Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Florida Keys Children Shelter, Tavernier, FL
Jelsema Program

November 20-21, 2019

Compliance Monitoring Services Provided by

FOREFRONT

Quality Improvement Review

Florida Keys Children Shelter – November 20-21, 2019
Lead Reviewer: Marcia Tavares

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity/ Expression	Satisfactory
2.09 Special Populations	Satisfactory
2.10 Stop Now and Plan (SNAP)	

Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Video Surveillance System	Satisfactory

Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Standard 4: Mental Health /Health Services

4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

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.

Reviewer

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services

Paula Friedrich- Department of Juvenile Justice

Teresa Clove - Thaise

Kali Fabal – Lutheran Services Florida Southeast

Richard Rabathaly-Miami Bridge Youth and Family Services Inc

Quality Improvement Review

Florida Keys Children Shelter – November 20-21, 2019
Lead Reviewer: Marcia Tavares

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care, and (4) Mental Health/Health Services which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2019).

Persons Interviewed

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

Documents Reviewed

- ☐ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☒ Logbooks
- ☒ Continuity of Operation Plan
- ☐ Contract Monitoring Reports
- ☐ Contract Scope of Services
- ☒ Egress Plans
- ☒ Fire Inspection Report
- ☐ Exposure Control Plan
- ☒ Table of Organization
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☐ Key Control Log
- ☒ Fire Drill Log
- ☒ Medical and Mental Health Alerts
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☒ Supplemental Contracts
- ☐ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☐ Visitation Logs
- ☒ Youth Handbook
- **4** # Health Records
- **4** # MH/SA Records
- **7** # Personnel /Volunteer Records
- **8** # Training Records
- **21** # Youth Records (Closed)
- **13** # Youth Records (Open)
- _ # Other:

Surveys

- **3** # Youth
- **3** # Direct Care Staff
- **0** # Other: _____

Observations During Review

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

Comments

Additional Comments regarding observations, other important findings of interest, etc.

Strengths and Innovative Approaches

Rating Narrative

The Florida Keys Children's Shelter, Inc., is a non-profit community-based corporation contracted with the Florida Network of Youth and Family Services (Florida Network) to operate Children In Need of Services/Families In Need of Services (CINS/FINS) residential and non-residential services to youth and families in Monroe County. The program is located at the Tavernier's Jelsema Center, at the north-end of Monroe 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 that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and 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.

In April of 2016, the Florida Keys Children's Shelter (FKCS) was successfully re-accredited through July 31, 2020 by the Council on Accreditation (COA) and has been continuously re-accredited by the Council on Accreditation (COA) since its accreditation in May 2004.The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

Per FKCS strategic plan, the agency has fully launched the residential coaching program with the addition of three coaches: Life Skills Coach, Kirk Steputis; Education Coach, Ursula Cervone; and Recreation Coach, Erin Mckay. All have college degrees and specific expertise that empower the organization to better support the youth served. With FKCS higher pay scale, it is hopeful that the program will be able to retain these qualified professionals long-term. One of the agency's largest funders, the Ocean Reef Community Foundation, granted $50,000 to support the second year of the coaching program.

Over Summer Break 2019, the agency held several free week-long High Point Camps for at-risk youth ages 11-17 with activities, field trips, group counseling, and motivating

guest speakers. The referrals for the camp were so high that the program had to hold several camps to accommodate the families in need. Many of the High Point Campers did not want to go home at the end of the week because they were having such a great time. The coaches and counselors experienced noticeable progress in youth behaviors during each of the summer camps. Due to the camp's success, FKCS will continue to offer sessions of camp when youth are on scheduled breaks from school.

For the third academic year, the organization has provided free classroom space to the Monroe County School District for its Upper Keys Alternative Classroom. Each weekday, 6-9 students attend school in the building; the program provides complimentary use of its recreational facilities, meal preparation, coaches, and counselors. The agency currently has a Monroe County school teacher assigned to the classroom and a full time Monroe County para-professional to assist the teacher.

Recruitment and retention of employees continues to be one of FKCS’s biggest challenges being located in a rural area with high cost of living. During the last year, the agency increased pay to all employees. It also gave qualifying workers both mid-year and end-of-year bonuses. In addition, it held parties for staff and their families at a restaurant once during the year and the holidays, created monthly employee newsletters, and continued its Employee of the Month program with gift card incentives. Currently the program has three employees on their 90 day probation period without any vacancies in the CINS/FINS programs.

FKCS recently received donated funds from the company "Iptor" to paint the outside of the building; the paint has been purchased and the maintenance individuals are painting sections of the building when they are not working on other urgent projects.

During the last couple of months the program worked with the boys scouts of Monroe County to create environmentally friendly and sustainable planters. The maintenance personnel ensure the planters are watered daily and interested youth are taught to maintain and grow fresh herbs, fruits, and vegetables.

Standard 1: Management Accountability

Overview

Narrative

FKCS has been in operations for over 30 years. 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, abuse, neglected, or at risk.

The program has a Senior Management team that is comprised of a Chief Executive Officer, a Chief Operating Officer (COO), and a Financial Manager. In addition, the program has program leadership as follows: a residential coordinator, counseling services coordinator, SNAP services coordinator, and street outreach coordinator. There is also a licensed Mental Health Clinician (LMHC) on staff. At the time of the onsite QI review, there were no staff vacancies reported.

Notably, the Florida Keys Children's Shelter restructured its administrative staff for increased efficiency and productivity as follows:

- New COO - Alvin Bentley transitioned to Chief Operating Officer, with a focus on managing the team of employees to effect quality operations across the county so every young person served can achieve his or her greatest potential.
- New Financial Manager- Michelle Monday was hired to oversee accounting and finance, data management, and grant reporting.

Also of note, the Florida Keys Children's Shelter has upgraded its residential team:

- New Assistant Residential Coordinator- Sebastian Rivera who transitioned from the Recreation Coach into this key supervisory role. Sebastian has many years of experience and holds a master's degree in social work from Florida International University. He is known by his peers to be friendly and open-minded and is a welcome addition to the leadership team.
- New Recreation Coach- Erin Mckay. After Sebastian vacated the recreation coach position, Erin was recommended for the position by Sebastian due to their previous work together. Erin's life experiences and positive attitude makes her a perfect fit for the organization and provides much needed support for the youth and families we serve.

Besides the administrative changes mentioned above, the program has not reported any major challenges, incidents, administrative review, or current external investigation.

The agency has a systematic process for analyzing and reporting data. There are protocols in place regarding data collection and analysis as well as the reporting of various sources of information to identify patterns and trends. In addition, the program convenes monthly leadership meetings where the executive staff and coordinators discuss current concerns, progress, and other various topics. Incidents, accidents, and grievance data is collected monthly and compiled in a quarterly Risk Prevention and Management (RPM) Report. The information is shared quarterly at the Executive Council meeting and an annual report is compiled and presented to the Board members.

The following indicators in standard 1 were rated satisfactory with exceptions:

- 1.03 - Incident Reporting: 2 reportable incidents were not recorded in the shelter log book by staff on duty.
- 1.04 -Training Requirements: 2 staff members did not complete 2 trainings within the 120 day time frame and some deficiencies were noted in the policy and procedure with regards to mandated time frames and annual hours required for community based counselors.
- 1.06 –Transportation: van log does not accurately record the number of passengers that are being transported
- 1.07 – Outreach Services: the program did not have documentation verifying attendance to 3 of the 4 DJJ Board meetings that were held.

All other indicators in standard one were rated satisfactory with no deficiencies.

Standard 2: Intervention and Case Management

Overview
Rating Narrative

FKCS is contracted to provide both shelter and non-residential services for youth and their families in Monroe County. The program provides centralized intake and screening twenty-four hours per day, seven days per week, and every day of the year. Staff are trained staff to determine the conduct screening and immediately assess the needs of the family and youth. Residential counseling services are provided by Master's/Bachelor level counselors who conduct individual, family, and group services. Case management and substance abuse prevention education are also offered in both the residential and non-residential service programs.

The community-based program offers both school and home based services that are divided between three (3) full time master's level counselors under the supervision of a licensed (LMHC) counseling services coordinator. The counselors are responsible for providing case management services and linking youth and families to community services. The community based services span the entire Monroe County. The program's non-residential counselors work out of local schools in the upper (1), middle (1), and lower Keys (2) in Key West, and provide prevention services to youth in the county utilizing several schools as the base of operations in their respective communities. Referral and aftercare services begin when the youth are admitted for services. Aftercare planning includes referring youth to community resources, on- going counseling, and educational assistance.

FKCS non-residential program does not offer Intensive Case Management (ICM) and Family and Youth Respite Aftercare Services (FYRAC). At the time of the review the program had not provided any staff secure, domestic minor sex trafficking, or probation respite services. However, the programs have provided domestic violence and SNAP services. The agency is currently maintaining paper files but youth records are maintained in a neat and orderly manner and needs assessments are typed.

The following indicators in standard 2 were rated satisfactory with exceptions:

- 2.04 - Case Management and Service Delivery: one of the files reviewed did not have counseling notes regarding the goals on the service plan and 2 files were missing discharge summaries.
- 2.05 - Counseling Services: provider policy stated that at least one group session will be held monthly addressing substance abuse issues but this was not a practice.
- 2.08 –SOGIE: knowledge/ training on FN policy #5.08 was not evident for five current staff.

- 2.09 – Special Populations: there was no transition to CINS/FINS for one DV youth whose length of stay exceeded the 21 days limit. Also, JJIS data entry within 24 hours of intake and 2 hours of discharge was documented and/or verifiable.
- 2.10 – SNAP: four youth files reviewed were missing the post CBCL and were also missing pre and post teacher report form. Additionally, there were no post evaluations for youth participants and teacher for one group reviewed and the pre evaluation was not completed by the teacher in a second group reviewed.

All other indicators in standard two were rated satisfactory with no deficiencies.

Standard 3: Shelter Care

Overview
Rating Narrative

FKCS is located in Tavernier, Monroe County, Florida and serves the entire county. It provides services to youth in the Department of Juvenile Justice CINS/FINS program and is licensed by the Department of Children and Families as a nineteen (19) bed child caring facility. The license is effective through January 31, 2020. At the time of the review there were 4 CINS/FINS youth and 2 DCF youth in the shelter.

The shelter program staff includes: a Residential Coordinator; an Assistant Residential Coordinator; one Youth Advocate; ten Youth Support Staff (YSS); a Food Service Manager; three coach positions one each for education, recreation, and life skills; a part time nurse; and maintenance staff. In addition, the clinical component has and one residential counselor.

A tour of the facility revealed that it has a clean and well maintained facility with adequate accommodations for the clients which include bed linens and separate beds in each room, adequate furnishings, clean functional bathrooms and adequate lighting. The day room has several chairs for youth to sit and relax. Next to the day room is the dining area with an adjacent television room/library. In the middle of the facility, between the boys and girls wing is the observation area where the mentors and shift leads go about their duties. Also in the observation room is the monitors for the video surveillance system. There are schedules generated for weekly activities and weekly school schedules.

During the QI visit, the team observed the exterior of the building being painted and the environmentally friendly and sustainable planters installed for growing of fresh herbs, fruits, and vegetables.

The behavior management system is comprised of three levels, orientation, level 1, and level 2 and each level has progressive incentives and responsibilities. Progression through the levels is achieved by earning a minimum number of points for a specified number of days with a maximum of seventy-two points available to earn each day. All newly admitted youth begin on Orientation level. To advance to level 1, youth must abide by all program rules for at least two consecutive days and earn at least fifty-four points. To achieve promotion to Level 2, youth must abide by all program rules for at least two consecutive days and earn at least 64 points. Zero to six points are awarded individually at each activity dependent upon each youth's behavior during the activity.

The following indicators in standard 2 were rated satisfactory with exceptions:

- 3.02- Program Orientation: the orientation of two youth did not include provision

of a map of the facility's layout or information on what to do in the case of suicidal ideation, as the information was not included in the revised handbook.

- 3.04-Logbook: staff are not consistently logging the time of their review of the log book or consistently striking through errors correctly; instances of overwriting and scribbling out were observed in the logbook.
- 3.05- Behavior Management Strategies: the revised resident handbook does not adequately describe the behavior management point system in terms of minimum points to be achieved and/or minimum points to be earned to progress to Level 1 or Level 2.
- 3.07 – Video Surveillance: there were four out of twenty instances where more than the required maximum of fourteen days occurred between supervisory reviews of the video recording.

All other indicators in standard three were rated satisfactory with no deficiencies.

Standard 4: Mental Health/Health Services

Overview
Rating Narrative

The residential counseling services in the shelter are overseen by a Licensed Mental Health Counselor who serves as the clinical services coordinator. Designated trained youth care coordinators complete screening and the CINS/FINS Intake assessment during intake. All direct care staff members are trained on the suicide risk screening process and utilize the CINS Intake form to immediately identify youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The licensed clinical professional is notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. This information is documented on the alert board that discreetly mounted in the staff control room and in the youth files using a color coding system.

At the time of the QI review the provider had a licensed part time registered nurse (RN) contracted to provide services on-site. The duties assigned to the registered nurse includes: oversight of the general practice of distributing medication to residents in the shelter; oversight of medication inventory and storage practices; training of all staff authorized to distribute medication; and completion of health screenings and medical follow ups on an as needed basis. All training files reviewed onsite supported staff maintained valid CPR/First Aid training certificates.

During the tour of the facility, medications were observed to be stored in a locked room in their own separate containers in client specific drawers in the Pyxis Med Station 4000. Topical medications are stored separately from oral medication. The program has a list of staff who are authorized to distribute medication including super users. Medication records for each youth are maintained in the youth's file.

The program maintains 14 written agreements with other community partners which include medical and mental health services and a comprehensive referral process.

All indicators in standard four were rated satisfactory with the exception of 4.02-Suicide Prevention and 4.03- Medications. The exception noted in 4.03 was due to medication discrepancies not being cleared after every shift as required. All other indicators in standard four were rated satisfactory with no deficiencies.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☒ YES ☐ NO (explain) The agency has a current policy and procedures that address the background screening of all employees and volunteers. The provider's policy number 1.12 was last approved on 9/1/2019 by the Chief Executive Directors and Chief Operations Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of seven (7) background screening files were reviewed for six new hires and one staff who met the criteria for 5-year background screening. Since the last onsite visit, the program has not utilized interns/volunteers who met the criteria for background screening. The six new hire personnel had timely background screenings completed prior to their hire dates. The program also provided E-verify documentation for all of the new staff, verifying authorization to work. Similarly, an eligible 5-year re-screening was requested and approved prior to the employee's 5-year anniversary date. The provider submitted its Annual Affidavit of Compliance with Level 2 Screening Standards on January 17, 2019 prior to the January 31st deadline. Since January 2019, FKCS has utilized a self-created Suitability Questionnaire screening tool that is comprised of 11 open ended questions, I of which is a bonus question. The Suitability Questionnaire tool captures responses to 11 typical job related scenarios for direct-care positions and was used to evaluate the 6 new staff hired during the review period. The tool has a pass rate of 70% and it was verified that each staff hired met or exceeded the pass rate. FKCS Policy 1.12 upon initial review did not include the pass rate for hire after completing the pre-employment assessment tool. The policy was updated on 11/20/19 during the QI review.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ YES ☐ NO (explain) The program has comprehensive policies and procedures that meet the requirements for this indicator to ensure the provision of an abuse free environment including: Code of Conduct (policy # E.1, reviewed 9/8/19), Abuse Reporting policies #1.07.01 to 1.07.03 and Grievance Process #3.22, approved 9/1/19. The policies were signed and dated by the CEO and COO.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation that is signed and dated by each employee during their initial orientation. The agency has signage at the front entrance, as well as lobby, common areas, and youth hallways reflecting that all youth are accepted regardless of sexual orientation, gender identity, or gender expression, etc. There is one posting of the Florida Abuse Hotline in the common area. The program documents child abuse hotline calls in a binder that is located in the Monitoring Room. Three 3 new direct care staff training files were reviewed. All 3 staff members have completed the DJJ Skill Pro Child Abuse: Recognition, Reporting and Prevention training module. There was no corrective action rendered by the administration against staff, due to incidents of abuse, since the last review of the agency. There are 2 locked grievance boxes located outside each dorm, as well as grievance policies posted in each youth hallway. The grievance boxes are only accessed by the residential coordinator. Direct care staff do not handle the grievances. Two grievances were documented by youth since last review and were processed properly within the 72 hour time frame. Grievances were also maintained on file for a	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						minimum of 1 year.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) The provider's policy and procedure for Incident Reporting #1.13 were last reviewed on 9/1/19 and approved by the CEO and COO. The policy fully meets the requirements for this indicator.	No exceptions
RATING	☐	☒	☐	☐	☐	All 13 of the CCC reportable incidents that occurred during the review period were reported within the 2 hour time frame. The program has completed all requested follow up with the CCC. Per the residential coordinator and CEO, on 7 of the reportable incidents, follow up was not required by the CCC. All incidents are documented on the agency's incident reporting forms, and are reviewed and signed by program supervisors; ten of the thirteen reportable incidents were recorded in the shelter log book by staff on duty. There was also one reportable incident that was reportedly documented in the electronic log book. At the time of the review, the agency was unable to access the old records from the E-log book; therefore, documentation of the incident being recorded in the log book could not be verified. The DJJ CCC Hotline number is posted in the shelter common area and is also in the staff monitoring office.	**Exception** Two of the thirteen reportable incidents were not recorded in the manual shelter log book by staff on duty.
1.04: Training Requirements **Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☐ YES ☒ NO (explain) The provider's policies and procedures for Training Requirements #5.01, 5.02, 5.03 & 5.04 were last reviewed on 9/1/19. They were approved by the CEO and COO. The policy does not fully meet the requirements for this indicator.	Florida Network QI Standard 1.04 lists which trainings must be completed by new employees within 120 days of hire as well as which trainings must be completed within their first year of employment. The program's policy does not delineate the

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
							mandated time frames for the trainings. Florida Network's Child Abuse Reporting training, which is mandatory for new employees within their first 120 days, is not listed in the agency's policy. The program also stated in their policy that part-time community based counselors are required to complete a minimum of 20 hours of training annually which is not in compliance with the 40-hour QI Standard requirement. During the review, the policy was updated by the CEO to reflect proper compliance with the QI indicator.
RATING	☐	☒	☐	☐	☐	A total of 8 employee training files were reviewed for three 1st year direct care staff, four in-service direct care staff, and one new clinical shelter staff. Each staff has an individual training file that includes a training plan/log and supporting documentation. Training is maintained annually based on the individual's date of hire. Of the three first-year direct care staff files reviewed, one of the 3 staff members completed all of the required topics within the 120 day time frame. All four in-service direct care staff files reviewed demonstrated the staff were in compliance with training requirements by completing all required topics and exceeding the required 40 hours of training annually. One clinical shelter staff's file was reviewed for documentation of non-licensed mental health clinical staff training for Assessment of Suicide Risk. The staff member was in compliance with the training requirements and verification of completing the training signed off by a licensed mental health professional.	**Exception** Of the three new employee training files reviewed, 2 staff members did not complete 2 trainings within the 120 day time frame: 1) DJJ Skill Pro Suicide Prevention parts 1 and 2 and, 2) DJJ Skill Pro Child Abuse Recognition, Reporting, and Prevention.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Explain						
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The SNAP coordinator and SNAP case manager's files were reviewed for SNAP Certification. The staff members were in compliance with the training requirements.	
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) The program has multiple policies and procedures (P&P) to ensure adherence to the requirement of Indicator 1.05, Analyzing and Reporting Information. The P&P are listed as follows: Statistical Information - #1.20; Case Record Review- # 3.50; Service Satisfaction Questionnaires – # 3.55; Outcome Goals - #1.21; Incident Reporting – # 1.13; Grievances – # 3.22; and Risk Management and Internal Quality Monitoring – # 1.23. All of policies and procedures were reviewed and approved by the CEO and COO 9/1/2019.	No exceptions
RATING	☒	☐	☐	☐	☐	Case File Review is conducted quarterly by the clinical team. The agency submitted Case Record Reports for the FY 2019-2020 1st and 2nd quarter reviews of residential and non-residential files. A total of 65 records were reviewed, 30 in the 1st quarter and 35 in the 2nd quarter. The reviews are documented on Case File Review forms. The clinical supervisor reports findings to the Co-CEO who distributes a copy of the report to the Executive Council and Leadership. Any deficiencies are corrected within two weeks of the records review. Incidents, accidents, and grievance data is collected monthly and compiled in a quarterly Risk Prevention and Management (RPM) Report. The RPM reports for the 4th quarter of FY 2018-2019 and 1st quarter of FY 2019-2020 were reviewed during the visit. The information is shared quarterly at the Executive Council meeting and an annual report is compiled and presented to the Board members. Consumer surveys are administered annually in Survey Monkey. The	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						annual youth survey data aggregated by the CEO was reviewed for the report completed as of 3/5/2019 based on 48 responses. Outcomes data is generated by CEO and COO and included in the Provider's Monthly Leadership Report. Data is collected on program effectiveness, client outcomes, and CQI. The outcomes data incorporates all of the contract, Netmis, and program benchmarks required by the Florida Network and DJJ. A review of the reports prepared for the leadership meetings for the months July-October 2019 and also Board meeting held August 2019 supported this practice. NetMIS outcome data is reviewed monthly and is presented at the Leadership meetings. The CEO reviews this data and activities are discussed to increase performance as needed. It was evident that management meets monthly to review and discuss findings and trends identified. It was also evident that this information was disseminated and communicated to staff and/or staff are involved in discussing improvements. Staff meeting agendas reviewed for July, August, October, and November 2019 included evidence of discussion of outcomes and NetMIS data as well as discussion of key data with regards to incidents/accidents, grievances, client satisfaction data.	
1.06: Client Transportation **Policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						☒ YES ☐ NO (explain) The provider's policy and procedure for Client Transportation #10.03 was last reviewed on 9/1/19. The policy fully meets the requirements for this indicator and was approved by the CEO and COO.	No exceptions
RATING	☐	☒	☐	☐	☐	The agency has implemented a transportation policy with drivers approved by the administration. The approved drivers have valid Florida drivers' licenses and are covered under the organization's insurance policy.	**Exception** The agency's van log did not accurately record the number of passengers that are being transported on a trip, per Florida

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The policy prohibits transporting a client without maintaining at least one other passenger in the vehicle. The 3rd party must be an approved volunteer, intern, agency staff, or other youth. In the event that a 3rd party is not present, the supervisor considers the client's history, evaluation, and recent behavior before giving approval for transport. The staff has appropriately documented cases where single driver transport has been approved. A review of the program's travel logs for the past six months documented name and/or initials of youth, staff driver name, date, time, mileage, purpose of travel, and location. A review of the program logbook supported there is documentation of approval by a supervisor for one youth to be transported by one staff as needed.	Network QI indicator 1.06. During the review, the van log form was updated to correct this issue. There was one reviewed trip that was recorded in the log book but not on the van log.
1.07: Outreach Services **The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) The provider's policies and procedures for Outreach Services #9.01, 9.02, & 9.03 were last reviewed on 9/1/19. The policies fully meet the requirements for this indicator and were approved by the CEO and COO.	No exceptions
RATING	☐	☒	☐	☐	☐	Over the review period, the agency documented 107 attended outreach events in the NETMIS system. The agency's CEO is their lead staff member designated to attend the DJJ Board and Council meetings. The program maintains 14 written agreements with other community partners which include services provided and a comprehensive referral process.	**Exception** During the review period, three DJJ Board and Council Meetings were held. The program only has documentation verifying attendance to one of those meetings.

STANDARD 2: INTERVENTION AND CASE MANAGEMENT

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Two – Intervention and Case Management							
2.01: Screening and Intake							
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☒ YES ☐ NO (explain) The agency has written policies; 2.01 Initial Screening/ Assessment Process, 3.03 Program Services, 2.06 Orientation to the Program, and 3.22 Grievance Procedure that addresses all the key elements of the CQI indicator 2.01. All policies identified were last reviewed and signed on September 1, 2019 by the CEO and COO.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of five (5) non-residential files (three closed and two open cases) and five (5) residential files (three open and two closed cases) were reviewed. All files were screened for eligibility within 7 calendar days of referral. Youth and parent/guardian were all made aware of available service options, rights and responsibilities, notice of privacy, provided a client hank book and brochure. Parent/guardian and youth signed these forms at intake. All ten files reviewed showed all forms were completed; available service options, rights & responsibilities of youth and guardians, parent/guardian brochure, CINS/FINS services, and grievance procedure. Three (3) residential youth were interviewed regarding this indicator. All youth answered YES to knowing about the grievance process and rated the grievance process as “fair”, “very good”, and “good” All three youth were also able to identify adults in the program they can talk to if there is an issue in the shelter.	No exceptions
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the						☒ YES ☐ NO (explain)	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
requirement for Indicator 2.02						The agency has a written policy, 2.05 Needs Assessment, that addresses all the key elements of the QI indicator 2.02. The policy identified was last reviewed and signed on September 1, 2019 by the CEO and COO.	
RATING	☒	☐	☐	☐	☐	A total of five (5) non-residential and five (5) residential files were reviewed. In the five residential files reviewed, the needs assessment was initiated within 72 hours of admission. All five non-residential needs assessments were done within 2 to 3 face to face contacts after the initial intake or updated if most recent assessment is over 6 months old. All needs assessments were completed by a Bachelor or Master's level staff. All needs assessments were also signed and reviewed by a supervisor who is a Licensed Mental Health Counselor. One of the ten files was identified with an elevated risk of suicide. Youth was placed on elevated supervision. The Assessment of Suicide Risk was completed and reviewed by a licensed mental health clinician.	No exceptions
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) The agency has written policies, 2.02 Service Plans, 2.03 Service Plan Implementation and Review, and 2.04 Revised Service Plans that address all the key elements of the QI indicator 2.03. All policies identified were last reviewed and signed on September 1, 2019 by the CEO and COO.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of five (5) non-residential files (three closed and two open cases) and five (5) residential files (three open and two closed cases) were reviewed. In all ten files reviewed, the service plans were developed within 7 working days of the needs assessment and had individualized and prioritized needs and goals identified by the needs assessment. All non-residential and residential service plans had the following: service type, frequency, location, person responsible, target date for completion, actual completion date, signature of youth,	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						signature of parent, and signature of counselor and supervisor. All service plans also had initiated dates. On one non-residential file reviewed the service plan was not reviewed within the 14 days; however, the reason was documented in the counselor's notes.	
2.04: Case Management and Service Delivery							
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) The agency has written policies: 3.01- 24 Hour Agency Access, 3.02- Referrals, 3.03 - Program Services, 3.04 - Exit Planning, Aftercare and Follow Up, 3.05 - Family Involvement, 3.06 - Case Staffing Committee, 3.07 - Schedule of Case Staffing Committee, 3.08 - Requesting a Case Staffing Committee Meeting, and 3.09 - Written Report from the Case Staffing Committee. All of the policies address the key elements of the QI indicator 2.04. All policies identified were last reviewed and signed on September 1, 2019 by the CEO and COO. However, Policy 3.04 was revised on 11/20/19 and approved by CEO and COO to remove statement that "all community residential youth would be referred to a Community Based Counselor".	No exceptions
RATING	☐	☒	☐	☐	☐	There were ten (10) cases reviewed in total. All five residential and five non-residential cases reviewed were assigned a counselor. In nine files, the counselors coordinated service plan implementation and monitored youth/ family's progress in services by reviewing goals every 14 days. On one non-residential file reviewed that service plan was not reviewed within the 14 days; however, the reason was documented in the counselor's notes. Out of the ten cases, only two required a counselor to make a referral for services based on the needs assessed. In all files, the counselors coordinated service plan implementation and monitored youth/ family's progress in services by reviewing goals every 14 days. Counselors also provided support to work through issues according to case notes/documentation made. No files/clients required out- of-home placement monitor. Out of the ten files reviewed, none of the	**Exception** One of the residential files did not have counseling notes that addressed the goals identified in service plan yet the service plan indicated the goal was accomplished. Two closed residential files did not have a discharge summary or appropriate discharge form in the file. A new form was created during the review to document residential discharge.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						cases required a referral for CINS case staffing committee or assistance in appearing at court hearings. Out of the ten files, five required a termination summary. Two of the five files did not have a discharge form or summary. Four of the ten files required a 30-day follow-up which was provided. Three of the ten files required a 60-day follow-up which was provided. The other closed case reviewed had not reached a 30-day follow-up. All other cases were still opened and did not require follow ups. Three (3) residential youth were interviewed regarding this indicator. Each youth was asked if they have a counselor, all answered YES. Each youth was asked if they were participating in services for mental health and substance abuse. One youth skipped the question, one youth stated "no", and another stated yes and rated the service as "very good".	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) The agency has written policies: 1.14 - Client Case Records, 1.17 - Confidentiality, 3.50 - Case Record Review, and 3.16 - Group Sessions/House Meetings for Youth that address all the key elements of the QI indicator 2.05. All policies identified were last reviewed and signed on September 1, 2019 by the CEO and COO.	No exceptions
RATING	☐	☒	☐	☐	☐	During the review, there were ten files reviewed for five residential and five non-residential cases. All presenting problems were assessed by completing needs assessments and identified goals listed on the service plans were monitored through counseling services. All residential and non-residential files provided evidence of counseling services by documentation of case notes by counselors. When reviewing the group log book for the shelter, the forms included: initials of clients who participated, length of groups, facilitator of groups, time of group, and date of group.	**Exception** Policy 3.16 Group Sessions/ House Meetings for Youth stated that at least one group session is presented monthly addressing substance abuse issues. Last substance abuse group noted was in July 2019. The policy was revised and approved on 11/21/19 by CEO and COO to remove above statement.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Three (3) residential youth were interviewed regarding this indicator. First question to youth were if their counselor asked them what they would like to work on. All youth answered YES. Next they were asked to identify the goals they are working on; one youth wrote, "just waiting till 18", another youth wrote "school" and the last youth wrote "staying humble, not being physical, go to school, and get a job". All three (3) youth answered YES to counseling services helping them reach their goals.	
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) The agency has written policies: 3.05 - Family Involvement, 3.06 - Case Staffing Committee, 3.07 - Schedule of Case Staffing Committee Meetings, 3.08 - Requesting a Case Staffing Committee Meeting, and 3.09 - Written Report from the Case Staffing Committee that addresses all the key elements of the QI indicator 2.06. All policies identified were last reviewed and signed on September 1, 2019 by the CEO and COO.	No exceptions
RATING	☒	☐	☐	☐	☐	During review there were two (2) non-residential cases that were taken to case staffing but determined not to be adjudicated CINS. Both cases reviewed had a case staffing that was initiated by parent/guardian. Both files had case staffing meetings that were held within 7 days of being requested. All parents/guardian and committee members were notified no less than 5 working days prior to staffing. The case staffing committee members included representatives from the local school district, a DJJ representative, parents/guardian, and other concerned members. In both files reviewed there was no mental health representative, substance abuse representative, law enforcement representative, or DCF participants. The youth and family were provided a new or revised plan for services as a result of the case staffing committee meeting. Documentation and parent signature on recommendations from staffing show that written reports	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						are provided to the parent/guardian within (7) seven days of case staffing meeting.	
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) The agency has written policies: 1.14 - Client Case Records and 1.17 - Confidentiality (general and HIPPA) that address all the key elements of the QI indicator 2.07. All policies identified were last reviewed and signed on September 1, 2019 by the CEO and COO.	No exceptions
RATING	☒	☐	☐	☐	☐	During the review there were five (5) residential files and seven (7) non-residential files reviewed. The agency has a secure room or locked file cabinet that is marked “confidential”. The agency also has black locked boxes to keep files when they are transported out of the office. All boxes observed had combination locks built into the black boxes. All 12 cases reviewed were maintained in a neat and orderly manner. All 12 cases reviewed were marked “confidential” on the outside of the file folder.	No exceptions
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☐ YES ☒ NO (explain) The agency has a written policy and procedures # 3.61 that address most of the required elements of the QI indicator 2.08 - Sexual Orientation, Gender Identity, and Gender Expression. The policy was last reviewed on 9/1/2019 by the CEO and COO.	FKCS Policy 3.61 upon initial review did not address staff, service providers, and volunteers gaining knowledge of Florida Network policy #5.08. The policy was updated on 11/20/19 during the QI review.
RATING	☐	☒	☐	☐	☐	The agency has the following standards of service required for compliance with this policy. Youth will be addressed by their preferred name and gender pronouns. Staff is prohibited from discussing youth’s sexual orientation, gender identity, or gender expression with other youth in services without the documented consent from the youth. All staff, service providers, and volunteers are prohibited from engaging in any form of discrimination or harassment of youth based	**Exception** Verification of knowledge and/or training of FN policy #5.08 was not provided for five current staff.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						upon their actual or perceived sexual orientation, gender identity, or gender expression. Staff will also report to CCC if there are incidents /allegations of harassment of youth based on their actual or perceived sexual orientation, gender identity, or gender expression. Areas in which youth reside or are served will have signage indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Youth will also be identified in the log book and all public facing documents by their preferred name and gender pronouns. Youth is assigned a room aligning with their gender identity, or the program will provide specific documentation as to why other room was determined to be suitable. Youth will be provided with hygiene products, undergarments, and clothing that affirms their gender identity or gender expression. During the tour of the facility it was observed that the agency has signage placed in all common areas and in the administrative areas stating “Everyone is Welcome Here…..Everyone Belongs”. During the review, there were no residential files of clients who were identified as SOGIE. There was one (1) non-residential file reviewed in which youth was identified as trans-male. In the file reviewed, the youth’s preferred name was noted and the counselor addressed youth by preferred name and preferred pronouns. The program has copies of the FN ZINE brochure, accessible in the day room of the shelter, providing education and information about LGBTQ. The program has documentation to support some but not all of the staff being made aware/having knowledge of Florida Network policy #5.08.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the						☒ YES ☐ NO (explain)	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
requirement for Indicator 2.09						The agency has a written policy and procedures, 3.13.1, that address all key elements of the QI indicator 2.09, Special Populations. The policy was last reviewed/revised on 9/1/2019 and signed by the CEO and COO.	
RATING	☐	☒	☐	☐	☐	FKCS provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, youth referred by the Juvenile Justice Court System for domestic violence/ probation respite, and SNAP. During the review period, the provider did not serve any youth who met the criteria for Staff Secure, DMST, or Probation Respite since the last QI review. Two (2) closed DV Respite files were reviewed for this indicator. The two files had documentation of youth pending DV charges and had evidence of being screened by JAC/Detention and does not meet the criteria for secure detention. Data entry into NetMIS was verified to be within 24 hours of intake and 72 hours of release. JJIS data entry timeframes was not documented or verifiable as staff did not have access to see the data entry log. One of the youth was admitted in the program for 23 days but no evidence of transition to CINS/FINS was documented in the file. The case plan reflected goals consistent with the issues identified regarding aggression, coping skills and effective communication in 1 applicable file; the other youth was discharged prior to the timeframe required for development of the case plan. Documentation was provided to support services were provided consistent with all other general CINS/FINS program requirements.	**Exception** Two DV youth files were reviewed. One of the youth was admitted in the program for 23 days; the DV program length of stay is 21 days and there was no transition to CINS/FINS as required. JJIS data entry within 24 hours of intake and 72 hours of discharge was not tracked by the staff and access to the system was not given to the staff to pull report.
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☐ YES ☒ NO (explain) ☐ N/A (explain) The agency has a written policy and procedures #3.62 that address some key elements of the QI indicator 2.10, SNAP. The policy was last reviewed/revised on 9/1/2019 and signed by the CEO and COO.	FKCS Policy 3.62 upon initial review did not address required documents to be completed at discharge. The policy was updated on 11/20/19 during the QI review.

Quality Improvement Review

Florida Keys Children Shelter – November 20-21, 2019
Lead Reviewer: Marcia Tavares

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☐	☒	☐	☐	☐	There were four closed SNAP clinical group files reviewed. All four files documented the youth were screened to determine eligibility using the NETMIS screening form and the SNAP Brief Intake screening form. There was a signed consent form in each file signed by the parent/guardian prior to receiving services. A needs assessment was completed at intake in each file. One of the four files had a completed pre-CBCL completed at intake in each file but noted none at discharge due to no response from the parent; the other 3 files did not have a completed pre/post-CBCL but proof of 2 emails sent by staff to each caregiver requesting the completed checklists was in the files. A pre/post Teacher Report Form (TRF) was not completed in any of the files at intake or at discharge and no documentation of this form being given to the teacher and attempts to have the form filled out was on file. An EARL assessment was completed at intake for each youth but no PAT assessments were completed because the staff were awaiting DJJ training/authorizations at the time. At discharge, all four closed files had completed post-EARL and post-PAT assessments completed as well as a SNAP Discharge Report Summary. There were two sessions for SNAP in Schools reviewed. Both sessions documented weekly attendance sheets with the youth's name and signature of the teacher and SNAP facilitator for all thirteen sessions. Both sessions documented the Class Shoot for Your Goal sheet was completed. For one of the groups there were no post evaluations completed for the youth participants or no post evaluation completed by the teacher. In the other group, the pre evaluation was not completed by the teacher. Both sessions documented one Fidelity Adherence Checklist was completed.	**Exception** A total of 4 youth files were reviewed for SNAP clinical groups. All four youth were missing the post CBCL and were missing pre and post teacher report form. 2 SNAP in school groups were reviewed. For one of the groups there were no post evaluations completed for the youth participants or no post evaluation completed by the teacher. In the other group, the pre evaluation was not completed by the teacher.

STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Three – Shelter Care							
3.01 Shelter Environment **The shelter's environment is safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development.**							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						☒ YES ☐ NO (explain) The program maintains policy 3.18 to address residential sleeping quarters and shower facilities, policy 3.15 to address the daily activity schedule, policy 3.17 to address faith and community based opportunities, policy 3.31 to address food service health inspections, policy 4.01 to address safety inspections, policy 4.02 to address evacuation egress plans, policy 4.04 to address fire prevention, and policy 4.06 to address control of flammable, poisonous and toxic materials. The policies were last updated on 9/1/19 and signed by the CEO and COO.	No exceptions
RATING	☒	☐	☐	☐	☐	The program tour demonstrated the shelter is clean, well-kept and very organized. All areas of the facility were very pleasant smelling and clean and furnishings were observed to be in good repair. Lighting was adequate throughout the facility. There was no indication of any pest infestation. No graffiti was observed. The facility grounds were well kept and free of hazards. The outdoor gym/wellness area was covered with cushioned rubber matting. The program's dumpster has an attached cover which was observed to be closed during the facility tour. The facility has two sets of clothing washers and dryers maintained in locked laundry rooms which were clean and organized to maintain the program's supply of bedding, towels and clothing. The annual fire inspection was successfully completed on January 14, 2019 by the Islamorada Department of Fire Rescue. The fire alarm system was inspected on December 27, 2018. The kitchen fire	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						suppression system completed quarterly inspection on October 17, 2019. A total of eighteen fire drills were conducted in the prior six months with drills conducted three times each month from May through October, exceeding the minimum monthly requirement. All fire drills were successful in completing facility evacuation in less than two minutes during each drill. The program also conducted a total of seventeen mock emergency drills over the prior six months, with an average of three per month. Observations confirmed dry and shelf-stable goods were properly stored in the kitchen pantry and the program's refrigerator and freezer were clean with temperatures maintained at 38 and 4 degrees respectively. The program engages youth in structured activities with daily activities scheduled throughout each weekday with minimal idle time. The daily program schedule is posted and available to all youth as well as included in the resident handbook. Facility operating policy 3.09 provides youth the opportunity to participate in faith-based activities.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) The agency has a policy and procedure in place, #2.06 for program orientation that addresses the requirement of the indicator. The policy was signed and dated on 9/1/2019 by the CEO and COO.	No exceptions
RATING	☐	☒	☐	☐	☐	Two closed records and two open records were reviewed. It is the program's current practice to review the resident handbook with each youth at the time of intake and document orientation to the program on the statement/consents form with the youth, parent/guardian and staff signatures. Previously the youth and parent/guardian acknowledged orientation to the program by their signature on the resident/parent handbook form. Orientation to suicide prevention/alert notification is documented on the individual safety plans which were completed within twenty-four hours of each youth's admission.	**Exception** Two open records reviewed were for youth admitted after revision of the new residential handbook on 07/12/2019. The orientation of these two youth did not include provision of a map of the facility's layout or information on what to do in the case of suicidal ideation, as the information was not included in the revised handbook. An interview with the COO indicated youth

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
							are provided a tour of the facility, dependent upon the time of day the youth is admitted. The new handbook refers youth to the egress maps posted throughout the facility for emergency evacuation. An interview with program staff indicated not all staff are using the resident handbook revised on 07/12/2019. It was additionally mentioned the program was aware these areas were missing from the handbook which is a work in progress.
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) The agency has a policy and procedure in place, #3.14 for room assignment that addresses the requirement of the indicator. The policy was signed and dated on 9/1/2019 by the CEO and COO.	No exceptions
RATING	☒	☐	☐	☐	☐	Four youth records were reviewed; two open and two closed. The policy requires review of available information about the youth's history, status and exposure to trauma, initial collateral contacts, initial interactions with and observations of the youth, separation of younger youth from older youth, separation of violent youth from non-violent youth, identification of youth susceptible to victimization, presence of medical, mental or physical disabilities, suicide risk, sexual aggression and/or predatory behavior. One reviewed closed record did not document the youth's gender identification (expression), which was left blank. An interview with the COO indicated it is the program's practice to assign youth individually to sleeping rooms whenever the program's census allows. Same gender sibling pairs may request to be assigned to the same sleeping room, if they wish. Alerts are to be immediately entered into the programs alert system when a youth is admitted with	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						special needs and risks including risk of suicide, mental health, substance abuse physical health or security factors.	
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) The agency has a policy and procedure in place, #3.26 for logbooks that addresses the requirement of the indicator. The policy was signed and dated on 9/1/2019 by the CEO and COO.	No exceptions
RATING	☐	☒	☐	☐	☐	A review of the program's log books for the prior six months confirmed the program utilizes the logbook to document daily activities, events, and other major occurrences. Logbook documentation included issues related to safety and security, incidents, youth supervision, movement and counts, visitation and home visits, transportation, grounds and facility checks, distribution of medication, and other significant events.	**Exception** • Staff are not consistently logging the time of their review of the log book but did note the date. • Staff are not consistently striking through errors with a single line and writing "void" by the error. Instances of overwriting and scribbling out were observed in the logbook, including overwriting the time of the entries. • 7/20/19 had an entry stricken through but was not initialed (a post-it note in the logbook identified this problem) • Safety and security issues that could impact the youth and/or program are required to be highlighted by the indicator. The program's policy and procedure require crucial log book entries to be highlighted. Whereas entries including staff review of the logbook are highlighted, there is inconsistent highlighting of youth returning to the facility highlighted. It is unclear what entries fall into the category of "crucial" logbook entries.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable		
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The agency has a policy and procedure in place # 3.47 to address the program's behavior management system which was approved on 9/1/2019 by the CEO and COO.	No exceptions
RATING	☐	☒	☐	☐	☐	Youth are oriented to the point-based behavior management level system upon intake. Individual point sheets are maintained and completed daily by the staff for each youth and point sheets are maintained in each youth's individual case management record. The behavior management system is comprised of three levels, orientation, level 1, and level 2 and each level has progressive incentives and responsibilities. Progression through the levels is achieved by earning a minimum number of points for a specified number of days with a maximum of seventy-two points available to earn each day. All newly admitted youth begin on Orientation level. To advance to level 1, youth must abide by all program rules for at least two consecutive days and earn at least fifty-four points. To achieve promotion to Level 2, youth must abide by all program rules for at least two consecutive days and earn at least 64 points. Zero to six points are awarded individually at each activity dependent upon each youth's behavior during the activity. Points are not taken away from youth as a consequence once the points have been earned. However, youth who commit any major infraction, which are listed in the handbook, may have their level dropped and must work again to earn promotion to the higher level. Staff are provided feedback regarding their compliance with the behavior management system by the residential coordinator. Each staff receives performance evaluations at the end of their three-month	**Exception** The youth handbook and posted information on the behavior management system clearly states the youth responsibilities for each level. However, the revised resident handbook does not state the minimum number of points which must be achieved nor the number of consecutive days the minimum points must be earned to progress to Level 1 or Level 2. The posted Youth Development System information does not state the minimum number of points which must be achieved nor the number of consecutive days the minimum points must be earned in order to progress from Level 1 to Level 2.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						probationary period and at least annually thereafter to include evaluation of each staff's overall compliance and degree of success with the application of the behavior management system.	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) The agency has a policy and procedure in place # 3.46 to address Staffing Ratios which was approved on 9/1/2019 by the CEO and COO.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has all direct care staff certified in CPR. The program sets staff schedules to ensure there is at least one staff on duty of the same gender as the youth whenever possible. A schedule is provided to staff and is posted in a place accessible to staff. The program maintains a roster of on-call staff to ensure operation within the required staff-to-youth supervision ratio of 1:6 during awake hours/community activities and 1:12 during sleep periods. Overnight shifts are staffed with a minimum of two staff present. The residential coordinator produces a staffing schedule which meets the requirements of twenty-four-hour awake supervision and the schedule is posted in the staff room. A review of staff schedules covering the review period and a review of video surveillance footage confirmed the presence of at least two staff on duty during the overnight shifts. The program reported no vacancies at the program at the time of the annual compliance review.	No exceptions
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) The agency has a policy and procedure in place # 4.23 on video	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						surveillance and recording signed and approved by the CEO and COO on 9/1/19.	
RATING	☐	☒	☐	☐	☐	The program has a twenty-four-camera digital video surveillance system recording 24/7 throughout and outside the facility except for bathrooms and youth sleeping rooms. The system captures video which is maintained for at least 30 days and has a battery backup which allows cameras to operate during a power outage. The system notates the video date, time, and location and maintains resolution sufficient to enable facial recognition. The program has the capability to provide third party review of video in such instances as program quality improvement reviews or incident investigations as required by local, state, or federal law enforcement agencies. Notice of on-site video recording is posted publicly on premises. Video recordings for three randomly selected dates were reviewed for overnight bed checks with the COO and residential coordinator. All checks were conducted within 15-minute intervals or less and documented in the facility logbook. Camera #24 of the system was observed to have technical problems connecting with the network to display live video on both days of the annual compliance review; however, an interview with the COO indicated the camera view of #24 was an outside camera with zoomed-in duplicative aspect of another operational camera in the system; therefore, no gaps of video coverage occur when camera #24 is off-line.	**Exception** A review of documentation for the review period indicated supervisory review of video was conducted by the residential coordinator; however, there were four out of 20 instances of supervisory reviews where more than the maximum of fourteen days occurred between supervisory video reviews. The gaps between supervisory reviews ranged in length from 15 days to 19 days over the following periods: May 14 to May 29 June 25 to July 10 July 15 to July 31 Sept 26 to Oct 15 None of the supervisory reviews noted any deficiencies in staff conducting checks at least once every 15-minutes.

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

Quality Improvement Indicators	Rating: Explain — Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard Four – Mental Health /Health Services							
4.01: Healthcare Admission Screening							
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						☒ **YES** ☐ **NO (explain)** Policy and procedure # 4.01, Healthcare Admission Screening, addresses all the key elements of the QI indicator. The policy was last updated on 9/1/19 and signed by the CEO and COO.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of four (4) residential files were reviewed for this indicator, two (2) opened and two (2) closed. All the healthcare screenings were completed by staff on the day of intake and were reviewed by the nurse within 24 hours of intake. All four (4) healthcare screenings addressed current medications in which one (1) resident came in with medications and one (1) took his ADHD medication at school. The other 2 residents were not prescribed medication. Only three (3) residents came in with a medical condition/illness (Epididymis, ADHD and alopecia) that had been addressed prior to entering the shelter. One (1) was on medication for Epididymis while in the shelter and had no follow up scheduled appointments while in care. The other resident took medication at school for his ADHD and the resident that had alopecia was not on medications. The healthcare screening forms in the case files notated that none of the 4 residents had allergies, had any pain or other physical distresses nor did they have scars, tattoos or any skin markings.	No exceptions
4.02 Suicide Prevention							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
There is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ **YES** ☐ **NO (explain)** Policy and procedure # 4.14, Suicide Prevention, addresses all the key elements of the QI indicator. The policy was last updated on 9/1/19 and signed by the CEO and COO.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of four residential client files including, three closed files and one open file were reviewed. The program utilizes the Suicide Risk Screening on the CINS/FINS intake form. Youth who answers 'yes' to risk factor questions 1-6 on will be placed on sight and sound and referred to a licensed staff or non-licensed staff with the required training for a suicide risk assessment. Suicide Risk Screening forms were completed in their entirety and completed in the required time frame at intake. A total of four (4) residential files were reviewed for this indicator, two (2) opened and two (2) closed. The suicide risk screening occurred during the intake session by staff on the day of intake and was reviewed by the license professional within 24 hours of intake. Three (3) residents were placed on sight and sound at intake but were released from sight and sound the same day after the license professional completed an additional suicide screening. The license professional reviewed the suicide assessment, signed it and documented it in the resident's case files.	No exceptions
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ **YES** ☐ **NO (explain)** Policy and procedure # 3.41, Medication Distribution and Storage, addresses all the key elements of the QI indicator. The policy was last updated on 9/1/19 and was signed by the CEO and COO.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☐	☒	☐	☐	☐	A total of four (4) residential files were reviewed for this indicator, two (2) opened and two (2) closed. All medications are stored in the Pyxis Med-Station 4000 which is not assessible to residents. Florida Keys Children's Shelter has a total of 3 Super Users: the CEO, Nurse, and residential coordinator. Florida Keys Children's Shelter does not accept residents that are prescribed injectable medications except for epi-pens users. None of the four (4) residents uses epi-pens as noted in their case file. The peer reviewer observed that all oral medications are stored separately from the epi-pens and all narcotics and controlled medication are stored in the Pyxis Med-Station 4000. There is a medical refrigerator in the medication room that stores all medications that need to be refrigerated. No medication to be refrigerated was stored at this time. The temperature of the refrigerator was in the required range of 36 – 46. The thermometer stated the refrigerator was at 40 degrees Fahrenheit. All staff have been trained in the use of the Epi-pen and are trained in administering medication stored in the Pyxis Med-Station. The staff training dates and certificates were noted, reviewed and given as proof of the trainings. Shift to shift medication count and the inventory count are documented and witnessed by another staff member for all control substances. The medication count and inventory forms are kept in a log book in the Med-station and were reviewed by this peer reviewer. Syringes and sharps are counted weekly and are kept in the Med-station. The nurse has a log indicating they are being counted weekly. There was one medication error that was noted. It was documented	**Exception** The indicator states that medication discrepancies are to be cleared after each shift. The nurse reported that she asked the staff to wait to clear the discrepancies after she had an opportunity to review them. Consequently, discrepancies are not being cleared after every shift which is in contradictory to the policy.

Quality Improvement Indicators	Rating: Explain — Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon — Document Source: Interview/Surveys, Observation, and/or Type of Documentation — Summarize Findings Based on Completed Worksheets	Notes — Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						in the client case file, documented on the medication log and an incident report was sent to CCC informing them of the medication error.	
4.04: Medical/Mental Health Alert Process							
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						☒ **YES** ☐ **NO (explain)** Policy and procedure # 7.03, Medical and Mental Health Alert, addresses all the key elements of the QI indicator. The policy was last updated on 9/1/2019 and was signed by the CEO and COO.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of four (4) residential files were reviewed for this indicator, two (2) opened and two (2) closed. Three (3) residents had documentation that they had a medical or mental health condition. One (1) resident had no medical or mental health condition. The program has a medical alert system in place. Three (3) residents were appropriately placed on the program's medical alert system. The medical alert codes were placed on the front of the resident case file chart and on the roster board in the monitoring station. Staff are all trained in the medical alert system as it is a part of their medical training given by the nurse. Medical training certificate were noted for all staff.	No exceptions
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** Policy and procedure # 4.19, Emergency Medical and Dental Care, addresses all the key elements of the QI indicator. The policy was last updated on 9/1/2019 and was signed by the CEO and COO.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of three (3) closed residential files were reviewed for this indicator. All three (3) residents were taken off site for emergency treatment. An incident reporting form was completed by staff and a call was made to CCC. The parents were notified which was documented in the log book and in the resident's case file notes.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Daily logs were maintained on these residents as seen in the log book. All staff were trained on emergency medical procedures, CPR and First Aid, medical equipment, epi-pen, and other medical procedures as seen in their training files. Knife-for-life and wire cutters are located in the monitoring station. The first aid kits are in every van and in the medication room. The medication room houses a first aid cabinet on the wall and a portable first aid kit.	