Florida Network for Youth and Family Services
Compliance Monitoring Report for

SMA Healthcare
3875 Tiger Bay Road
Daytona Beach, FL 32124

May 7-8, 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 SMA Healthcare (Beach House) for the FY 2022-2023 at its program office located at 3875 Tiger Bay Road Daytona Beach, 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. SMA Beach House 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 Baldwin Davis, Consultant for Forefront LLC, and Department of Juvenile Justice Peer Reviewer, Kristine Harshaw. Agency representatives from SMA Beach House present for the entrance interview were Pam Palmer, Director of Residential Adolescent Services; Melissa Alton, Clinical Director; Jeffery Honaker, Director of Operations Adolescent Services; Kim Stone, Operations Supervisor. The last QI visit was conducted February 23 - 24, 2022

In general, the Reviewer found that SMA Beach House is in compliance with specific contract requirements. SMA Beach House **received an overall compliance rating of 100% for achieving full compliance** with all 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 05-07-2022-2023

Agency Name: SMA Healthcare Beach House	**Monitor Name: Baldwin Davis, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 3875 Tiger Bay Road Daytona Beach, FL.**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 7-8, 2023**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: General Liability through Alliance of Nonprofits for Insurance for limits of coverage $1,000,000 each $3,000,000 aggregate, and $20,000 medical expense, effective 6/30/22-6/30/23. Workers Comp insurance through Accident Fund Insurance Company of America for limits of coverage $1,000,000 each accident, effective 4/1/2023 – 4/1/2024. Automobile insurance through Alliance of Nonprofits for Insurance for combined limits of liability/property damage for $1,000,000 each and aggregate. Policy effective for 6/30/2022-6/30/2023. Professional Liability Claims insurance through Alliance of Nonprofits for Insurance for limits of coverage	**No recommendation or Corrective Action.**

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						$1,000,000 each/$2,000,000 aggregate effective 6/30/2022-6/30/2023. Florida Network is listed as the certificate holder.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in the Financial Services Policy and Procedures Manual. The manual is divided into eight sections with subsections in each one. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. Policies have two revision dates of May 2019 and November 2020.	**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 site program review in February 2022. Reviewed petty cash Policy and Procedure FS0305. The Petty Cash fund does not exceed the established minimum of $250. Petty cash is stored in a secure locked location in the building. Petty cash is reconciled on a consistent basis (monthly/quarterly) by	**No recommendation or Corrective Action.**

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Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): May 7-8, 2023	
	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)
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						designated Administrative Assistant and reviewed by the Supervisor. Disbursements and invoices are approved by the Program Supervisor as required.	
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 and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2022, and 2021 was completed by James Moore, C.P.A. and Consultants and dated December 7, 2022. Per the audit report, follow up action to a prior finding was reported as part of this audit report. A separate Management Letter requiring a Corrective Action Plan is documented as not required and was not issued by the auditor. A copy of the audit was submitted to the FNYFS.	**No recommendation or Corrective Action.**

CONCLUSION

SMA Beach House 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.

SUMMARY OF RECOMMENDATIONS

Recommendation

There were no recommendations as a result of this review.

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 SMA Healthcare, Inc. - Daytona Beach
CINS/FINS Program

DATE: May 7th-8th 2023

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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	**Limited**

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 50 %
Percent of indicators rated Limited: 50 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Baldwin Davis - Lead Reviewer, Forefront LLC/Florida Network of Youth and Family Services
Kristine Harshaw – 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	X	Nurse – Part time
	Chief Operating Officer		Advocate		# Case Managers
	Executive Director		Direct – Care Full time		# Program Supervisors
X	Program Director		Direct – Part time	1	# Food Service Personnel
X	Program Manager		Direct – Care On-Call	2	# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
X	Clinical Director		Volunteer	1	# Other (listed by title): Quality Improvement Coordinator
	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		# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log		# Personnel /Volunteer Records
	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
	Contract Scope of Services		Precautionary Observation Logs	5	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	5	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

	Intake		Posting of Abuse Hotline	X	Staff Supervision of Youth
X	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
	Social Skill Modeling by Staff		Youth Movement and Counts	X	Signage that all youth welcome
X	Medication Administration		Staff Interactions with Youth	X	Census Board

Surveys

4	# of Youth	5	# 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

The following programmatic updates were provided by the agency:

The agency reports that SMA Healthcare corporate management structure has changed significantly over the past year and since the last QI review. Nicole Sharbono moved into their Chief Operations Officer (COO) position after Rhonda Harvey retired at the beginning of this year, 2023. As a result of that staff move, Jennifer Stephenson moved into the Vice President (VP) of Volusia County position. Andrea Schweizer was promoted to Chief Financial Officer (CFO) and Sarah Burman was promoted to Chief Administrative Officer (CAO). The Senior Director of Residential Services in Volusia County, Andrew Williams moved into the VP of Flagler County position and Burt Thomas moved into the Senior Director of Residential Services for Volusia County. The agency was recently CARF reaccredited survey for another three years, in April 2023. Over the past year the agency fit a new roof to the resident building on campus and paved the parking lot and driveway and also added five more security cameras to improve security on campus. The facilities department donated time and received donations for the plants and wood to complete a beautification project in the front entrance of Beach House. They also started ordering new furniture for Beach House and as a result of a donation from Jeep Beach of $5K, they were able to purchase three new chairs and an activity table for the Beach House group room. Repairs have started to their ROPES course which was damaged from the past years' hurricanes and storms. SMA Beach House is actively seeking funds to complete the entire roof across all buildings, purchase the rest of the group room furniture and complete the ROPES course and provide training and re-certification for staff on the safety elements of the ROPES course. The agency reported to have also received $2.5K from the Variety Foundation and Eagles each, to purchase clothing and duffle bags for youth who come in with no clothes to ensure that all youth leave the shelter with more dignity. During the Christmas holidays they receive gifts for Beach House and CINS/FINS families from Volusia County Schools Transportation Department, The Margaretville Community Residents, The HO HO HO Girls Charitable Organization and TAG V Bear Charitable Organization.

SMA Beach House has experienced significant staff changes over the past year, staff moving to other positions include the Beach House Full-time counselor who transferred to Outpatient and another from part-time into the full-time position. A Behavior Health Technician (BHT) III was transferred to Training Specialist in Human Resources and another transferred to Reality House as a Corrections Tech. As a result, Beach House currently has two full-time Behavior Health Technician positions and two part-time positions open and a part-time counselor position. The agency reports also that they had to terminate four staff this year, two of which were in Beach House. One Beach House staff was sleeping and falsified bed checks and the other Beach House staff was terminated for violating the code of ethical conduct on social media. This has added to the challenges the agency has in finding appropriate candidates for hire and get them through the background screenings timely but are continuing to find creative ways to attract applicants. BHT's at minimum must have a High School diploma, Operations Supervisors must have at minimum a two-year degree with two years supervisory experience and Counselors must have at a minimum Master's degree in the field of social work, psychology or other human service fields. The Community Counselors all have at minimum a Bachelor's degree in a related field and case management experience. In addition, SMA also hired a Director of Clinical Excellence who is overseeing all Interns for the agency and building relationships with colleges and Universities. The Director of Operations and Supervisors participate in monthly Crisis Intervention Training for local law enforcement/911 operators to discuss our services and how we can assist them with youth.

Beach House Shelter Counselors and Community Based Counselors have been operating business as usual over the past year, it is in person and meaning that youth are seen in shelter, family visits are conducted, transportation occurring when necessary and on campus school is in actively operating. All staff including administrative personnel works on campus, in person, as they continue to serve youth 10–17 year old youth and their families in the communities of Volusia and Flagler Counties. Currently, Beach House CINS/FINS youth files are paper documents supplemented by Avatar as their electronic medical record with a goal to have all documents and case management managed by Avatar, their ERM of use. The agency reported having several medications errors that fortunately did NOT lead to any serious issues, were reported to the Central Communications Center (CCC) and staff were appropriately cautioned and retrained. The agency also hosts Volusia County high School Futures Tomorrow Leaders seminar on campus to explain their services, discuss career options to work in Social Service field, provide a tour, participate in a ROPES course team building activity and youth testimonies about how the program helped them. SMA had a recent visit from Florida Senator Thomas Wright who toured the campus in order to detail the services provided and see the importance of supporting mental health, prevention and substance abuse funding to the community. The Flagler CINS/FINS Community Counselor Sheila McLaughlin was trained and uses the LINC referrals system with Flagler County Schools, a quick and easy way to receive referrals, track progress and communicate with all parties involved with the youth and their family.

Due to the agency's reported staffing shortage for the past year in Beach House, they combined the programs at night starting March 22, 2022 and had to lower the census to seven youth to be in compliance with ratio. On February 17th 2023 the agency was able to separate the programs and increase the census to ten youth, now twelve youth at the time of this review. The agency states this necessary arrangement was reported to the Florida Network Youth and Family Services, now they are at full capacity of twelve youth at the time of this QI review. The program has an appropriate and planned schedule which is posted. The agency is currently licensed with DCF with a renewal license date posted for May 24th, 2023. The practical and working capacity at Beach House is for twelve youth but the facility is licensed for nineteen youth. With a census currently of twelve youth in Beach House, the Community Counselors have been exceeding performance measures of having twenty youth admitted to the program monthly.

SMA Beach House has been able to retain both of the Registered Nurses who are part-time and work a staggered shift so that that can provide medical, mental health and wellness support to youth on Mondays through Fridays from 6:30 a.m.- 4:00 p.m. The agency reported having several medications errors that they are trying hard not to repeat. The nurses utilize the Pyxis medication cart and will start reporting discrepancies as the CINS/FINS standards require. Operations Supervisors are being trained to be Certified Trauma Resilience Practitioners and both from Beach House have completed the training. They are training all agency supervisors for their ADEPT supervisor's training, which is a six months long program. The Director of Adolescence who oversees Beach House reports to have completed the program this past September and currently have two more staff members from both Beach House and undertaking that training.

Narrative Summary

SMA Beach House is contracted by the Florida Network of Youth and Family Services to provide CINS/FINS services to youth and families in need. Located just North West of the main Daytona Beach area, the program is easily accessible and provides residential, community counseling, and case management services over two counties, Volusia and Flagler and across Circuit 7. The CINS/FINS program is managed by a Director of Adolescent Services who is based on site and oversees a Manager of Operations and a Shelter Supervisor. The youth shelter operates 24 hours a day, 365 days a year and is licensed for up to ten CINS/FINS shelter beds.

The overall findings for the QI Review for **SMA Healthcare - Daytona Beach** are summarized as follows:

Standard 1: Three indicators were reviewed for this standard. Indicator 1.01 received a Limited rating. Indicator 1.04 received a Limited rating. Indicator 1.06 was rated Satisfactory with no exceptions.

Standard 2: One indicator was reviewed for Standard 2. Indicator 2.03 was rated Satisfactory with no exceptions.

Standard 3: Two indicators were reviewed for Standard 3, Indicators 3.01 and 3.06. Indicator 3.01 was rated Limited and Indicator 3.06 was rated Satisfactory with exceptions.

Standard 4: Two indicators were reviewed for Standard 4, 4.02 and 4.03. Indicator 4.02 was rated as Satisfactory with no exceptions. Indicator 4.03 was rated Limited.

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

Standard 1:
Indicator 1.01 is rated Limited due to exceptions with suitability assessment being completed late after the date of hire for one staff member, five staff files reviewed showed the background screening was not completed prior to start/hire date, and the annual affidavit of compliance was submitted to the Department of Juvenile Justice on 05/12/2023 outside of the January 31st deadline requirement.

Indicator 1.04 is rated Limited due to exceptions as none of four newly hired staff training files reviewed has received all of the required trainings. One staff was missing Florida Network suicide prevention training and two staff were missing fire safety training. Additionally, for in-service staff, two of four staff were missing the Florida Network suicide prevention training and one of the four staff missed doing the crisis intervention training. Two of four staff were missing fire safety training. Managing the training is challenge for the agency as it has three different locations for training records. According to the program, all trainings are managed at the corporate level and it is apparent that there is no cohesive process for keeping training records in one location. The program has been rated "Limited" for this indicator for the past two years, prior to this review.

Standard 3: Indicator 3.01 is rated Limited because the agency did not have a current fire inspection certificate for its facility as the last inspection was conducted 03/07/2022. The inspection in March 2022 revealed some facilities fire safety deficiencies that were consequently corrected by the agency, reinspected and signed off by the fire department was completed on 06/22/2022. The program only completed three fire drills during the review period despite being fully operational. The agency provided an explanation letter stating that these drills did not occur because of unspecified hurricane related maintenance issues, however, staff could not explain what these specific issues were.

Standard 4: Indicator 4.03 is rated Limited. The Central Communication Center for DJJ reports there were ten medication errors reported by the program for the review period, 3/13/22, 5/23/22, 6/11/22, 9/21/22, 10/8/22, 10/29/22, 10/30/22, 2/5/23, 2/18/23, 3/9/23. The deficiencies exposed in medication management reflects that shift-to-shift counts were not always done and the perpetual inventories are not monitored by each staff. In all cases, the error was caught by the staff on the next shift when distributing medication, with the exception of one. This one was a staff gave a youth two pills instead of one.

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			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**NO** There is no current policy governing background Screening or Suitability Assessment. The agency changed its policy format since the last review to one corporate policy document that excluded this requirement. Agency Policy and Procedure was revised October 2022 by the COO. Also provided was a Policy 1-007 Titled: Employee Eligibility Background Check; Effective on 04/19; Revised on 04/2023.	
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.	**Exception**	The agency hired seven new staff since the last QI Review and uses an employment suitability assessment called the Impact Assessment Tool that includes a pass rate and/or score. The assessment was completed for five of the seven new staff hired.	No suitability assessment was completed for one intern and one staff completed their suitability assessment after their hire date.
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors	**Exception**	The agency hired seven new staff and one intern since the last QI Review. Three out of eight files indicated background screening eligibility was obtained prior to hire or start date.	Five files reviewed did not have the background screening completed prior to hire/start date and the agency brought staff onboard early to complete training and orientation. All five files reviewed provided documentation to demonstrate the required background screenings were completed prior to working with youth.
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 hired had a break in service for less than 90 days.	
Five-year re-screening completed every 5 years from initial date of hire	**No eligible items for review**	The organization had no staff who required a five year re-screen since the last QI Review.	

Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Exception**	The annual affidavit of compliance was submitted five months late to the Department of Juvenile Justice (DJJ). There is no policy regarding this requirement.	The annual affidavit of compliance was submitted to the Department of Juvenile Justice on 05/12/2023 after it was flagged and brought to the attention of the agency by Lead Reviewer at post QI Review of documents, as being missing. Evidence of its submission to the DJJ was provided prior to the review.
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	E-Verify was completed for all staff who were hired within the review period.	
Additional Comments: **There are no additional comments for this indicator.**			
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**NO** There is no training policy but the cover page with the training plan was observed and reviewed. The training plan was signed by Sarah Burman, Chief Administration Officer; Jessica Nelson, VP of QA; and Kelly Mellencamp, Chief HR Officer on February 7, 2023.	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	Of the four files reviewed, all of the staff received all of the required trainings required for pre-service training for 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**	All four of the staff files reviewed completed the Civil Rights and Federal Funds training.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	All four newly hired staff received more than eighty hours of training in their first year of employment.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	All four of the newly hired staff have received most of the mandatory training but each file reviewed was missing one or more trainings required within the first 90 days. No staff were applicable for Notivational Interviewing at the time of review.	One staff was missing Florida Network suicide prevention training. Two staff are missing fire safety.

Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**No eligible items for review**	None of the newly hired staff required NIRVANA training.	
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**	None of the newly hired employees are non-licensed mental health clinical shelter staff.	
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**	One out of the four reviewed staff training files had all of the required trainings.	Three out of four files reviewed are missing the required trainings. Two of four staff are missing Florida Network suicide prevention training. One of the four is missing crisis intervention training. Two of four staff are missing fire safety 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.	**Exception**	The agency does not have one designated staff member responsible for managing all employee's individual training files who completes routine reviews of staff files to ensure compliance.	The program has three different locations for training records. According to the program, all trainings are managed at the corporate level.
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 program does not maintain 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. The program has three separate locations for training records, namely "The Bridge", MyLearningPointe.com, and SkillPro. According to the program, all training documentation is managed at the corporate level.	There are no complete staff training files. Information has to be pulled from the three different locations when training for a staff is requested. There is no cohesive process for keeping training records in one location, nor is there a central system for tracking training hours.
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** The agency has a transportation policy titled: Vehicles Procedures. The policy was revised and implemented in October 2022 by the corporate Chief Operations Officer.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency maintains a list of staff approved to transport clients.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	All approved drivers have a valid Florida driver's license and are covered under the company's vehicle insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	Reviewed policy titled "Vehicle Procedures". The policy states that "at no time are staff to transport a minor without a parent/legal guardian present".	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	In the event that a 3rd party cannot be obtained for "emergency" transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	All of the transportations reviewed for the past six months included a 3rd party that was either another agency staff or youth present.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**No eligible items for review**	During the review period there was no supervisor approved transportation that occurred over the past six months.	
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 mileage logs were reviewed for the last six months for the three stated vehicles used for the program. All logs were properly completed and included the date, the name of the driver, the destination/purpose, mileage, time in, time out, total passengers, vehicle performance comments, and staff initials.	
Additional Comments: **There are no additional comments for this indicator.**			

2.03 - Case/Service Plan			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** The agency has a policy titled: Assessments and Treatment Planning: Policy was revised 10/1/2022 by the corporate Chief Operations Officer.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	All five of five youth records reviewed, reflects that case plans are developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All five youth service plans were created 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**	Each of the five case plans contain individualized and prioritized needs and goals identified by the NIRVANA, service type, frequency, location, person(s) responsible, target dates for completion and Actual completion dates, signatures of youth, parent/ guardian, counselor, and supervisor, and the date the plan was initiated with the following exception: one youth refused to sign any documents. This was noted and signed by a witness.	
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 five case plans were reviewed for progress by the counselor and parent/guardian every 30 days for the first three months, and every 6 months after, as applicable. Two of the five files have not met the thirty-day threshold for reviews.	
Additional Comments: **There are no additional comments for this indicator.**			

3.01 - Shelter Environment			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		YES The agency has a policy titled: Shelter Environment. The policy was revised on 10/1/2022 by the corporate COO.	
Facility Inspection	Compliance	The facility tour was provided by the Director of Adolescent Residential Services. During the tour, the following was observed: Furnishings were in good condition, all beds appeared sturdy and functional, and no insect droppings or infestation was observed. The shelter cottage sits on a large 10 acre campus with other program buildings. All exterior areas are well maintained and free of debris/hazard. A large oversized dumpster is located at the extreme rear of the facility and was observed to be covered during the visit. All bathroom facilities were clean and functional. Both boys and girls have access to two full bathrooms and a half bathroom, each full bathroom has a toilet, sink, and one shower. Walls were clean and void of staining or graffiti. The facility was adequately lit throughout, with the bathroom lighting being sensor controlled. The program uses three vehicles to transport youth, a large 12 seater chevy bus, a Chevy Trax and a Ford Escape. All vehicles are equipped with first aid kits, flashlights, fire extinguishers, glass breaker, and seat belt cutter and airbag deflator. The fire extinguishers equipped in the vehicles had fire inspection tags. The program's external and internal doors are secure with key access as required. Chemicals are kept locked in a closet and inventoried perpetually, when removed from inventory. No chemicals were seen outside of its locked location. Program has shadow boxes located on the girls' and boys' wings as well as in the main hallway and group room. Postings in the shadow boxes include: Egress plans, abuse hotline information, rights/responsibilities, grievance procedures, SOGIE signage and program schedules.	
Additional Facility Inspection Narrative (if applicable)	The program has a current DCF license effective through 7/11/2023. The program has two laundry rooms, one on each wing and equipped with 2 washers with automatic detergent/fabric softener dispensers and 2 dryers. These were observed to be clean. All beds occupied by youth had a pillow and was covered with bed sheets and a comforter. Labeled lockers are located in the lobby area of the shelter and are assigned to individual youth to store belongings.		

Fire and Safety Health Hazards	**Exception**	The most recent annual facility fire inspection that was presented at the time of the review was completed by Volusia County Fire Prevention Bureau on 03/07/2022.	The agency does not have a current fire inspection certificate for its facility as the last inspection was conducted 03/07/2022. The inspection in March 2022 revealed some deficiencies that were corrected, reinspected and signed off by the fire department on 06/22/2022.
Additional Fire and Safety Health Hazards Narrative (if applicable)	In the past 6 months, the program conducted monthly emergency drills per month on each shift, this supersedes the requirement to conduct drills quarterly on each shift. The program completed three fire drills during the review period. Food is prepared offsite and the dining room/cafe is not equipped with a kitchen, instead it is a dining room with hot and cold storage appliances. The hot food is stored in a warmer and food is labeled and dated. Refrigerator temperature is at 38 degrees Fahrenheit and there is no freezer. All fire extinguishers in the facility were inspected 1/27/2023 by Pye Barker Fire Safety. Alarm and emergency equipment testing was completed 2/27/23 by Signal 21 Security Systems Inc. Agency is CARF certified and is effective through 4/30/26. Satisfactory DOH Group Care inspection was completed 5/11/23 and a satisfactory DOH Food inspection was completed 3/16/2023 with no violations found.		The program only completed three out of the required 18 fire drills during the review period despite being fully operational. The agency provided an explanation letter stating that these drills did not occur because of unspecified hurricane related maintenance issues.
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 procedure for youth, including grievance forms, and a locked box which are easily accessible to youth in the main common area.	
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**	Grievance boxes are in place and staff indicated that these are checked by the shift supervisor daily. Staff indicated there were no grievances to 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 program has a weekday, weekend and holiday schedule with structured youth activities each day. Physical activity is scheduled for at least one hour daily. Youth are provided an opportunity to attend religious/faith based activities on the weekend and alternative activities are available to youth who do not choose to participate. Youth are given the time and opportunity to do homework and read and the program has a library with a variety of age appropriate books for youth to read. The daily schedule is posted in the shadow boxes and mounted throughout the facility.	
Additional Comments: **There are no additional comments for this indicator.**			
3.06 - Staffing and Youth Supervision			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** The agency has a policy titled: Client Monitoring. The policy was revised on 10/1/2022 by the corporate 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	**Exception**	Staff schedules for the past 6 months were requested for review. The reviewer utilized program logbook signed entries to determine staffing ratios over the past 6 months. The actual working staffing schedules used to verify real-time staff on shift were missing for the period of the review and, therefore, verified using the log book entry against the original posted schedules.	One entire day of log book entry did not occur for 1/3/2023, so staffing ratio could not be properly verified for that day as it could not be match against the schedule.

All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Each shift is staffed with a minimum of two staff on duty, a supervisor and a behavior health technician or two staff with the supervisor.	
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**	All staff included on the staff schedule have been background screened and received the required youth care training prior to providing youth supervision.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	Schedule is posted on the medication room door and various staff offices and is accessible to staff.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The program is able to maintain a hold-over roster and utilize CINS/FINS cross-trained staff from other program when necessary. If the subsequent shift does not have full coverage management is used as a backup in the event direct care staff is not available to cover a shift.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	Bed checks are documented on observation logs maintained for each youth in their individual files. Eight youth files were observed for fifteen minute checks during sleeping hours. Each of the eight files contained client observation forms with documented checks during the hours the youth were sleeping. All time logs all documented by different staff carrying the standard 15 minutes on the hour incremental entry.	Bed check times are not documented in real time with individual staff initialing each entry indicating that bed checks were done at those exact 15 minute times.
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** The agency has a policy titled: Suicide Prevention: The policy was last revised 10/1/2022 by the corporate 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**	All five youth records reflected suicide risk screening was conducted during the initial intake and screening process. Five of five suicide screening results were reviewed and signed by the supervisor and documented in the youth's case file.	

The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The assessment, the Columbia Suicide Assessment is used by the program, and is approved by the Florida Network of Youth and Family Services. Assessments are done through Avatar and additional version in NIRVANA.	
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**	All of the five youth were placed on the appropriate level of supervision following a suicide risk assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	Three of the five youth were required to stay on a higher level of supervision after being assessed, and each were monitored by direct care staff as required. Each file contained documented monitoring of the youth in 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**	Each of the three youth's supervision level was not changed until a mental health professional had completed a full follow-up 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 of three youth were identified as requiring a suicide risk assessment. Both were completed immediately by a mental health professional, and parents and supervisor were notified of the results.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**Compliance**	In each case, the program's mental health professional was available to complete the full suicide 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 files, the youth requiring suicide assessments received information on resources available in the community for further assessment and the information was provided to the parent/guardian. All referrals for resources are 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**	In both instances, the parents were available, which is documented in the youth file.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	None of the five files indicate screenings were completed during school hours on school property.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** The agency has a policy titled: Medication Administration and Observation, Medication Administration Record, Medication Delivery and Monitoring, Medication Distribution Guidelines for FNYFS, Medication Occurrence Reporting, Medication Storage, Inventory, Security and Access: The policy was revised on 10/01/2022 by the corporate 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 agency has two part time registered nurses. Each RN has clear and active licenses 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**	All program medications are stored in the Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff). The Pyxis is located in the locked medical office, stored in accordance with guidelines in FS 499.0121 and program policy. Oral medications are stored separately from injectable epi-pen and topical medications. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose. At this time, there are no medications requiring refrigeration. Narcotics and controlled medications are required to be stored in the Pyxis ES Station, however there are no controlled medications on-site at this time. Pyxis keys with required labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction.	

Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	**Compliance**	The program maintains three site-specific System Managers or "super-users" for the Pyxis ES Station. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics). A Medication Distribution Log is used for distribution of medication by non-licensed and licensed staff. The program verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual. When nurse is on duty, it was confirmed medication processes are conducted by the nurse. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy. The program does not accept youth currently prescribed injectable medications, with the exception of epi-pens. Documented training of non-licensed staff have received training in the use of epi-pens provided by a registered nurse was observed. The program keeps a list of users certified to use the Pyxis station.	

Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Exception**	The program keeps a perpetual inventory of controlled substances with running balances when youth in their care have controlled medications. Perpetual inventories of over-the-counter medications are completed and documented weekly by the nursing staff. The program has no syringes or sharps on the campus at this time, but retains a binder section for it in case any are obtained.	The reviewer observed that shift-to-shift counts are not always done and the perpetual inventories are not monitored by each staff. In all cases, an error was caught by the staff on the next shift when distributing medication, with the exception of one.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Monthly reviews of Pyxis reports are completed and documented by nursing and administration staff.	
Medication discrepancies are cleared after each shift.	**Exception**	The nursing staff report medical discrepancies should be cleared after each shift, however, there have been ten instances of medication errors over the last year that were reported to CCC.	Agency did not provide evidence that discrepancies are cleared after each shift at the time of review.
Additional Comments: **There are no additional comments for this indicator.**			