunity weekly to participate in faith-based activities. Non-punitive structured activities such as reading, journaling, tutoring, education, recreational board game and counseling are offered to youth as an alternative to youth who do not choose to participate in faith-based activities. Daily programming includes opportunities for youth to complete homework and access books in the facility library that have been approved by the agency. Daily programming schedule is publicly posted in the dayroom and also provided to the youth.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency has the required policy and procedure # 3.06 in place that was approved January 13, 2023 by the regional director.	
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**	Staff schedules for the period June through December 2022 were reviewed. The program maintained the required ratio of one staff to six youth during awake hours, and community activities, and one staff to 12 youth during the sleep period.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Reviewed schedules show a minimum of two staff are scheduled on each shift.	

Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Compliance**	Staff in training are designated as such on the schedule and do not work independently until they complete the minimum required training. All new staff were background screened and current prints were maintained in the clearinghouse for in-service staff.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	A staff schedule is posted in the youth care supervisor's office area accessible to staff. A copy of the schedule was observed during the onsite tour.	
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**	Staffing challenges experienced by the program continues to impact the availability and access to additional staff to create a holdover roster; however, program manager, supervisors, team leads, counselors, and other trained agency staff are utilized to fill in gaps.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	Bed checks dates were randomly selected and conducted for the following dates and times: • August 7th, 12am-2am • September 14th, 2am-4am • October 21st, 4am-6am • November 17th, 1am-3am • December 24th, 3am-5am Reviewed information confirm inconsistencies in bed checks completed by staff for several days while youth were in their sleeping room during sleep period.	Reviewed documentation confirmed bed checks were late or missed during the following months: • August 7th, should be at 12:20am and was done late at 12:22am • September 14th, 2am-4am, bed checks were missed between 3:04am to 3:35am; 3:49am to 4:16am; and 4:34am to 5:19am. • November 17th, 1am-3am, checks were late between 1:16am to 1:39am; and missed between 2:26am and 2:58am

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

4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has the required policy and procedure # 4.02 in place that was approved January 13, 2023 by the regional director.	
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**	Reviewed a total of three closed residential youth records for suicide risk. Each record indicated the youth was screened for suicide risk upon admission and during the intake process. Each screening was reviewed and signed by a supervisor and maintained in the youth record as required.	
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 for the fiscal year.	
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**	Each of the reviewed youth was placed on the appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	The agency require observation checks to be conduct at 10 minute intervals for youth on suicide risk. Each of the three youth were monitored using the Alert System Precautions Observation Log which documents the youth's behavior every 10 minutes while on sight and sound supervision.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	Reviewed documentation confirm supervision level was not changed/reduced until the program's licensed clinical supervisor completed a further assessment.	

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**	The agency stated they did not have any community counseling youth identified as suicide risk 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**	No applicable youth.	
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**	No applicable youth.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	No applicable youth.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	No applicable youth.	
Additional Comments: **There are no additional comments for this indicator.**			

4.03 - Medications			Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency has the required policy and procedure # 4.03 in place that was approved January 13, 2023 by the regional director.	
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 agency has a Registered Nurse (RN) with valid credentials effective through 7/31/2024.	
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 shelter utilizes the Pyxis Med-Station Medication Cabinet to maintain and store medication. Observation of the cabinet indicated it is located in a locked room with no access to youth. All oral medications including narcotics, controlled and over the counter medications are stored in the Pyxis cabinet and stored separately from topical medication. Medications requiring refrigeration is maintained in a refrigerator designed for medication only. Observation of the refrigerator indicated the temperature inside was approximately 36 degrees Fahrenheit. The shelter maintains emergency keys to the Pyxis which are kept in the Shelter Manager's office. Observation of the keys verified the top cover back panel, left tall cabinet lock, left back panel, right tall cabinet lock and right back panel keys are maintained.	

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 nurse, youth care specialist III and the shelter manager are system managers for the Pyxis Med-Station; however, when the nurse is on duty, medical procedures are done by the nurse. The shelter maintains a list of staff who are trained in medication distribution and the use of the epi-pen. A medication distribution record is maintained for youth on medication. A review of three applicable training records validated each staff received training in medication distribution and the use of an epi-pen. The shelter utilizes the Six Rights method to verify medications when administering prescription medication to youth. When a youth is admitted with prescribed medication, the shelter ensures the medication is in its original prescription bottle with a legible label. The shelter will contact the pharmacist to verify the youth is proscribed the medication and dosage. The shelter does not accept youth who have to be administered injectable medication.	
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	**Compliance**	The Pyxis Med - Station maintains a perpetual inventory of controlled substances and over the counter medication. A running balance and a shift-to-shift count is conducted for controlled substances with two staff including the staff leaving and staff coming on duty. In this instance both staff will initial the form to verify accuracy. The shelter does not maintain syringes or sharps and do not accept youth who require the use of them. Inventory reports are run by the nurse to monitor accuracy of medication counts.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Exception**	The nurse indicated weekly inventory reports are run for accounting purposes but was not knowledgeable about the knowledge portal or types of reports available.	The agency did not have any documentation to support monthly reviews of medication management practice via knowledge portal or pyxis med-station reports.
Medication discrepancies are cleared after each shift.	**Compliance**	Medication discrepancies are cleared prior to the next shift. The Pyxis Med-Station identifies any discrepancies which are cleared and witnessed by a second staff.	
Additional Comments: **There are no additional comments for this indicator.**			