Florida Network for Youth and Family Services
Compliance Monitoring Report for

Boys Town of Central Florida
975 Oklahoma Street
Oviedo, FL 32765

April 12-13, 2023

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the Boys Town CINS/FINS program for the FY 2022-2023 at its program office located at 975 Oklahoma Street, Oviedo, 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. Boys Town 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, Jesin Miah. Agency representatives from Boys Town present for the entrance interview were: Laurie Stern, Executive Director, Telma Favors, Senior Director of Program Operations; Catherine Melendez, Financial Officer; Rochelle Davis, Program Support Services Coordinator; Jennifer Mauco, Program Director (IHFS); Al McCray, Shelter Program Director; Justin Colson, Clinical Support Coordinator; Melissa White, Clinical Support Specialist; Carmen Rodriguez, Business Manager; and Administrative Assistants, Arlene Smith and Davine Hardy. The last onsite QI visit was conducted March 23, 2022.

In general, the Reviewer found that Boys Town is compliant with specific contract requirements. **Boys Town received an overall compliance rating of 100% for achieving full compliance** with all four applicable indicators of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit.

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

2022-2023 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-12-2022-2023

Agency Name: Boys Town	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 975 Oklahoma Street, Oviedo, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 12-13, 2023**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
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	☐	☐	☐	☒	☐	General Liability through Philadelphia Indemnity Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, personal injury for $1,000,000, and medical expense for $5,000, effective 10/01/2022 through 10/01/23. Automobile insurance through Philadelphia Indemnity Insurance company for combined single limits for $1,000,000. Policy effective date 10/01/22 through 10/01/23. Workers Compensation through Sentry Casualty Company with limits of $1,000,000 each/aggregate, effective 12/31/2022 – 12/31/2023. The Florida Network is listed as certificate holder.	No recommendation or Corrective Action.

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**							
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**	☐	☐	☒	☐	☐	The agency maintains Accounting Policies and Procedures in place for: fiscal management, cash, petty cash, support, program service fees, revenue, and receivables, expenses for program and supporting services and accounts payable, payroll and related liabilities, governmental financial assistance programs, property and equipment, debt and other liabilities. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls and effective/review dates are indicated for each procedure.	No recommendation or Corrective Action.
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Boys Town has procedures for petty cash that references governing policy #8600. Petty cash is stored in a locked box in the shelter supervisor's office. All receipts are submitted for accounting and requesting	

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Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						reimbursement as needed and the fund is reconciled. Reimbursement comes in the form of a check made out to the Program Director who will then cash it and place money in the petty cash box. The fund does not exceed $200. Petty cash was reviewed with the supervisor during the visit and was found to have a total balance of $192.52. In addition to petty cash, supervisors and Senior youth care workers have purchasing cards.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	Documentation: No new inventory was purchased in the past year with Florida Network funds. The provider also indicated there is no current DJJ inventory.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous	☐	☐	☒	☐	☐	Documentation: A financial audit was conducted as of December 31, 2021, by KPMG LLP per letter dated June 6, 2022. A separate Management Letter requiring a corrective action plan was	

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Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
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**						not issued by the auditor. Per the executive director, KPMG has completed the financial audit for year ending December 31, 2022 and the final report is pending for June 2023.	

CONCLUSION

Boys Town has met the requirements for the CINS/FINS contract as a result of full compliance with all four applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One of the five indicators was not applicable because the provider does not have any current inventory purchased with DJJ/FN Funds. Consequently, t**he overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations 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 Boys Town of Central Florida - Oviedo, Florida
Residential Program

April 12-13, 2023

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	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	Limited
3.06 Staffing and Youth Supervision	Satisfactory

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

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 87.5 %
Percent of indicators rated Limited: 12.5 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Jesin Miah – 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	2	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
X	Program Coordinator		Intern		# Maintenance Personnel
X	Clinical Director		Volunteer		# Other (listed by title): ___
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	11	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	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	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		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

7	# of Youth	12	# 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

Boys Town of Central Florida (Boys Town) is located in Oviedo, Florida. The program is an affiliate of its national non-profit agency Father Flanagan's Boys Home with headquarters located in the Village of Boys Town, Omaha, Nebraska. Boys Town Central Florida provides a variety of services from its main campus as well as in the surrounding community. Services include intervention and assessment; treatment family homes; in-home family services (IHFS); a national hotline; free online resources; Common Sense Parenting; a comprehensive behavioral health clinic (located in Winter Park); and behavioral assessments. Community support services enable children and parents to tap into a wide variety of resources from agency experts or through direct specialized services. The Boys Town National Hotline® (800-448-3000) is a free resource and counseling service that assists youth and parents 24/7, year-round, and nationwide. Boys Town Press® produces books, audio products, DVDs, display materials and other resources to assist children, parents, caregivers, educators, and other professionals. YourLifeYourVoice.org is a special website that enables and encourages teens to share their problems and concerns in positive ways and provides access to immediate help in a crisis. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The agency also provides specialized services to youth who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). The youth census during the Quality Improvement (QI) visit was 6 CINS/FINS and 4 DCF (Department of Children & Families) youth. Boys Town is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through December 31, 2026.

The following programmatic updates were provided by the agency:

Staffing

Leadership staff across all programs have remained consistent with just one director (In Home) resigning during the year for 2022, 80% retention. Leadership at the shelter has remained stable to include supervisors (until 2023) and shift leads. The shelter became fully staffed during 2022 to add layers for coverage. Though there was frequent staff turnover in In Home, the team hired bring many strengths and skills to the program. This includes prior child welfare experience which furthers assistance and resources to the families; teaching experience; and addition of a part time administrative assistant which is helping tremendously with maintaining organization and timeliness. There was a vacancy, position posted in December 2022 for the program nurse. The agency is continuously struggling with finding a candidate for this part time position.

Program

As of the date of the QI visit, the shelter occupancy was 98% (1662 bed days) and In Home occupancy was 86% (91 intakes) for the current fiscal year. There's been no changes with any address with the program. Both Department of Children and Families (DCF) re-licensure and Council on Accreditation (COA) reaccreditation occurred in 2022. The shelter is licensed through December 4, 2023 and COA accreditation expires December 31, 2026.

Facility

Upgrades to the Oviedo campus include: new paint for administrative office, Quest and Pavilion; air conditioning unit was replaced at administrative office; new floors were installed in the shelter; "new to us" beds and dressers were added to the shelter; basketball court pavement was newly done in March 2023; and the basketball hoop was replaced.

Funding/ Finance/ Development

Boys Town signed a 5 year, 2 million dollar match campaign with Demetree Foundation (400K per year). The agency also successfully changed the end of the year Tree Lighting Ceremony on campus to include restaurant sponsorships of each family home and the shelter, and this permitted the family teachers, staff, and youth to enjoy the evening as a celebration, vs. serving the guests.

Residential Program Only

Boys Town was relicensed on 12/5/2022 by DCF for a total capacity of 18 as an emergency shelter-Child Caring Agency (CCA). The Shelter maintains a total of 12 youth as maximum occupancy due to staffing and attempts to maintain 50% CINS, 50% DCF dependent on referrals.

Governance and Community

Central Florida met the goal of moving from 10 to 13 board members, and doubled its female diversity on the board from 20% female representation to female representation being 39% of the board.

Major Challenges

Recruitment and retention continue to be a post pandemic struggle. Staff continue to resign due to finding more flexible roles that permit some work from home opportunities whereas specifically pertaining to the shelter, this is not possible.

Narrative Summary

Boys Town, located at 975 Oklahoma Street, Oviedo, FL 32765, is under the leadership of a management team that consists of an Executive Director, Senior Director of Program Operations, Program Support Coordinator, Clinical Support Coordinator, Residential Program Director, and IHFS Director. The residential program is managed by the residential director and staffed by an Administrative Assistant, two youth care supervisors, 14 youth care workers, and a nurse. The community counseling program is managed by a program director and staffed by an administrative assistant, a supervisor, and two case manager consultants. At the time of the onsite visit there were two youth care worker positions, the nurse, and IHFS case manager position vacant.

The overall findings for the QI Review for **Boys Town** are summarized as follows. A total of eight indicators were reviewed during the QI visit.

Standard 1:

Three indicators were reviewed for this standard: 1.01 Background Screening of Employees/Volunteers, 1.04 Training Requirements, and 1.06 Client Transportation. All three indicators were rated Satisfactory with the following exceptions: 1.01 - rehire of staff with a 2-year break in service without conducting a new background screening; 1.04 - three pre-service staff missed one mandatory training and two were late completing one training each, during the 90-day required timeframe; and 1.06 - 26 of the 199 single transports reviewed did not support prior approval by the manager/supervisor.

Standard 2:

One indicator was reviewed for Standard 2, indicator 2.03 Case/Service Plan. Indicator 2.03 was rated Satisfactory with exceptions because: 1) for one record, the NIRVANA was completed on November 2, 2022 and the case plan was developed on November 22, 2022, not within seven working days of NIRVANA. For the remaining record, the case plan was developed 1/25/23, prior to NIRVANA completion on 2/1/23, and 2) for one record, the case plan was missing the youth signature; for another record, the case plan was missing the supervisor's signature; for a third record, the case plan was missing the counselor and supervisor's signature.

Standard 3:
Two indicators were reviewed for standard 3: 3.01 Shelter Environment, and 3.06 Staffing and Youth Supervision. Indicator 3.06 was rated Satisfactory but indicator 3.01 was rated as Limited.

Standard 4:
There are 2 indicators that were reviewed for standard 4, indicators 4.02 Suicide Prevention, and 4.03 Medications. Both indicators were rated Satisfactory with exceptions because the suicide risk assessment did not identify the appropriate level of supervision based on the results of the suicide risk assessment (4.02) and two new staff hired in 2023 did not receive EpiPen training by registered nurse (4.03).

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

Indicator 3.01:
The exceptions observed for 3.01 was due to inaccurate chemical inventory, Material Safety Data Sheet (MSDS) missing for one chemical in use, facility walls needing repainting, and missing fire and emergency drills.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator.		Review Based Upon Document Source *For example: Interview/Surveys, Observation, and/or Type of Documentation*	Notes Explain any items that have any deficiencies, exceptions or are not applicable.
Standard One – Management Accountability			
1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**NO** If NO, explain here: Policy CINS/FINS Protocol 7, IAP 19 does not address requirement for contracted providers to be background screened. The provider's policy and procedures, CINS/FINS Protocol 7 and IAP 19, were last reviewed and approved by the Executive Director (ED) on January 13, 2023. Protocol 7 was revised during the QI review to include contracted providers, grant recipient employees, and mentors.	
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**	Boys Town uses the Hiring Manager Interview (HMI) pre-assessment tool to determine eligibility rating for employment that was implemented October 9, 2019. An eligible pass rate for a youth care worker is a minimum of 26, and 24 for In-Home Consultant. The tool was utilized to screen seven applicable direct care new hire staff, all of whom received passing scores. Two additional new hires, a program director and clinical consultant, did not complete the HMI upon hire because their positions do not provide direct services to youth.	

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	**Exception**	A total of nine new staff were hired since the last onsite QI visit. Eight of the nine background screenings were initiated prior to hire dates with eligibility documented on the Clearinghouse results. No exemptions were applicable. Human Resources (HR) checked Clearinghouse eligibility prior to re-hire of one staff with a 2-year break in service; however, a new screening was required due to length of separation beyond 90 days. Upon notification, HR submitted the screening request on 4/12/23.	DJJ background screening was not submitted for new staff who had a 2-year break in service.
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**	There are no applicable new hires with a break in service for less than 90 days.	
Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	The program had two eligible staff who met the criteria for 5-year re-screening. Both staff were re-screened and/or had valid retained prints in the clearinghouse.	
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 had a signed and notarized Annual Affidavit of Compliance with Level 2 Screening Standards that was completed, notarized, and faxed on January 3, 2023 to the Background Screening Unit, prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of E-Verify work authorizations were maintained in all nine new hire files.	
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)			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES**	
		If NO, explain here:	
		The provider has the required policy and procedure CINS/FINS Protocol 5 and IAP Protocol 37 that was last reviewed and approved by the ED on January 13, 2023.	
First Year Direct Care Staff			

All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	Training records for three new hires were reviewed. All three staff completed new hire pre-service training prior to working independently with youth.	
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**	All three new hire staff training records indicated the staff received the United States Department of Justice Civil Rights and Federal Funds training within 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**	All three staff completed an excess of 80 training hours during the first year.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	All three training records reviewed for trainings due within the first 90 days of employment have documentation of completion of all but one required training each, and two records showed one late training. Per the program director, the medication distribution training was not completed because the provider does not currently have a nurse to conduct the training.	Three new staff did not complete all mandatory trainings due within the first 90 days as follows: 1) One staff did not complete Motivational Interviewing training and completed the NIRVANA training 17 days late. 2) A second staff completed Universal Precaution 71 days late and is missing Medication Distribution. 3) A third staff is missing Medication Distribution training
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 community counseling staff completed the required NIRVANA training. There were no applicable new staff who are responsible for JJIS data entry.	
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 did not hire any non-licensed mental health clinical shelter staff during the review period.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Compliance**	Three in-service direct care training records were reviewed. All three training records had an excess of 40 hours of training and demonstrated staff completed all mandatory annual Florida Network, Skill Pro and job related and/or refresher training.	
Required Training Documentation			
The agency has a designated staff member responsible for managing all employee's individual training files and completes routine reviews of staff files to ensure compliance.	**Compliance**	It is the responsibility of the employee to make sure they meet their annual training requirements. The program support compliance coordinator monitors overall compliance or any non-compliance and informs the supervisors and employees of upcoming required trainings via the Mandatory Tracking System via email.	
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 training records for all staff which include tracking hours on a document. Each file reviewed contained certificates of completion, training logs for Bridge, Skill Pro, and DCF training, as well as sign-in sheets for trainings attended.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The provider has the required policy and procedure CINS/FINS Protocol 2 and IAP Protocol 10 that was last reviewed and approved by the ED on January 13, 2023.	

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The program provided a list of 14 agency staff approved by administrative personnel to drive clients in agency or approved private vehicles. Approved drivers are confirmed by Human Resources (HR) to have a valid driver's license and successfully complete the Adult Driving Review training.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Per the agency's policy, approved drivers are covered under the agency's automobile policy. The current automobile insurance is provided by Philadelphia Indemnity Insurance Company and is effective through 10/1/2023.	
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**	Per transportation policy, the agency "strives to have a third party (staff, youth, volunteer, and intern) in the vehicle as best practice" when transporting youth at all times. The policy does provide for exceptions in the event a 3rd party is not present in the vehicle while transporting.	
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**	In the event a 3rd party is not present in the vehicle while transporting, the policy states a program director or supervisor will consider the client's history, evaluation, and recent behavior prior to approval of single transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency has two vehicles, a grey 2015 Ford and a blue Nissan NV3500 HD van, used to transport youth. Transportation logs for the two agency vans were reviewed for the period October 2022 - March 2023. All non-single transports reviewed had a staff or youth listed as 3rd party.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	Review of transportation logs for both agency vehicles revealed the program performed 199 single youth transports during the annual review. Supervisor's approval is documented on the transportation logs by their initials and time of approval. Prior approval by the program's manager/supervisor was evidenced for 173 of the 199 single transports conducted.	Twenty-six (26) of the 199 single transports reviewed did not support prior approval by the manager or supervisor. Three of the 26 approvals were documented after transport was initiated and 23 were missing supervisor's approval.

There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	The program maintains a vehicle transportation log for each vehicle where drivers and other staff present identify themselves, note the date, time out/in, mileage out/in, number of youth present, destination, purpose for travel, and supervisory approval as well as time of such approval, as needed.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The provider has the required policy and procedures CINS/FINS I-10 and IAP Protocol 38 that was last reviewed and approved by the ED on January 13, 2023.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Exception**	For nine of the ten case plans reviewed, the case plan is developed based on the information gathered during the initial screening, intake, suicide screening and NIRVANA	For the remaining one record, the case plan was developed prior to administering NIRVANA and not based on the NIRVANA assessment.
Case/Service plan is developed within 7 working days of NIRVANA	**Exception**	For eight of the ten records reviewed, the case plan was developed within seven working days of NIRVANA.	For one record, the NIRVANA was completed on November 2, 2022 and the case plan was developed on November 22, 2022, not within seven working days of NIRVANA. For the remaining record, the case plan was developed 1/25/23, prior to NIRVANA completion on 2/1/23.
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**	For seven of the ten reviewed records, the case plan included all required elements.	For one record, the case plan was missing the youth signature; for another record, the case plan was missing the supervisor's signature; for the remaining record, the case plan was missing the counselor and supervisor's signature.

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**	For all ten reviewed records, the case plans were reviewed for progress as required within the required time frame.	
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The provider has the required policy and procedures IAP Protocol 52 that was last reviewed and approved by the ED on January 13, 2023.	
Facility Inspection	**Exception**	A tour of the facility was conducted with the Program Manager. During the tour, the furnishing was observed to be in good condition with no rips or tears. All beds appeared sturdy and functional. No insect droppings or infestation was noticeable. The shelter is located on a large campus with adjacent residential cottages used for other funding agencies. The exterior areas are well maintained and free of debris/hazard. The campus has adequate recreational spaces for outdoor activities. A large dumpster is located across from the entrance to the facility and was observed to be covered during the visit. All bathroom facilities were clean and functional. Girls have access to two full bathrooms and boys also have access to two full bathrooms. Each bathroom has a toilet, sink, and one shower. The facility is well lit throughout. The program uses two minivans to transport youth. Both vehicles are equipped with first aid kits, fire extinguishers, glass breaker, flashlights, and seat belt cutter. Doors are secure with key access required. Staff use electronic key fobs to gain access to key areas in the facility. There are three sets of keys for staff to use in addition to a set kept by the program director and one set for each senior YCW. Program has postings located on the girls' and boys' wing that includes abuse hotline information, rights/responsibilities, SOGIE signage, program schedules, egress plans, and grievance forms. Egress plans are also posted in the kitchen and office areas.	Observed peeling paint, blotches of primer covering graffiti, and soiled walls in various areas of the facility in need of repainting.

Additional Facility Inspection Narrative (if applicable)	Each wing is equipped with a laundry room furnished with a washer and a dryer. No lint was observed in the dryers during the tour. Girls and boys wings each have four bedrooms. Three of the bedrooms on each wing has two beds and one has three beds. All beds had a pillow and was covered with bed sheets and a comforter. No contraband was observed. Youth have a safe lockable place to keep electronics in the residential director's office and contraband is locked up in individual drawers in the staff's office. Each bedroom has dressers with a drawer assigned per youth for storing clothing items. Chemicals are stored in a locked closet behind the kitchen area. A perpetual inventory is maintained and posted on the closet door. Inventory of chemicals was reviewed and found to be inaccurate during the review. Material Safety Data Sheets (MSDS) were available for all but one item (Lysol wipes) in use. DCF license is issued by Department of Children and Families for 18 beds effective through 12/04/2023 and copy is on file with reviewer.		Chemical inventory was not accurate when reviewed during the tour as follows: Clorox wipes show one but two were in storage and Lysol spray shows two but only one was observed. Also, a few chemicals in use were missing from the inventory list, namely, hand soap, Super Sorb, and Lysol wipes. MSDS was missing for Lysol wipes.
Fire and Safety Health Hazards	**Exception**	Annual fire inspection was completed by Seminole County Fire Department on 9/22/22; one violation was cited regarding missing breakers in the electrical panel not having blanks installed. The violation was cleared during the reinspection on 11/17/22. Annual Alarm testing was conducted by Reasonix DBA High Security on 12/28/22. Annual Fire extinguisher inspection was completed on 3/23/23 by United Fire Protection for seven facility and two vehicle fire extinguishers. Last quarterly alarm and sprinkler system inspection was conducted by Ace Flow Control on 4/7/23.	There's no evidence the program conducted quarterly emergency drills during the past 6 months or monthly fire drills on all shifts. The first shift missed a fire drill in February 2023, the second shift did not complete any during that period, and the third shift only completed one in January 2023.
Additional Fire and Safety Health Hazards Narrative (if applicable)	Fire drills were not completed monthly as required for the past 6 months on each shift nor were emergency drills conducted at least quarterly during the review period. Refrigerator temperature is 42 degrees Fahrenheit and two freezers' temperatures were zero and negative 5 degrees Fahrenheit. Department of Health (DOH) Food inspection was completed 3/1/23 - with five violations cited which were all cleared during the reinspection on 3/22/23. Unsatisfactory DOH Group Care inspection was completed 3/21/23 with two violations noted. Reinspection by DOH was still pending at the time of the QI visit.		
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. A blue youth grievance box is mounted in the dining room. Grievance forms are accessible and are available next to the grievance box.	

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**	Four grievances were reported during the past six months. All four were resolved 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**	The youth are engaged in meaningful, structured activities seven days a week during awake hours and idle time is minimal as evidenced by the daily schedule of activities provided and posted around the facility. The program has a weekday and weekend schedule with structured activities each day. The schedule is posted on each wing as well as staff office. Physical activity is scheduled for at least 1 hour daily. Youth are provided an opportunity to attend religious/faith based activities on Sundays at 10:30am and or community service for youth who do not choose to participate in faith-based activities. Youth are given the time and opportunity to do homework and read between 3:30-5:30 pm daily. The program schedule is posted on each wing and in the staff office, accessible to both youth and staff.	
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: The provider has required policy and procedures IAP Protocol 18 which was last reviewed and approved by the ED on January 13, 2023.	

The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	The program maintains a minimum staffing ratio as required by the Florida Administrative Code and contractual requirement including one staff to six youth during awake hours and community activities and one staff to twelve youth during sleeping hours.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Program schedules were reviewed for the last six months which validated there were at least two direct care staff present on each shift who met the minimum 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**	Program staff included in the staff-to-youth ratio included staff who were background screened and properly trained.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule is posted in the shelter and visible to staff.	
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**	An informal interview with the program's Quality Assurance Coordinator revealed the supervisors will call and contact the available staff to provide appropriate coverages if holdover or additional coverage is needed.	
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	**Compliance**	The program maintains bed check logs to document staff observing youth while they are in their sleeping rooms. Bed checks logs were reviewed for five randomly selected days during the last month: October 21st, 12am-2am; November 17th, 2am-4am; December 24th, 4am-6am; January 15th, 1am-3am; and February 8th, 3am-5am. Staff observed youth at least every fifteen minutes while there were in their sleeping rooms.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The provider has required policy and procedures IAP Protocol 5 which was last reviewed and approved by the ED on January 13, 2023.	

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**	Five youth records were reviewed for two residential and three community counseling youth. In all five records reviewed, the suicide risk screening occurred during the initial intake and screening process. The suicide screening results were reviewed and signed by the supervisor for each record and documented in the youth's case file.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**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.	**Exception**	Five youth records were reviewed, two of which were from shelter/residential. For one of the two applicable records, the youth were placed on the appropriate level of supervision based on the results of the suicide risk assessment.	For the one remaining applicable record, the suicide risk assessment did not identify 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**	Five youth records were reviewed, two of which were from shelter/residential. For both applicable records, staff person assigned to monitor youth documented youth behaviors at thirty minutes or less intervals.	
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**	For both applicable records, all assessment of suicide risks were completed as required and supervision level was not changed until a licensed professional completed 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.	**Compliance**	Five youth records were reviewed, three of which were community counseling. For each of the three applicable record, the youth were assessed by a licensed professional after being identified for suicide risk during intake process.	

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.	**Compliance**	For each of the three applicable records, the parent/guardian were notified of the suicide risk findings and the youth were assessed by a licensed professional after being identified for suicide risk during the intake process.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**Not Applicable**	Each youth was assessed by the provider's licensed professional after being identified for suicide risk during the intake process and did not have to be referred to an outside provider.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Not Applicable**	For each of the three applicable records, the parent/guardian were contacted and notified of the suicide risk findings.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	None of the reviewed screenings were conducted on school property.	
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 provider has required policy and procedures IAP Protocol 13 which was last reviewed and approved by the ED on January 13, 2023.	
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.	**No eligible items for review**	The program has been without a Registered Nurse and/or a Licensed Practical Nurse since December 2022. The program indicated they advertised for this position and have been trying actively to fill the position; however, it has been very difficult to find an appropriate candidate for the position.	
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**	Observations during the review revealed all medications are stored in a Pyxis Med-Station, in accordance to the required policy and guidelines, which is inaccessible to youth. Narcotics and controlled medications are stored in the Med-Station. The program maintains keys to access the medication if there is a malfunction with the Med-Station. The program did not have any injectable epi-pen during the review week, but injectable epi-pen will be kept separately from oral medication if there is any injectable epi-pen. The program has a locked refrigerator which was empty during the review week and at a temperature of 42-degree Fahrenheit.	
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	**Exception**	The program has a list of six super users who have access to the Pyxis Med-Station including controlled substances. The program did not have any Registered Nurse and/or a Licensed Practical Nurse since December 2022. The program indicated they advertised for this position and trying actively to fill the position; however, it has been very difficult to find appropriate candidate for the position. When the nurse is on-site, the nurse is responsible for the medication process. The program utilizes a Medication Distribution Log when non-licensed staff provide medications according to the FNYFS Medication Management and Distribution Policy. The program verifies medication by using the Lexi Comp, one of the approved methods listed in the FNYFS Operations Manual. The program only accepts youth with epi-pen and no other injectable medications. The registered nurse (RN) conducted the EpiPen training on July 25, 2022 for non-licensed staff. There was no RN since December 2022 and there are currently two non-licensed staff hired after December 2022 who have not received the EpiPen training by an RN.	Two new staff hired in 2023 did not receive EpiPen training by registered nurse
Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	Reviewed medication inventory documentations revealed the program conducts shift-to-shift counts for controlled substances which are witnessed and documented and maintains a perpetual inventory with running balances. The program does not have any sharps. All over-the-counter medications accessed regularly are inventoried weekly by maintaining a perpetual inventory.	

There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The program conducts monthly reviews and prints out monthly discrepancy report to monitor medication management practice.	
Medication discrepancies are cleared after each shift.	**Compliance**	Reviewed medication inventory documentations found medication discrepancies are cleared after each shift.	
Additional Comments: **There are no additional comments for this indicator.**			