Florida Network for Youth and Family Services
Compliance Monitoring Report for

Children's Home Society
WaveCREST Shelter

4520 Selvitz Road,
Fort Pierce, FL 34981

March 8-9, 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 Children's Home Society WaveCREST (CHS WaveCREST) for the FY 2022-2023 at its program office located at 4520 Selvitz Road, Fort Pierce. 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. CHS WaveCREST 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 from 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, Christine Calvert. Agency representatives from CHS WaveCREST present for the entrance interview were Sabrina Barnes, Executive Director; Kristi Walsh, Director of Program Operations; Kelly Barnett, Residential Supervisor; Megan Edge, Community Counseling Program Supervisor; and Esther Samuelson, Residential Counselor. The last QI visit was conducted February 16 – 17, 2022.

In general, the Reviewer found that CHS WaveCREST is in compliance with specific contract requirements. CHS WaveCREST **received an overall compliance rating of 100% for achieving full compliance** with four 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 03-08-2022-2023

Agency Name: CHS WaveCREST	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 4520 Selvitz Road, Fort Pierce, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 8-9, 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 medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☐	☒	☐	Documentation: General Liability through Alliance of Nonprofits for Insurance, for limits of coverage $1,000,000 each $3,000,000 aggregate and medical payments for $5000, effective 7/01/22-7/01/23 Auto Insurance through Alliance of Nonprofits for Insurance, with combined single limit coverage for $1,000,000, effective 7/01/22-7/1/23 Workers Compensation through United Wisconsin Insurance Co, with limits of $1,000,000 for each incident and $1,000,000 policy limit, effective 7/01/22-7/01/23. Directors and Officers liability policy through Alliance of Nonprofits for Insurance, with limits of $1,000,000,	**No recommendation or Corrective Action.**

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	Explain Rating					**Ratings Based Upon:**	**Notes**
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
						per occurrence, effective 7/01/22-7/1/23. The Florida Network of Youth and Family Services, Inc. is listed as certificate holder on the certificate of coverage.	
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: Fiscal Policies and Procedures are maintained in the agency's Accounting Policies and Procedures Manual. The Accounting Policies and Procedures were last reviewed on December 1, 2019. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for accounts receivable, accounts payable, cash management, contributions, purchasing, travel, and Payroll. Fiscal files are located in the agency's corporate office.	**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 No change in practice was reported for the agency since the last onsite program review in February 2022	**No recommendation or Corrective Action.**

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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**		
						Petty cash is maintained and reconciled by the Secretary monthly or as needed. The reconciliation is accompanied by a log including the date, vendor, amount, account, and sub-account for each activity. Policies and procedures are maintained in the Fiscal Manual under the Cash Management section. The maximum petty cash account for WaveCREST shelter is $400. The funds are kept locked up in the Administrative Secretary's office. Requests for petty cash are informal but are accompanied by an up-to-date log of activities and receipt that is maintained by the custodian.	
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**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**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	☐	☐	☒	☐	☐	Documentation: The financial audit was conducted for year ending June 30, 2022, by RSM	**No recommendation or Corrective Action.**

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	Explain Rating					**Ratings Based Upon:**	**Notes**
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
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**						US, LLP and dated 11/30/2022. The single audit disclosed no findings in the Schedule of Findings and Questioned Costs and no unresolved findings exist from any previous years' single audits. No Management Letter was required as there were no findings required to be reported in a separate management letter. A copy of the financial audit is on file with the Reviewer.	

CONCLUSION

CHS WaveCREST has met the requirements for the CINS/FINS contract as a result of full compliance with all four applicable indicators of the Modified 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, **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 Childrens Home Society - WaveCREST
Residential Program

March 8-9, 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	Limited

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

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory

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

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	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
Christine Calvert – 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		Direct – Care Full time	1	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
X	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer		# Other (listed by title): ___
	Counselor Licensed		Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records		# Health Records
X	Logbooks		Key Control Log	6	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	7	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	9	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	3	# 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	X	Staff Interactions with Youth	X	Census Board

Surveys

6	# of Youth	7	# of Direct Staff		# of Other

Comments

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

Monitoring Purpose

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and/or community counseling services.

Strengths and Innovative Approaches

Children's Home Society WaveCREST (CHS WaveCREST) is a non-profit community-based corporation contracted with the Florida Network of Youth and Family Services (Florida Network) to operate Children in Need of Services/Families in Need of Services (CINS/FINS) residential program and community counseling services to youth and families in the Treasure Coast area. The program is located at 4520 Selvitz Road, Fort Pierce, Florida. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence and probation respite. CHS WaveCREST's services span across four counties-- Indian River, Okeechobee, Martin, and St. Lucie, in Circuit 19. Children's Home Society is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through June 30, 2025. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards. CHS WaveCREST is currently licensed for twelve beds by the Department of Children and Families effective through 2/27/2024.

The following programmatic updates were provided by the agency:

Staffing

The current management structure includes: Regional Executive Director- Sabrina Sampson; Director of Program Operations, Kristi Walsh; Residential Program Supervisor Kelly Barnett; and Community Counseling Program Manager Megan Edge. Ms. Edge is the new community counseling program manager for CHS WaveCREST who also oversees CHS Osceola Community Counseling. CHS eliminated one Program Supervisor Position previous held by Brittany Brown. The nurse contract is held by Christina Kelly, RN, who is scheduled twice weekly, Monday and Thursday from 5:30 to 9:00 pm. At the time of the annual compliance review, the program had three full time and one part time youth care positions and two full time community counseling case manager positions vacant.

Program Updates

New CINS/FINS program initiatives include attendance at Truancy Court in all four counties, Indian River, St Lucie, Okeechobee and Martin Counties of the DJJ Circuit 19.

Other non-CINS/FINS activities that complement the program are the National Safe Place program that promotes outreach and community partnerships to assist runaway and homeless youth.

Community counseling services offer groups, virtual/office services, school, and in-home service provision. The program is currently utilizing paper versus electronic records.

In an effort to be more competitive, Children's Home Society (CHS) increased the starting wages for Youth Care Specialists to $15.00 per hour.

Facility

Within the last year, the program obtained a new refrigerator and dishwasher. Planned facility updates for the future include surfacing the gravel parking lot with asphalt and investigating removal of Oak tree and fixing lifting sidewalk.

Funding/Finance

The program is happy to announce receipt of new funding for the community counseling program, granted by the Children's Services Council.

Major Challenges

Despite the increase in wages for direct care staff to $15/hour, the program is still having a challenge hiring qualified youth care staff to fill vacancies.

Narrative Summary

CHS WaveCREST is under the leadership of a management team that consists of a Regional Executive Director, a Director of Program Operations, a Residential Program Manager, and a Community Counseling Supervisor. The residential program is staffed by a group living manager, one residential counselor, four full-time Youth Care Workers (YCW) positions, and one part time YCW. An additional four YCW positions were vacant positions during the annual visit. The community counseling component of the program includes four full-time counseling positions, two of which were vacant during the visit.

The overall findings for the QI Review for CHS WaveCREST are summarized as follows

A total of eight indicators were reviewed during the annual compliance 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 no exceptions.

Standard 2:

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

Standard 3:

Two indicators were reviewed for standard 3: 3.01 Shelter Environment, and 3.06 Staffing and Youth Supervision. Both indicators were rated Satisfactory but Indicator 3.01 was found to have exceptions due to lack of perpetual inventory and inaccurate chemical count, a missed fire drill on one shift, and two non-working emergency lights.

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 no exceptions.

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

Standard 2

Indicator 2.03 - Limited

1) One of ten records reviewed did not contain a case plan.
2) The program's practice is to have the supervisor sign when available or at discharge. Three service plans were missing supervisor's signature and three plans were signed days or weeks later by the supervisor as follows: five residential records reflected one was signed by the supervisor, two were not signed, and two were signed between seven and twenty-seven days after plan development. Four community records reflected one had no supervisor signature, and one was signed five days after plan development. One service plan did not indicate actual completion dates. One plan did not indicate targeted completion dates. One plan had no signature or note indicating the parent/guardian agreed to or participated in plan development.
3) Two records had no service plan reviews within the record, and another record was missing two months of reviews.

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 CHS/7101 that was approved by the Director of Program Operations (DPO) on November 1, 2022.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.	**Compliance**	A total of three new staff were hired and one new nurse was contracted since the last onsite QI review. Two of the four, a data specialist and contracted nurse, are non-direct care staff and were exempt from completing the pre-employment assessment. The agency uses the Berke Assessment and completed the screening prior to hire for the two applicable staff. One of the two staff received a passing score. Documentation was provided to support management completed the CHS Interview Guide to further assess the staff who scored low who was then determined to meet the agency's expectation for the position.	
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**	Eligible Department of Juvenile Justice (DJJ) background screening results for all four new hires demonstrated staff were background screened prior to their hire dates. The program utilized two interns during the review period; similarly, both interns received eligible screening results prior to their start dates with the agency.	

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 staff were previously employed by the program.	
Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	There was one eligible staff due for five-year re-screening during the review period. The agency completed the re-screening within the required time frame.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The agency submitted the Annual Affidavit of Compliance with Level 2 Screening via email to the Background Screening Unit on 1/20/2023 prior to the January 31st submission deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Documentation of approval of E-Verify work eligibility was provided for the three applicable new staff hired by the agency.	
Additional Comments: **There are no additional comments for this indicator.**			
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**NO**	
		If NO, explain here: Policy CHS/7104, last updated 11/9/2022, does not include the required DJJ SkillPro Suicide Awareness #1523 training and also does not indicate which trainings must be completed prior to staff working independently with youth.	
		The agency has a policy and procedure CHS/7104 that was approved by the DPO on November 9, 2022.	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	Two applicable first year training records were reviewed for compliance: one direct care (Program Manager) and one non-direct care (Data Specialist) staff. All new hire pre-service training requirements were completed by the direct care staff.	
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**	Two applicable first year training records were reviewed. The two staff completed the DOJ Civil Rights 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**	One applicable direct care staff had completed 101 hours of training, and the other completed 87.8 hours of training exceeding the 80 hours required annually.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	Both staff completed all of the mandatory trainings required during the first 90 days of hire.	
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	One applicable staff completed the NIRVANA training as required. There were no applicable new staff 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**	Four in-service direct care training records were reviewed. After the first year, training is calculated based on the calendar year for all staff. All four training records had an excess of 40 hours of training and demonstrated staff completed all mandatory annual Florida Network, DJJ SkillPro 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**	The program managers are responsible for managing their employees' individual training files and conduct periodic reviews to monitor and ensure compliance with the training requirements.	

The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	All six training records reviewed contained individual training plans for each staff including an annual training tracking form indicating the name of the training, date completed, and the number of training hours received. The files also contained sign-in sheets, certificates and/or agendas of the training received.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency has the required policy and procedure CHS/7106 that was approved by the DPO on November 1, 2022.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	Per agency policy, drivers are approved by Human Resources Talent Department who performs initial and annual motor vehicle record (MVR) checks. Employees placed on "no drive status" are not allowed to transport youth. HR provided clean MVRs for seven staff approved to drive agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	A review of the agency's automobile insurance policy documented liability insurance coverage provided through Alliance Nonprofits for Insurance with combined single limits of $1,000,000 effective through 7/1/2023. Per the residential supervisor, the agency's automobile policy includes coverage for all approved agency drivers.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency's policy that was reviewed addresses one-on-one staff-to-client transport and the exception that can be made if a 3rd party is not available. The transportation log and logbook documents authorization given by a supervisor/manager for single client transports.	
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 of a single transport of youth, per the transportation policy, approval is required by the program manager or designee who considers the client's history, evaluation, and recent behavior. These individuals were observed as providing single transport approvals on the transport logs.	

The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency uses a 2020 Ford Transit 350 HD van to transport youth. Transportation logs were reviewed for the period September 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.	**Compliance**	Single transport is documented on the transportation log as well as in the program logbook. During the review period, a total of 20 single transports were reviewed. Supervisory approval was documented for all 20 single transports.	
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 agency's transportation log documents names/initials of the driver in the vehicle, number of passengers, date and time of transport, mileage, and location/purpose of the trip.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has the required policy and procedure CHS/7203 that was approved by the DPO on November 1, 2022 and revised during the annual review on March 8, 2023 to clarify supervisors are not required to participate in the development of the service plan as previously implied.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Exception**	Five residential and five community records were reviewed. Each record contained an intake questionnaire, screenings, and a NIRVANA completed upon admission. Nine of the ten records contained a case plan which was developed based on and after the initial screening, intake, suicide, and NIRVANA information was obtained.	One of ten records reviewed did not contain a case plan.
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All nine case plans that were developed were completed within seven working days of the completion of the NIRVANA.	

Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	Nine of the ten reviewed records contained a case plan/service plan. Each of the nine plans documented the individualized and prioritized needs and goals identified by the NIRVANA, service type, frequency, location, person(s) responsible, initiation days of the plan, and signature of youth. Eight plans documented the counselor signature, target dates of completion and the actual completion dates of the goals. Four of the nine reviewed plans were signed by the parent/guardian and four documented the plan was discussed with the parent/guardian by telephone. The program's practice is to have the supervisor sign the service plan when available or at discharge. Consequently, four plans were signed days or weeks later by the supervisor. Five residential records reflected one was signed by the supervisor, two were not signed, and two were signed between seven and twenty-seven days after plan development. Four community records reflected one had no supervisor signature, and one was signed five days after plan development. The program updated policy CHS/7203 during the annual compliance review to indicate the "supervisor will sign the service plan indicating the service plan was reviewed" and the plan "is to be developed with and signed by the youth, parent/legal guardian and counselor.	Three service plans, two residential and one community counseling, were missing supervisor's signature. One service plan did not indicate actual completion dates. One plan did not indicate targeted completion dates. One plan had no signature or note indicating the parent/guardian agreed to or participated in plan development.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Exception**	Nine of the ten reviewed records contained a case plan/service plan. Each of the nine available plans were applicable for documented progress reviews and six documented the reviews were completed.	Two records had no service plan reviews within the record, and another record was missing two months of reviews.
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 CHS/7301 that was approved by the DPO on November 9, 2022.	
Facility Inspection	**Exception**	A full tour of the facility's interior and exterior areas and transportation vehicles was conducted. Furnishings were adequate and functional to serve the shelter's expectation. The facility appeared to be free of any termite or insect infestation. The exterior grounds was void of landscaping and there was no observed hazard or debris. All bathrooms and shower areas were found to be clean. The girls' and boys' dorm sleeping rooms contained adequate and clean bedding with individual pillows for each youth. Youth are provided space in a safe kept in the pantry or in the outside shed for safe keeping of valuable items requiring lock-up in the shelter. The lighting throughout the building including the dorm areas was operational and provided adequate illumination. A large dumpster is located on the premises and is kept covered. Vehicles parked on the premises were secure and locked when checked during the visit. The program uses one minivan to transport youth. The van is equipped with a first aid kit, flashlight, fire extinguisher, glass breaker, and seat belt cutter. The facility is equipped with one washer and dryer. Both were observed to be in good condition, were clean, and the dryer was free of lint.	Chemical inventory was inaccurate and no evidence of perpetual inventories being conducted when reviewed during the annual visit. The inventory reflected one can of Rid spray but two cans were observed.
Additional Facility Inspection Narrative (if applicable)	The program has two sets of keys distributed on each shift and additional sets are distributed to management. There is also a locked key box for storage of keys for equipment, vehicle, lockers, fire alarm, closets, and the gate. Egress plans are located in the lobby, hallways, dorms, offices, and common areas. Abuse hotline number is also visibly posted throughout the facility. Grievance box and forms are accessible to youth in the dinning room. SOGIE signage was observed posted throughout the facility. Current DCF license and COA accreditation certification were displayed in the lobby area. No contraband was observed. Chemicals are stored in a locked cabinet in the laundry room. Inventories are conducted weekly but not perpetually and was found to be inaccurate during the review. MSDS were available for all chemicals used.		

Fire and Safety Health Hazards	**Exception**	All fire and safety inspections were found to be current during the review. A satisfactory annual fire inspection was conducted by St. Lucie County Fire District Fire Marshall's office on 1/11/2023. Pye-Barker conducted semi-annual suppressions system inspections on 6/7/22 and 12/23/22 and also conducted fire extinguisher inspection for 8 fire extinguishers (2-vans, girls and boys hallway, kitchen, front door, den hall, PC room) on 10/17/22. Monthly fire drills were conducted on each shift, with evacuation time less than two minutes each, between September 2022 and February 2023 with the exception of one on the first shift in November. During the same period, the program conducted mock emergency drills quarterly on each shift.	The first shift missed a monthly fire drill for November 2022. Two emergency lights on the girl's wing, one at the entrance and one in the hallway, were not working when checked during the facility tour. Upon notification, a service call was made and the batteries to the emergency lights were replaced the following day on 3/9/2023.
Additional Fire and Safety Health Hazards Narrative (if applicable)	A combined Group Care and Food inspection was conducted by the Department of Health 1/12/2023 and deemed satisfactory. A menu approved by a registered dietician was posted in the kitchen. All food was found to be properly stored during the tour. Two refrigerator temperatures were observed to be 37 and 40 degrees Fahrenheit, and the temperature for one freezer was minus 10 degree Fahrenheit.		
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. Grievance forms are accessible and are available next to the grievance box which is mounted on a wall in the dinning room.	
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 director and group living manager have possession of the keys to the grievance box. The grievance box was checked during the review and was found to be empty. No grievance was reported for the annual review.	

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. Youth in the program are provided at least one hour of physical activity daily and they are also provided the opportunity to participate in a variety of faith-based activities and provided alternatives for those that chose not to participate in these activities. Youth are also provided opportunities to complete homework and have access to computers, a variety of age-appropriate and program-approved books for reading and are allowed quiet time to do so. The schedule is publicly posted and accessible to youth and staff, in the main office, hallways and youth rooms.	
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 agency has the required policy and procedure CHS/7306 that was approved by the DPO on November 9, 2022.	

The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	The program maintains a monthly schedule posted in the youth care office space. Past schedules are maintained in a binder. A review of schedules for the past twelve months reflected the program schedules a minimum of two staff at all times as required. The program has a staff phone list to obtain fill in coverage when needed. The program's administration often serve as the back-up staff. The program reported staff do not leave their post until relief has arrived to maintain ratio requirements.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	A review of schedules for the past twelve months reflected a minimum of two staff are scheduled for all shifts. The only exception would be if the program has no youth in population. A review of schedules reflected the program routinely schedules staff from 8:00 am to 4:00 pm, 4:00 pm to 12:00 am, and/or 12:00 am to 8:00 am. No exceptions were noted with training. An interview with the program director explained staff who have not met the essential training requirements are not left alone with youth until they have done so.	
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**	Staffing schedules for the past six months (listed above) were reviewed to ensure staff included in the staff-to-youth ratio were background screened and properly trained youth care workers, supervision staff, and treatment staff. All new staff were background screened and current prints were maintained in the clearing house for in-service staff. Training files reviewed confirmed all residential program staff received the appropriate training prior to working independently with youth.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The program posts a monthly schedule in the youth care office space near the entrance to the program. All schedule changes and updates are completed by the program's administration. All past schedules are maintained in a binder at the program.	
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**	The program maintains a staff phone list for on-call coverage. The program's administration staff serve as the primary fill-in for unexpected absences/ coverage needs. The program does not have adequate staff presently to maintain an overtime rotation roster. The interviewed program director reported staff do not leave their post until coverage has arrived to maintain staff ratios.	

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 a bound logbook which is maintained in the youth care office space. The logbook documents checks completed during sleeping hours. The program policy and practice is to conduct youth observations every ten minutes while youth are in their sleeping rooms. While conducting checks staff are to confirm the youth's presence in the room and document the check within the logbook. Reviewed documentation for five separate days for two-hour intervals (October 21, 2022, 12am-2am; November 17, 2022, 2am-4am; December 23rd, 2022, 4am-6am; January 15, 2023, 1am-3am, and February 8th, 2023, 3am-5am) confirmed the staff were documenting ten-minute checks. Each documented check included the number of female and male youth and the status of youth (i.e.: ""appear asleep"", using restroom, sitting up, etc.") There were no missed checks or inconsistencies in check documentation reviewed. The program reported having thirteen cameras and all were operable at the time of the annual compliance review. The program has a middle common area and a north and south hallway. There is one bed in the common area reportedly used for youth under constant sight and sound supervision and rooms down the two hallways. The youth hallways are separated by gender and there is one room with three beds and the remaining rooms have two beds each. There is full visibility of the sleeping areas when the doors are open.	
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 CHS/7402 that was approved by the DPO on November 9, 2022.	
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	A review of six youth records indicated each youth was screened for suicide risk factors upon admission. Each admission questionnaire documented review and signature from a supervisor. Any youth with positive responses on the initial screening are placed on sight and sound supervision and referred for an assessment of suicide risk.	

The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program utilizes the Florida Network of Youth and Family Services approved suicide risk assessment form.	
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**	Three shelter youth were applicable for sight and sound supervision and documentation. All of the reviewed suicide risk screenings were completed during the initial intake process, and reviewed by a supervisor. This review was documented with a signature.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	The program documents youth supervision at ten minute intervals for all youth identified as suicide risk. Additionally, all youth on suicide precautions sleep in the day room during sleeping hours to ensure sight and sound supervision status. Supervision logs were completed in full at ten minute intervals. No lapses or errors were noted.	
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**	Each of the three applicable shelter youth had no change in supervision levels until assessed by the program's licensed clinical social worker (LCSW) and deemed appropriate for standard supervision.	
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**	Three community youth records were reviewed and two were applicable for suicide risk factors during the intake screening. Each was referred to a community provider, agreed to a safety plan, and the parent/guardians were notified. There were no school notifications needed due to the intakes occurring outside of school. The program's practice is to email the community provider and the program manager when youth requiring additional assessments are identified.	

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**	Two records were applicable for parent/guardian notification and each was made as required. Both youth agreed to a safety plan and were subsequently referred to a community provider for additional assessment.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**Compliance**	In the two applicable instances were suicide risk factors were identified the parent was notified in person. The information regarding a local provider was disseminated and an email referral was generated.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	There were no applicable records where the parent/guardian could not be notified.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	None of the two suicide risk community youth screenings were conducted on school property.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Satisfactory**
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 CHS/7403 that was approved by the DPO on November 9, 2022.	

The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The program has one registered nurse who is scheduled to be on-site each Monday and Thursday from 5:30 to 9:00 pm. The registered nurse conducts trainings, administers medications, runs reports, and complete inventories while on-site. A review of the nursing license was clear and active in the State of Florida.	
Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	The program maintains a policy and procedures for medication management. The outlined system includes receipt, storage, inventories, distribution, documentation, and disposal. The program does not accept residential youth currently prescribed injectable medications. All prescription medications are stored using the Pyxis ES system which in maintained under video surveillance in a locked room inaccessible to youth. The Pyxis system maintains a perpetual inventory of all medications and different types of medications are stored separately within the cart. The program conducts shift-to-shift counts of controlled medications which are double locked within the cart. One over-the-counter medication and one controlled medication was checked during the annual compliance review and counts were accurate. The program's back-up Pyxis keys were observed to be on-site and are maintained within a locked safe in the pantry area. The back-up keys are available to staff in the event the Pyxis malfunctions and they need to access youth medications. Observations of the medication refrigerator reflected it was double locked and the temperature was 38 degrees F.	

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**	Upon delivery, medications are verified by the intake staff by calling the prescribing pharmacy. Parent/guardian consent is required for all over-the-counter medications. Observed documentation verified this practice. The interviewed program director reported the nurse conducts inventories each time they are on-site. All direct care staff received epinephrine auto-injector training and reviewed training records supported this practice. The licensed nurse trains all direct care staff on medication administration and retrains as needed. The program had seven staff trained during the annual compliance review.	

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 program maintains and documents shift-to-shift inventories of controlled medications. The program had one youth prescribed controlled medications during the annual compliance review. The inventories were found to be accurate. The program has three over-the-counter stock medications within the Pyxis cart. Observed inventories were accurate. The program's only sharps are razors which are secured and inaccessible to youth. A review of the razor perpetual inventory showed it was accurate.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The program's practice is to run Pyxis reports weekly and monthly. The program maintains the printed reports within a binder and administration monitors the reports for errors, needed retraining and/or corrective action. The program prints and reviews the discrepancy and override reports weekly and the user summary report monthly.	
Medication discrepancies are cleared after each shift.	**Compliance**	Reviewed documentation indicated the program clears discrepancies at the end of each shift. Additionally discrepancy reports are run weekly and the nurse conducted inventory two times each week	
Additional Comments: **There are no additional comments for this indicator.**			