Florida Network of Youth and Family Services
Quality Improvement Program Report

Review of Florida Keys Children's Shelter - Tavernier
Residential Program

November 16-17, 2022

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	**Satisfactory**

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

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	**Satisfactory**
3.06 Staffing and Youth Supervision	**Satisfactory**

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

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	**Satisfactory**
4.03 Medications	**Satisfactory**

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
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
Rosa Flores - 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

X	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed	X	Nurse – Part time
X	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	Direct – Care Full time		# Program Supervisors
	Program Director		Direct – Part time		# Food Service Personnel
X	Program Manager		Direct – Care On-Call	1	# Healthcare Staff
X	Program Coordinator		Intern		# Maintenance Personnel
X	Clinical Director		Volunteer		# Other (listed by title): ___
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
	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	11	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	7	# Training Records
	Contract Scope of Services	X	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		Vehicle Inspection Reports		

Observations During Review

	Intake	X	Posting of Abuse Hotline		Staff Supervision of Youth
	Program Activities		Tool Inventory and Storage	X	Facility and Grounds
	Recreation	X	Toxic Item Inventory & Storage	X	First Aid Kit(s)
	Searches		Discharge		Group
	Security Video Tapes		Treatment Team Meetings		Meals
	Social Skill Modeling by Staff		Youth Movement and Counts	X	Signage that all youth welcome
	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

2	# of Youth	11	# of Direct Staff		# of Other

Comments

Due to COVID-19, this review was conducted on-site using the Modified QI Review Plan.

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 Florida Keys Children's Shelter (FKCS) contracts with the Florida Network to operate the Child in Need of Services and Family in Need of Services (CINS/FINS) program in Monroe County, Florida. The program is located at the Tavernier's Jelsema Center, at the north-end of the county next to the Tavernier Government Center. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old who are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk.

The agency provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). FKCS is not contracted to provide Intensive Case Management (ICM) services or SNAP. In addition to the CINS/FINS Program, the agency operates the Poinciana Emergency Shelter (birth through 10 years) and Poinciana Group Home (11-17 years old) in Key West, for children who have been removed from their families/homes as a result of abuse or neglect. It also provides street outreach through Project Lighthouse where staff conducts outreach in areas where homeless youth congregate with the goal of getting these youth help and providing a safe shelter.

FKCS is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through July 31, 2024. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards

Programmatic Updates

Staffing

The program hired a new residential counselor who works closely with the youth support team. The counselor has a bachelor's degree in Human Communications from Florida Gulf Coast University and has worked with the Girl Scouts of Tropical Florida, MARC House, and Kinder in the Keys and proves to be an excellent addition to the team.

A new community-based counselor was also hired who has a Bachelor of Science in Education from Eastern Kentucky University, a Masters of Higher Education from Morehead State University, and an Educational Specialist degree (Ed. S) in Administration and Supervision, K-12 from Nova Southeastern University. Additionally, he is a certified educator in the state of Florida and is a certified Guardian Ad Litem volunteer from 2020 to the present. His extensive background and experience in education uniquely positions him to be one of the most effective community-based counselors FKCS has had the privilege to employ.

Also of note, the Florida Keys Children's Shelter added two new members to its Executive Board. Ms. Diana Tweedy is a retired high school educator and counselor as well as a member of the Ocean Reef community. Ms. Tweedy offers an insightful perspective to all of the board meetings and endeavors. Mr. Dwight L. Hill is the market President of the Florida Keys for First Horizon. Mr. Hill provides unparallel expertise in several industries and his previous board experience and contacts are invaluable to the FKCS Executive Board.

Program Updates

The residential coaching program, now in its forth year, continues to provide critical services of three coaching positions - life skills, education, and recreation. All current and future coaches have college degrees and specific expertise that empower the program to better support the youth who reside in the shelter. With the retention of its higher pay scale, the FKCS has recruited qualified professionals long term with the support of one of its largest funders, the Ocean Reef Community Foundation, who once again granted $50,000 to aid this program.

The Jelsema Journey school break camp program, and the newly introduced Jelsema Mini-Camps, once again operated at capacity, receiving tremendous community support this past year. The camps were held as free week-long or mini, overnight program for at-risk youth ages 11-17 and offered field trips, group counseling, academic tutoring, counseling on conflict resolution and decision-making, during spring, summer and winter school holidays. Transportation, meals and incentives were all provided free of charge. As in years past, the referrals for the camps were so high that the program was at full occupancy with a large waiting list. This program provides a free, safe and educational alternative to at-risk youth who would otherwise lack adult supervision. The agency plans to continue with the Jelsema Journey camp program in 2023.

The agency was gratefully in a position to provide qualifying team members end-of-year bonuses. Other acts of demonstrating appreciation was a holiday party that was held for staff at a local restaurant with games and prizes. The agency continued its monthly employee newsletters and offered one month of free mental health services. It also promoted its Employee of the Month program with gift card incentives. Presently, the agency is in the process of creating quantifiable metrics that will be tied to holiday bonuses at the end of the 2023 calendar year and are researching affordable healthcare benefits for all FKCS team members.

Facility

FKCS implemented several improvements and updates to its facilities this year that included the following at the Tavernier/Jelsema Location:

- New parking lots/landscaping
- Touchless water and restroom upgrades
- Chickee hut construction and outdoor play area with ping pong table
- Lobby and office furniture
- Appliance repairs and replacements
- New carpet on internal stairway

In addition to the regularly-scheduled maintenance of all locations and vehicles, the program is looking into new signage for the outside of the Tavernier/Jelsema facility and replacing the bathroom vanities and towel racks. Lastly, FKCS has just recently explored the possible purchase of the building that houses the Project Lighthouse program located at 418 Eaton Street in Key West. The endeavor will require grant awards and possible match funding.

Funding/Finance

FKCS was recently honored with another federal grant award. This grant is for its Street Outreach Program and provides $148,000 annually over a three-year period, totaling $444,000. These funds will allow the continuation of Project Lighthouse in Key West. Young people who are on the street for whatever reason, including traveling through the country find a safe place to take a shower, pick up toiletries, and get a change of clothing. Youth can use computers and musical instruments, or participate in arts and crafts. The program helps connect youth with resources including food, medical care, employment, and lodging possibilities. The goal is to encourage each young person to become a contributing member of the community.

Governance and Community

The Florida Keys Children's Shelter has been a member in good standing for many years with the following chambers of commerce:

-South Dade
-Ocean Reef
-Key Largo
-Islamorada
-Marathon
-Key West
-Key West Business Guild

The agency also hold individual memberships and board positions through its leadership team with the following organizations:

-Key Largo Sunset Rotary
-Upper Keys Business and Professional Women
-First Key in Paradise (FKIP)
-Good Health Clinic (beginning January 2023)

External Corrective Action Plans

FKCS did not experience any Corrective Action Plans through other agencies this year.

Other

Recruitment and retention of employees have continued to be one of the agency's biggest challenges. During this past year, it was able to maintain the increased pay to all employees but is experiencing new obstacles in recruiting qualified employees, chief among them is an increased demand for a sustainable living wage and incentives that reflect the rising cost of living and inflation in the Florida Keys. With recent cuts in funding, it is difficult to sustain these higher payroll levels. It is vital to the momentum of the entire program and its continued success to maintain the pay level of youth support staff. The agency is actively pursuing new levels of private foundation funding to transition these higher salaries into its annual budget indefinitely.

Narrative Summary

FKCS is located at 73 High Point Rd, Tavernier, FL. The agency has an eleven-member Board of Directors/Trustees with representatives from the upper, middle, and lower keys, to oversee the agency's goals, objectives, and activities. The FKCS building houses the CINS/FINS shelter on the first floor and the agency's administrative offices on the second floor. The shelter provides separate female and male dormitories to children under 18 years of age that are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at risk.

The program has a Senior Management team that is comprised of a Chief Executive Officer, Chief Operating Officer (COO), Financial Manager, Chief Learning & Evaluation Officer, Counseling Services Coordinator, Residential Program Coordinator, and Executive Administrative Assistant. At the time of the onsite QI review, there were four staff vacancies reported.

The overall findings for the modified QI Review for Florida Keys Children Shelter 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. All three indicators were rated Satisfactory but indicator 1.06 was found to have exceptions.

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. Both indicators were rated Satisfactory with exceptions noted for indicator 3.01.

Standard 4:

There are 2 indicators that were reviewed for standard 4, indicators 4.02 Suicide Prevention, and 4.03 Medications. Both indicators 4.02 and 4.03 were rated Satisfactory with no exceptions.

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

None of the indicators reviewed as of the onsite QI review received a limited or failed rating.

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: Policy 1.12, Background Screening and Post Hire Arrest, was approved on 9/27/2022 by the Chief Executive Officer (CEO).	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.	**Compliance**	The agency use a self-created pre-employment suitability questionnaire screening tool that has a pass rate of 70%. The tool consists of 11 questions including a bonus question. All nine staff hired since the last QI visit completed the pre-employment screening and met or exceeded the pass rate.	
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**	The agency completed eligible Department of Juvenile Justice (DJJ) background screenings prior to hire dates of nine new staff. There were no interns utilized by the program during the 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 rehired any new staff during the QI period who had a break in service.	

Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	Program employee roster shows two staff were eligible for five-year rescreening. The agency conducted and provided evidence of timely five-year re-screenings and the clearinghouse roster shows effective retained prints for both staff.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The provider submitted its Annual Affidavit of Compliance with Level 2 Screening Standards on December 17, 2021 prior to the January 31, 2022 deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Documentation supported E-Verify work authorizations were completed for the nine new staff hired.	
Additional Comments: **There are no additional comments for this indicator.**			
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: Policy 5.01, Employee Training, was approved by the CEO on 9/27/2022.	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	The program has one eligible new staff who was hired on October 31, 2022, after the effective date of this requirement. The staff is a case manager who has completed all but four training topics. No youth cases were yet assigned pending completion of all required training.	
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**	Four new hire and/or first year training records were reviewed for training compliance. All four records show the United States Department of Justice (DOJ) Civil Rights & Federal Funds training was completed 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.	**Compliance**	Two of the four staff completed their first year of hire and training records show an excess of 80 hours of training. The other two staff are within the first year and have also completed more than 80 hours of training as of this onsite visit.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	Three of the four staff have been employed for more than 90 days. Two of the three staff completed all required training. The third staff was only missing Motivational Interviewing training because the scheduled training had to be cancelled due to Hurricane Ian.	
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 eligible staff have completed NIRVANA training and one completed all JJIS required training. The other staff was within three weeks of hire and has time to complete one remaining JJIS 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**	At the time of the onsite visit, there were no eligible clinical shelter training records to review.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Compliance**	Three in-service direct care files were reviewed. All three files had an excess of 40 hours of Florida Network, Skill Pro and job related training.	
Required Training Documentation			
The agency has a designated staff member responsible for managing all employee's individual training files and completes routine reviews of staff files to ensure compliance.	**Compliance**	The Chief Learning and Evaluation Officer (CLEO) is the designated staff member responsible for managing all employees' individual training files who also completes routine reviews of staff files to ensure compliance.	

The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	All seven training files reviewed confirm the program maintains an individual file for each staff which includes an annual employee training plan including a tracking form for hours completed and related documentation.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: Policy 8.02,Transportation of Youth, was approved by the CEO on 9/27/2022.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	Transportation policy states driver's licenses and driving records of staff who transport youth will be checked at hire and annually to maintain a roster of approved staff.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency provided a driver's schedule from Harleysville Insurance company, valid through 3/1/2023, that lists all staff covered under its 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**	The agency's policy does not specifically prohibit transporting a client without at least one other passenger in the vehicle but encourages the presence of a third party. Single transports require staff to alert the on-call or their supervisor to get permission. Supervisor's approval is documented in the logbook and on the transportation log.	
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**	Per Residential Program Coordinator, evaluation of client's history, evaluation, and recent behavior are factors considered when approval for single client transport is given.	

The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency policy reflects the 3rd party can be an approved volunteer, intern, agency staff, or other youth. These individuals were also observed on the transportation logs reviewed.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	A review of transportation logs for one of the three vehicles used to transport youth (Gray Honda Odyssey) and review of the corresponding logbook entries was conducted for the review period. A total of 61 single transports were reviewed. The supervisor was aware and provided prior approval for 60 of the 61 single transport. Supervisory approval for 43 of the 60 single transports was documented in both the logbook and on the transportation log, eight were documented only in the logbook, and nine were signed approvals only on the transportation log.	Exception One single transport was conducted without evidence of a supervisor's approval.
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Exception**	Transportation log includes name/initials of driver, date and time of transport, beginning and ending mileage, number of passengers, starting address, destination, and a column for supervisor's approval.	Exception Purpose of travel is not listed on the transportation log, only starting and destination address.
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: Policy 2.03, Service Plan Implementation and Review, was approved by the CEO on September 27, 2022.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	Ten youth records were reviewed, five from residential and five from community counseling. All ten records reviewed contained a service plan developed from information gathered at the initial screening, intake, suicide screening and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All five youth residential records and five community based counseling records had a service plan developed within 7 days of NIRVANA being completed.	

Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Compliance**	All ten records reviewed contained an individualized service plan and prioritized needs and goals identified at the initial screening, intake, suicide screening and NIRVANA. All of the service plans had the following: service type, frequency, location, person responsible, target date for completion, actual completion date, and signature of counselor and supervisor. Each of the youth records reviewed for residential and community counseling contained the youth's signature. Each of the youth records reviewed documented verbal consents obtained by the parent/guardian and were documented in the youth's case notes. Case notes documented the review of the service plan with the parent and youth. All service plans contained the initiated dates on each of the plans.	
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**	Two out of five youth records were applicable for residential and five youth records were applicable for community counseling; each reviewed record contained service plan reviews within the required 30, 60, and 90 day timeframes as required.	
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency has multiple policies and procedures to address this indicator as follows: 1.21 - Inspections; 2.05-Orientation to Program; 3.09- Shelter Program Services; 3.14- Food Service; 4.01- Emergency Disaster Plan; 4.02- Fire Prevention; 4.03-Flammable, Poisonous, and Toxic Control; 4.04-First Aid Equipment/Supplies; and 8.01- Agency Vehicles. The policies and procedures were approved by the CEO on September 27, 2022.	

Facility Inspection	**Exception**	The facility tour was conducted during the QI visit and the shelter was found to be clean and appealing. The grounds was well maintained and beautiful landscaping was observed along the front of the building. All of the toilets and showers observed during the tour were clean and functional. The shelter is well lit throughout including LED lighting in the dormitory hallways. No graffiti was found on the walls or furnishings. All agency vehicles and staff vehicles are locked and secure. Three vans are currently being used by the program: 2018 Honda Odyssey, 2015 Chevrolet, and 2016 Toyota Sienna. The 2018 and 2015 vans were checked and found to be equipped with a first aid kit, fire extinguisher, flashlight, and multi-function tool that includes glass breaker/air bag deflator and seat belt cutter. Two sets of keys are used on each shift and a drop box is used to deposit keys after each shift. Incoming staff signs out the key upon retrieval. Egress plans are located throughout facility in common areas and behind the door in each bedroom. A copy of the floor plan is also included in the resident handbook. Client rules are posted on a board enclosed in a cabinet at the entrance to each dorm wing. A board in the youth lounge includes abuse hotline and DJJ incident reporting number. Department of Children and Families Child Care License is displayed in lobby area and the license is effective through 1/23/2023. The Council on Accreditation certificate is posted and effective through 7/31/2024.	Exception A pile of metal pipes left over from demolition of adjacent jail building was observed behind shed.
Additional Facility Inspection Narrative (if applicable)	All interior areas are free of contraband and is free from hazardous unauthorized metal/foreign objects. All chemicals and Material Safety Data Sheets (MSDS) are located in small locked room behind the kitchen and each item is inventoried at minimum once per week during the review period. One set of washer and dryer is located in laundry rooms on each wing. All beds were equipped with sheets, pillows, and comforters. Each youth has an individual dresser for clothing. Other valuable items are stored in a locked storage cubby inside the locked file room.		Exceptions The chemical inventory that was last updated 11/16/22 was not accurate for two chemicals on the list; Clorox clean up bleach and degreaser listed on the inventory was not found in the storage. MSDS was missing for Clorox disinfectant.

Fire and Safety Health Hazards	**Exception**	Annual facility fire inspection was conducted 9/29/22 by Islamorada Fire Rescue, valid through 9/29/23 and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. Quarterly fire sprinkler inspection was conducted by Black Fire, 9/23/22. The semi-annual fire suppression equipment inspection was completed by Monroe County Fire Equipment on 6/30/22. Annual fire alarm inspection was completed 7/26/22 by Barnes' Alarm System Inc. The agency has a satisfactory Residential Group Care inspection report from the Department of Health (DOH) as of 11/17/2022. DOH completed a satisfactory annual food inspection 8/15/22; one violation was noted for items in refrigerator that were not date marked. Food menus posted were current and signed by licensed Dietician on 9/27/21. All cold food is properly stored marked as well as labeled. Dry storage and pantry area is clean and food properly stored. Refrigerators/freezers are clean and maintained at required temperatures. Fridge temperature showed a reading of 37 degrees Fahrenheit and freezer temperature showed a reading of minus 2 degrees Fahrenheit.	Exception: The menu was last signed by the licensed dietician on 9/27/2021, exceeding the annual requirement.
Additional Fire and Safety Health Hazards Narrative (if applicable)	For the period May-October 2022, the agency completed a minimum of one fire drill per month on each shift within two minutes or less. Mock emergency drills were conducted monthly on each shift except for June 2022 where it was only completed on the third shift and not completed on the first shift in July.		
Grievance			
There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	The agency has a formal grievance process, policy # 3.22. Grievance forms are accessible at the entrance to each dorm wing and a grievance box is mounted on a wall adjacent to the girl's dorm.	
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 coordinator has possession of the keys to the grievance boxes. Supervisor and manager manage grievances within 72 hours in accordance with agency policy and practice and direct care staff do not handle the grievances.	

Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	Youth are engaged in meaningful, structured activities such as groups, specialized treatment services, life and social skills training, recreation, and community service time. At least one of physical activity is provided daily during recreation/outdoor activity times. Youth are provided the opportunity to participate in a variety of faith-based activities on Tuesdays and weekends. Non- punitive structured activities are offered to youth who do not choose to participate in faith based activities. Daily programming includes opportunities for youth to complete homework during the homework time daily. Daily programming schedule is publicly posted on a board in the common area.	
Additional Comments: **There are no additional comments for this indicator.**			
3.06 - Staffing and Youth Supervision			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: Policy 1.14, Staffing and Youth Supervision, was approved by the CEO on September 27, 2022.	
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	The program maintains the minimum staffing ratios as required by Florida Administrative Code and contract. There is at least one staff to six youth ratio, during awake hours and community activities, and one staff to 12 youth during sleep hours. However, it is the program's practice to maintain a two staff to 12 youth ratio during sleep hours.	

All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Staff schedules for the review period were reviewed. All shifts consistently maintained a minimum of two staff present and all staff have met the minimum training requirements prior to working independently with youth.	
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 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. One community counseling staff in training during the review was not assigned to any cases on the youth roster.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule was observed to be posted in the youth care monitoring station along with the holdover roster.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The program maintains a holdover roster with contact numbers of staff to call to ensure operation within the required staff-to-youth supervision.	
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**	A review of the program's logbook was completed for a total of 5 randomly selected days and all days were reviewed for two hours during the overnight shifts as follows: June 18, 2022 - 12am-2am, July 3, 2022 - 2am-4am, August 10, 2022 - 4am-6am, September 23, 2022 - 1am-3am and October 16, 2022 - 3am-5am. All bed checks reviewed were found to be conducted at least every 15 minutes for the male and female rooms for all dates reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: Policy 2.01, Screening and Intake, and Policy 4.08 titled Suicide Assessment were approved by the CEO on September 27, 2022. The Mental Health/ Substance Abuse Services Plan was signed by the licensed mental health counselor (LMHC), residential coordinator, and CEO on November 8, 2022.	

Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	Five reviewed records for three residential and two community counseling youth each documented a suicide risk screening was completed on the day of admission during the initial intake and screening process. The intake paperwork was signed and dated by the supervisor indicating a review as required in each record.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program uses the Assessment of Suicide Risk form. This is a Florida Network approved form.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Three of the five records reviewed were applicable for placement on sight and sound supervision. All three youth were placed on the appropriate level of supervision as determined by the suicide risk assessment results and supervision levels were not changed until further assessment was completed.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Compliance**	The three applicable youth records reviewed contained supervision logs maintained for the duration the youth was placed on increased supervision. Each log documented youth behaviors at ten-minute intervals, not exceeding the thirty-minute requirement.	
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**	The program has a licensed mental health counselor (LMHC) on staff. All youth were placed on the appropriate level of supervision as determined by the suicide risk assessment results and supervision levels were not changed until further assessment was completed by the licensed professional or a non-licensed mental health professional under the supervision of a licensed professional .	
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 applicable community counseling records were reviewed. Each record documented the youth was assessed by a licensed professional or a non-licensed professional working under the direct supervision of the licensed professional within twenty-four hours, and the parent/guardian 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**	Each of the two reviewed records which identified a suicide risk, where the appropriate staff was unavailable, demonstrated the youth was immediately referred by the provider, and parent/guardian were notified and was disclosed of the youth's suicide risk findings, and advised that an Assessment of Suicide Risk should be completed as soon as possible by a licensed professional.	
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**	Youth and the parent/guardian received information on resources available in the community for further assessments. Documentation reviewed in the youth's records, confirms this practice.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	Any and all attempts to contact the youth's parent/guardian are made and documented in one applicable community counseling youth record.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Compliance**	Two of the five records reviewed were applicable, where the screening for suicide risk was completed during school hours, on school property; documentation showed appropriate school authorities were notified.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: Program policy 3.16, Medication Management, was approved by the CEO on September 27, 2022.	
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The program maintains a part time licensed Registered Nurse (RN) on-site who oversees health and medication practices when on duty.	

Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	The program stores all medications in the Pyxis ES Med-Station Cabinet inaccessible to youth. The cart is stored inside the medical clinic in accordance with Florida Statute. The program's nurse and recreational therapist are designated "system managers" for the Med-Station. The program stores oral medications in a separate drawer from the topical medications and injectors. Observations during the annual review verified the program has a small refrigerator used for the storage of medications; however, the program did not have any youth requiring refrigerated medications during the review period. The refrigerator was located within the locked medical office, and the temperature was maintained between 36-46 degrees. All controlled medications and narcotics are maintained within the secured Pyxis ES Station. An informal interview with the Registered Nurse confirmed this practice. The program is required to have three Med-Station keys in the event the Pyxis system malfunctions. Observations conducted confirmed all keys were accounted for and maintained in the medical office.	

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 a minimum of two site-specific System Managers for the Pyxis ES Station. Only designated staff with proper user permissions have access to secured medications, and have limited access to controlled medications. The program uses a Medication Distribution Log to document all medication distributed by a non-licensed staff. Medication is only distributed by non-licensed staff when the nurse is off duty. The program policy clearly outlines a medication and delivery system aligned with Florida Network Policies. The program's policy stipulates epinephrine auto injectors are the only injectable medications accepted. The program maintains a list of staff trained and authorized to assist in medication distribution and the use of epinephrine auto injectors. In an informal interview with the nurse, it was indicated that all new staff are initially trained on the medication and delivery system process and annually thereafter.	

Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	Over the counter medication counts are completed weekly and controlled medications are counted shift to shift. The program practice is to count all medications each day at the end of each shift. Three counts are conducted regardless of medication class. Medication perpetual inventories and count practices were confirmed during record reviews. An observation of the shift to shift counts was conducted and verified the program's practice. All controlled medications are stored in the Pyxis ES station. A review of youth records and an interview with the program nurse confirmed the program maintains perpetual inventories with running balances for all controlled substances. All medication, sharps and over the counter medication are maintained in the medical office which remains locked at all times. The RN indicated all syringe/sharp counts are counted on a weekly basis and are documented in the inventory logs.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Reviewed inventory lists confirmed the program conducts a full medical room inventory monthly and reviews medication management weekly through the Pyxis Med-Station Report review.	
Medication discrepancies are cleared after each shift.	**Compliance**	A review of policy, records, and the interviewed nurse verified all medication discrepancies must be cleared after each shift.	
Additional Comments: **There are no additional comments for this indicator.**			