Florida Network for Youth and Family Services
Compliance Monitoring Report for

Family Resources - St. Petersburg

3821 5th Avenue North
St. Petersburg, FL 33713

May 24-25, 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 Family Resources St. Petersburg SafePlace2B for the FY 2022-2023 at its program office located at 3821 5th Avenue North, St. Petersburg, 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. Family Resources St. Petersburg 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 DJJ Peer Reviewer. Agency representatives from SafePlace2B present for the entrance interview were: Nicole Leslie, Vice President of Impact; Delia Faggart, Residential Supervisor; Kayla O'Neal and Heidi Bullen, Counselors; and Sydney Swan, Case Manager. The last onsite QI visit was conducted April 13, 2022.

In general, the Reviewer found that Family Resources St. Petersburg is in compliance with specific contract requirements. Family Resources St. Pete **received an overall compliance rating of 100% for achieving full compliance** with 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. 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 05-24-2022-2023

Agency Name: Family Resources – St. Petersburg SafePlace2B	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 3821 5th Ave. North, St. Petersburg, FL 33713**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 24-25, 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 Ins. RRG, for limits of coverage $1,000,000 each $3,000,000 aggregate and medical expenses of $20,000 for any one person, effective 6/1/2022-6/1/2023. Workers Compensation through Benchmark Insurance Company with limits of $2,000,000 each and aggregate, effective 6/1/2022-6/1/2023. Automobile insurance through Alliance of Nonprofits for Ins. RRG with combined single limits of $1,000,000, effective 6/1/2022-6/1/2023. An umbrella policy through Alliance of Nonprofits for Ins. RRG, with limits of	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						$4,000,000 each/aggregate, effective 6/1/2022-6/1/2023. Directors and Officers Liability insurance through Alliance of Nonprofits for Ins. RRG with limits of $1 million each/ $2 million aggregate, effective 6/1/2022-6/1/2023. Florida Network is listed on the Certificate of Insurance as Certificate Holder.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	The agency has an employee fiscal manual. The agency's fiscal manual appears to be consistent with Generally Accepted Accounting Principles (GAAP). Specifically, the manual addresses procedures for the agency's budget process, authorization levels, credit cards, donations, capital assets, petty cash, sales tax exemption, required vendor information, journal entries, investment policy, general ledger, cost allocation, internal controls, travel, and purchasing process.	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
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 site program review in April 2022. Reviewed petty cash Policy and Procedure Finance 8.0. The Petty Cash fund does not exceed the established minimum of $150. Petty cash is stored in a secure locked location in the shelter. Petty cash was observed as being reconciled by Shelter Supervisor. Disbursements and invoices are approved by the Program Supervisor as required.	**No recommendation or Corrective Action.**
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 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	☐	☐	☒	☐	☐	Documentation: The agency produced Financial Statements, Supplemental Information and Regulatory Reports for Family Resources, Inc. for June 30, 2022 and 2021. The audit is completed by ASSURANCE Dimensions Certified Public Accountants and Associates	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**						per letter dated September 22, 2022. Per the audit report, a separate Management Letter requiring a Corrective Action Plan is not required and was not issued by the auditor.	

CONCLUSION

Family Resources St. Petersburg 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, 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 Family Resources - St. Petersburg
Residential Program

May 24-25, 2023

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	**Satisfactory**

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

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	**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: 62.5 %
Percent of indicators rated Limited: 37.5 %
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
Marvin Bliss - 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	X	Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed		Nurse – Part time
X	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	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	1	# Other (listed by title): VP of Impact
	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	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	7	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	7	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	7	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	6	# 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	X	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	X	Meals
X	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	3	# 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

Family Resources Inc. is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families through the Children In Need of Services/Families In Need of Services (CINS/FINS) program. The central office is located in Pinellas Park, Florida and CINS/FINS SafePlace2B shelters are located in Clearwater, St. Petersburg, and Bradenton, Florida. SafePlace2B Clearwater shelter is located at 1615 Union Street, Clearwater. Family Resources serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The program is also contracted to provide services for Staff Secure Shelter and is a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, domestic minor sex trafficking, and Family/Youth Respite Aftercare Services (FYRAC). The program is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to run away and homeless youth. The agency is currently accredited by the Council of Accreditation (COA) effective through December 31, 2024.

The following programmatic updates were provided by the agency:

Staffing

Shelter staff report directly to the Residential Supervisor, Delia Faggart. Currently, Ms. Faggart reports directly to the COO, Andy Coble, but this would change once new structure/positions are in place. The residential supervisor, was promoted from case manager to supervisor in December 2022. The current case manager was promoted from Youth Development Specialist (YDS) in February 2023. A new residential counselor joined the team effective April 2023. There are many new faces on the YDS team. Current vacancies includes one community counseling supervisor, and two YDS staff- one full and one part time.

Program

The agency is in the process of transitioning to electronic client records through Lauris. The testing phase was recently completed and the shelter will be the first agency program to make this transition. Full transition to Lauris is expected by the next fiscal year.

Facility

There were no facility improvements reported for the St. Petersburg SafePlace2B shelter during the past year.

Funding

The St. Petersburg programs have not received any new funding. The counseling program remains 100% funded by the Florida Network. The shelter was awarded continued funding this fiscal year (FY) through both Juvenile Welfare Board and Department of Health and Human Services through a Basic Center Program grant.

Governance and Community

The agency's previous Chair, Paul Horowitz, ended his term in 2022 and is now the Vice-Chair. The new Board Chair is Janie Peticca. In September a long-time member, Gary Shephard, resigned from the Board and a new member was voted onto the Board. The agency is actively seeking to recruit new members. The St. Petersburg shelter does not have any corrective action plans (CAPs) with other funding agencies.

Major Challenges

Recruitment and retention continue to be a post pandemic struggle despite salary increases. There is no influx of staffing for all direct care positions including counseling staff. Staff continue to resign and the background screening process is taking longer, lasting between four to five weeks for DCF screenings.

The shelter program has seen an increase in youth having access to and using vape pens due to the variety of inconspicuous products on the market including ones that look like computer thumb drives. This requires staff to be more educated on the trends and more diligent during searches.

Narrative Summary

Family Resources SafePlace2B St. Petersburg provides both residential and non-residential CINS/FINS services for youth and their families in Pinellas County and the surrounding areas. The program is under the leadership of a CEO, a Chief Operating Officer, Vice President of Impact, a Director of Client Success for community services, a residential supervisor, and a community services supervisor (vacant during the visit). Community counseling program is comprised of a supervisor and a counselor. The shelter is staffed by a counselor, a case manager, eleven YDS, a cook, an administrative assistant, and a part time nurse. The shelter is licensed for 12 beds by the Department of Children and Families effective through December 2023. At the time of the annual QI review, the shelter had a census of eight youth.

The overall findings for the QI Review for Family Resources SafePlace2B St. Petersburg are summarized as follows:

Standard 1:

Three indicators were reviewed for this standard: 1.01 Background Screening of Employees/Volunteers, 1.04 Training Requirements, and 1.06 Client Transportation. Indicator 1.01 was rated Satisfactory with no exception. Indicators 1.04 and 1.06 received a Limited rating.

Standard 2:

One indicator was reviewed for Standard 2, indicator 2.03 Case/Service Plan. Indicator 2.03 was rated Satisfactory with no exceptions.

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 with no exceptions but 3.01 received a Limited rating.

Standard 4:

There are 2 indicators that were reviewed for Standard 4, indicators 4.02 Suicide Prevention, and 4.03 Medications. Indicator 4.02 was rated Satisfactory with no exceptions noted. Indicator 4.03 was rated Satisfactory with exceptions because a verified shift-to-shift count for controlled medication was not conducted by staff on 5/20/2023 (1st and 2nd shift had only one staff doing the shift to shift count), and on 5/21- 5/24/2023 where no shift to shift counts took place.

Summary of Deficiencies resulting in Limited:

Standard 1:

Indicator 1.04 - Limited

1) Two staff did not complete all mandatory trainings required during the first 90 days. One of the staff, DOH 11/14/22, completed the following three trainings beyond the 90 day requirement: CPR/First Aid, medication distribution, and SOGIE. There was also no evidence of completion of behavior management and adolescent youth development trainings. The second staff, DOH 2/3/23, has not yet completed CPR/First Aid, and has no evidence of completing behavior management and adolescent youth development trainings due within 90 days.
2) Training records for two of three in-service staff reviewed showed each staff did not complete one of the mandatory trainings required. One of the staff missed the managing aggressive behavior training that was due by 5/3/23 and the other staff did not complete the Florida Network suicide prevention training in the last full training year.
3) Three of six training records reviewed were not organized in training files and did not readily have all supporting documents available such as the orientation training or a training plan.

Indicator 1.06 - Limited

Sixty-three of the 72 single transports reviewed for November 2022 - April 2023 were not evidenced as being approved by a supervisor and sixteen of those did not document an open communication line was as required by the provider's policy.

Standard 3:

Indicator 3.01 - Limited

1) During inspection, the 2017 van was missing a working flashlight and a window breaker. The fire extinguisher in the van was not inspected and tagged by a professional. Rear passenger side door handle is not attached on one end and is loose.
2) A pile of unsecured hurricane window shutters were observed on the east side of the building exterior.
3) Cabinet door in laundry room labeled "light bulbs" has a loose bottom hinge.
4) Unclean bathrooms were observed in room 3 (mildew in corners of the shower), and room 4 (dirty smudge on wall next to toilet).
5) Chemicals are stored in three different locations (laundry room, kitchen cabinet, and chemical closet in pantry) but separate inventories are not maintained. The inventory is not maintained on a perpetual basis to accurately reflect reduction in count due to usage and the count was inaccurate for hand soap (shows 1 but multiple in laundry room) and antibacterial wipes (shows 4 but should be 6). Three stainless steel cleaners and a can of Rustoleum spray were not accounted for on the inventory. Material Safety Data Sheets (MSDS) were missing for the stainless steel cleaner and Rustoleum spray.
6) Fire drills were not completed monthly on the first shift in February 2023 and on the second shift between February and April 2023. Quarterly emergency drills were not conducted on the 1st or 2nd shifts during the past six months.
7) Grievance box was not secured as the lock was broken.

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 provider has the required policy 1.01 in place that was last reviewed in January 2022 by the Chief Operations Officer (COO).	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.	**Compliance**	A total of four new staff were hired since the last onsite QI review. All four staff met the criteria for a pre-screening assessment. The agency uses the Berke Assessment Tool and all four completed the Berke prior to hire with passing scores.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors	**Compliance**	Background screenings were completed prior to hire with eligible results for the four new staff. There were no interns utilized during the annual review period.	
Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.	**No eligible items for review**	The agency has not re-hired any staff during the review period who have had 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 three eligible staff who met the criteria for 5-year re-screening. All three staff were re-screened and 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 emailed on January 5, 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 the four new hire files.	
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The provider has the required 1.04 policy and procedures that was last reviewed in January 2022 by the Chief Operations Officer (COO).	
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 were reviewed for four new hires, including two youth care and two counseling staff. The two youth care staff have not completed all pre-service training requirements; however, staff neither of the two staff were scheduled to work independently on any shift during the past six months.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*	**Compliance**	Training records for the four new hires reveal they all completed the DOJ Civil Rights and Federal Funds training within 30 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.	**Not Applicable**	All four staff are within the first year of hire and had time remaining to complete the required 80 hours of training.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Two of the four staff completed all mandatory training during the first 90 days of hire.	Two staff did not complete all mandatory trainings required during the first 90 days. One of the staff, DOH 11/14/22, completed the following three trainings beyond the 90 day requirement: CPR/First Aid, medication distribution, and SOGIE. There is also no evidence of completion of behavior management and adolescent youth development trainings. The second staff, DOH 2/3/23, has not yet completed CPR/First Aid, and has no evidence of completing behavior management and adolescent youth development trainings due within 90 days.
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**	Two applicable counseling staff completed the required NIRVANA training. There are 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**	One of the two counseling staff is a non-licensed mental health clinical staff who was recently hired 4/3/2023. The staff is currently receiving new hire training and has time to complete the required Assessment of Suicide Risk training.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	Two of the three staff completed a minimum 40 hours of mandatory training. The third staff is in the second year of employment and has time remaining to complete 11 hours by December 31, 2023. One of the three staff completed all annual trainings required.	Training records for two of three in-service staff reviewed showed each staff did not complete one of the mandatory trainings required. One of the staff missed the managing aggressive behavior training that was due by 5/3/23 and the other staff did not complete the Florida Network suicide prevention training in the last full training year.
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**	Per the agency's 1.04 policy, supervisors will maintain an individual training file for each employee to include documentation of training, including certifications, re-certifications, examinations, practicum, and test results. Supervisors will review the training requirements with each employee and work with the employee to schedule time to meet these requirements. Employees are expected to take an active role in their staff development and training process by identifying training needs and interests and communicating these during individual supervision, staff meetings, and through the annual needs assessment survey.	
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.	**Exception**	The COO indicated the agency is in the process of transitioning all training records to electronic files. Three of the six training records reviewed were still maintained in a training binder/file that contained a log of training topics, dates, and hours completed. The training files also included some documentation such as training certificates, sign-in sheets, and training worksheet.	Three of six training records reviewed were not organized in training files and did not readily have all supporting documents available such as the orientation training or a training plan.
1.06: Client Transportation			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**NO** If NO, explain here: The provider's transportation policy was missing the requirement for approved drivers to be covered under the agency's automobile policy. The policy was updated during the visit. Provider has a policy and procedure 1.10 that was last reviewed September 2021 by the COO.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The program maintains a list of staff who have a valid driver's license and clear motor vehicle check and are approved by Human Resources (HR) to transport youth in agency vehicles.	

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Per interview with the COO, approved drivers as confirmed by HR are covered under the agency's insurance policy. The agency maintains a valid automobile insurance policy with Alliance of Nonprofits for Insurance RRG, effective through June 1, 2023.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency's policy prohibits transporting a youth without another passenger in the vehicle. There are provisions in place in case a 3rd party is not present in the vehicle. The policy notes they can have an open call system, when 1:1 transport is conducted, and the driver will call the on-site staff and leave the phone open for the duration of the journey.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The agency's policy states in the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel considers the clients' history, evaluation and recent behavior when approving single youth transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency has a 2017 Ford Transit 12 passenger van used to transport youth. Transportation logs for the agency's van were reviewed for the period November 2022 - April 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 the period November 2022 - April 2023 showed a total of 72 single transports were conducted. Supervisor's approval is documented in the logbook and prior approval was evidenced for nine of the 72 single transports conducted. There was no evidence of supervisor's approval for 63 of the single transports; however, an open communication line was established, for the duration of the youth transport, between the driver and the shelter for 47 of the 63 single transports.	Sixty-three of the 72 single transports reviewed for November 2022 - April 2023 were not evidenced as being approved by a supervisor and 16 of those did not document an open communication line as required by the provider's policy.
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 that documents the date, time, name of the driver and initials of staff passengers, location and purpose of travel, number of passengers, initials of passengers, mileage out/in, and return time. Each page of the log is also reviewed and signed by the supervisor.	

2.03 - Case/Service Plan			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has the required policy 2.03 that was last reviewed in September 2021 by the COO.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	Ten youth records were reviewed for five residential (six closed, four open) and five community youth. All ten case plans reviewed were developed using information gathered during the initial screening, intake, suicide screening and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All ten records reviewed revealed the case plans were developed within seven working days of NIRVANA.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Compliance**	All ten completed service plans included individualized and prioritized needs and goals identified by the NIRVANA, service type, frequency, and location, person(s) responsible, target dates for completion and actual completion dates, signature of youth, counselor, and supervisor, and the date the plan was initiated.	
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**	Three of the 10 youth records were not applicable for a case review for progress. Seven of the ten youth service plans were reviewed for progress timely, every 30 days. Every youth record contained a case review as required.	

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 agency has the required policy, 3.01, that was last reviewed in January 2022 by the COO.	
Facility Inspection	Exception	A tour of the facility was conducted with the program manager during the onsite QI visit. During the tour, the furnishings were 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 exterior areas are well maintained and landscaped. The facility has a soft playground in the backyard with a basketball hoop, barbeque grill, picnic tables, and shed. Large trash receptacles were observed to be covered during the visit. All bathroom facilities were clean and functional. Facility has four bedrooms, two for boys and two for girls. Each bedroom has three beds, dressers, nightstands, and a closet. The bathroom is equipped with a walk-in shower, toilet, and sink. Most of the bathrooms were clean with no foul smell. Walls appeared clean and void of soil, stains, or graffiti. The facility is well lit throughout. The program has a 2017 Ford Transit 350 vehicle used to transport youth. The vehicle is equipped with a fire extinguisher, flashlight, compact device with seatbelt cutter, and mobile first aid kit. The program has three full sets of keys, one for the program manager, one that rotates through shifts, and one spare set. Doors are kept locked throughout the residential areas and accessible only with a key.	1) During inspection, the 2017 van was missing a working flashlight and a window breaker. The fire extinguisher in the van was not inspected and tagged. Rear passenger side door handle is not attached on one end and is loose. 2) A pile of unsecured hurricane window shutters were observed on the east side of the building exterior. 3) Cabinet door in laundry room labeled "light bulbs" has a loose bottom hinge. 4) Unclean bathrooms were observed in room 3 (mildew in corners of the shower), and room 4 (dirty smudge on wall next to toilet).
Additional Facility Inspection Narrative (if applicable)	Egress plans are located in hallways, in common areas and in each youth bedroom. Rights and responsibilities and abuse hotline number is posted on wall in the lobby and in the youth lounge. Grievance box and forms are accessible to youth at the entrance to the youth lounge. DJJ- CCC number is posted in the staff desk area. SOGIE signage was observed posted throughout the facility. Each youth has access to a safe for secured storage of valuables. No contraband was observed. There is a primary chemical storage area in the pantry closet; however, chemicals were also observed in a kitchen cabinet and in a laundry room cabinet. Inventories are not maintained for each storage location. The inventory is done weekly. Program has one laundry room equipped with 2 washers and 2 dryers. All were observed to be in great condition and were clean and free of lint. During the tour, all beds had a pillow and were covered with bed sheets and comforters. DCF license and COA accreditation is posted in the lobby. The facility is licensed by DCF for 12 beds effective through December 15, 2023 and COA accreditation is effective through 12/31/2024.		5) Chemicals are stored in 3 different locations (laundry room, kitchen cabinet, and chemical closet in pantry) but separate inventories are not maintained. The inventory is not maintained on a perpetual basis to accurately reflect reduction in count due to usage and the count was inaccurate for hand soap (shows 1 but multiple in laundry room) and antibacterial wipes (shows 4 but should be 6). Three stainless steel cleaners and a can of Rustoleum spray were not accounted for on the inventory. Material Safety Data Sheets (MSDS) were missing for the stainless steel cleaner and Rustoleum spray.

Fire and Safety Health Hazards	**Exception**	St Petersburg Fire Rescue conducted an initial fire inspection on 1/4/2023 that required a re-inspection on 1/11/2023. Three prior violations were cleared during the re-inspection. Fire extinguishers in the facility had valid inspections effective through November 2023. Piper Fire Protection completed an annual inspection of the alarm and sprinkler system on 10/31/2022 and fire extinguishers as well as hood inspection, and suppression system 11/3/2022. Satisfactory Department of Health (DOH) combined Group Care and Food Inspections were completed 1/18/2023. DOH Food Hygiene Assisted Living Facility Certificate expires 9/30/23.	
Additional Fire and Safety Health Hazards Narrative (if applicable)	Fire drills were completed on the third shift November 2022-April 2023 as well as quarterly drills for the same period. Two large first aid kits are located in the facility, one adjacent to the youth lounge and another in the dining room. Refrigerator temp is 38 degrees Fahrenheit. Freezer temperature was zero degrees Fahrenheit.		6) Fire drills were not completed monthly on the first shift in February 2023 and on the second shift between February and April 2023. Quarterly emergency drills were not conducted on the 1st or 2nd shifts during the past six months.
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.	**Exception**	The agency has a formal grievance process that is reviewed with youth during orientation and is also posted. A grievance box is mounted in the youth group room and grievance forms are accessible below the grievance box.	7) Grievance box was not secured as the lock was broken.
There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook. All grievances are resolved within 72 hours and documented by program director.	**Compliance**	The residential manager checks the grievance box daily and documents it in the logbook. Two grievances were reported during the past six months. A review of the grievances show the program responded to and addressed each complaint 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 program has an activity schedule for weekdays and weekends. Each weekday youth are engaged in activities from 5:40 a.m. to 10:00 p.m. and from 8:30 am to 11:00 p.m. on weekends. The schedule indicates one hour of recreation/physical activity is provided daily and alternative activities are available if youth do not want to participate in a faith-based activity. The schedule includes over an hour of time for youth to complete homework at 3:00 pm and 8:15 pm with additional time to read approved books. The daily schedule is posted in the program's main group/living area.	
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, 3.06, that was last reviewed in September 2021 by the COO.	
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	A review of staff schedules and corresponding program logbooks for the period November 2022 - May 2023 indicate there were two staff on each shift, each day of the monthly schedule, maintaining the required ratio of 1:6 during awake time and exceeding 1:12 ratio during sleep time.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	A review of the schedules indicate there were two staff assigned to each shift.	

Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Compliance**	Shelter staff scheduled in the staff-to-youth ratio included staff who are background screened and who have received necessary training to supervise youth. Staff in training are not allowed to work independently with youth.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule is posted in the manager's office and also behind staff desk.	
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**	A list of staff and contact numbers to reach if additional coverage is needed is located in the manager's office and also behind staff desk.	
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**	Bed check logs were reviewed for five randomly selected days during the past six months: November 11th, 12am-2am; December 21st, 2am-4am; January 19th, 4am-6am; February 5th, 1am-3am; and March 29th, 3am-5am. A review of the logs indicate staff observed youth at least every fifteen minutes while they were in their sleeping rooms.	
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 policies, 4.02A and 4.02B, for Comprehensive Master Plan for Suicide Prevention and Response. The policies were last reviewed in October 2021 by the COO.	
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	Five youth records were reviewed for three residential and two community counseling youth. All five records show the youth had a suicide risk screening completed upon intake. All were signed by the supervisor and documented in the youth record.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program continues to use the suicide risk assessment that was approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Each of the three residential youth were placed on sight and sound and monitored by staff every fifteen minutes 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**	Monitoring was documented on a Sight and Sound Observation Log. Observation logs for all three youth included documentation by staff person assigned to monitor youth's behavior at a minimum 15-minute intervals until the youth were removed from sight-and-sound supervision.	

Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	All three youth had a suicide assessment completed by a licensed professional or supervised unlicensed mental health professional the day of admission to the shelter and were promptly stepped down from sight and sound supervision by the licensed mental health professional following the review of the suicide 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**	Two community counseling youth records were reviewed for youth identified as having suicidal behaviors by the staff at intake. An assessment of suicide risk was completed by a licensed professional or non-licensed professional under direct supervision of a licensed professional.	
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**	One of the youth had a history of suicide and the assessment identified the risk. The licensed mental health professional was contacted and approved the community referral. Notification of the suicide risk findings and referral was made to the parent/guardian and noted in the youth's record.	
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**	One youth was referred for services in the community as required. The referral for services was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	One youth's parent could not be contacted and all attempts were documented as required.	
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.	

4.03 - Medications			Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency has the required medication distribution, storage, and management policies 4.03, 4.03A, and 4.03B in place that were last reviewed in September 2021 by the COO.	
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 a registered nurse who has been with the program since November 2016. The nurse's license is valid through 4/30/2024.	
Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	Medications are stored in the Pyxis ES Medication Cart located in the nursing office behind a closed door. The Pyxis machine is stored in the nurse's office according to state of Florida guidelines. Oral medications, controlled medications, and narcotics are stored separately from topical medications in the required Pyxis Med-Station. There is a refrigeration unit stored in the medical clinic for medication requiring refrigeration. When a youth is admitted with prescribed medication, the shelter ensures the medication is in its original prescription bottle with a legible label. Observation of the emergency keys verified the top cover back panel, left tall cabinet lock, left back panel, right tall cabinet lock and right back panel keys are maintained.	

Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	**Compliance**	There are two Pyxis system managers and five approved users on site. Only the five approved users and two managers have permission to pass medications. A list of approved staff is maintained in the nurses office and Pyxis machine. A Medication Distribution Log is utilized for the distribution of all medications and documents the staff who provided the medication and the youth's initials. Medication verification follows the three methods listed as required. When the nurse is on duty, she conducts medication distribution call. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution policy. The shelter does not accept youth who have to be administered injectable medication except for epi-pen. All staff have received epi-pen training by the nurse and she maintains documentation in the nursing office.	
Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Exception**	The nurse indicated they utilize their Medication Distribution Log as a perpetual inventory and to keep their count. The perpetual inventory was up to date as of 5/24/2023. There is also a spot to document a shift-to-shift count with a spot for staff and a witness to initial. Per the nurse, there are no over-the-counter medications maintained at the facility and parents must bring it in when needed. No syringes and sharps are maintained on site.	The medication distribution log had the issues on 5/20/2023 missing shift to shift counts on the third shift, and only one person conducting count on first and second shifts. On 5/22/2023 to 5/24/2023, there were no shift to shift counts documented in the medication distribution log.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The monthly reports the nurse reviews are staff needing training, discrepancies in medications, and controlled medications, all of which are discussed during monthly staff meeting.	
Medication discrepancies are cleared after each shift.	**Compliance**	The nurse reported all discrepancies are cleared out at the end of shift. Documentation was provided including discrepancy reports which have been printed out.	