Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Boys Town – Oviedo, Florida
Residential Program

October 9-10, 2019

Compliance Monitoring Services Provided by

FOREFRONT

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	Limited
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.29%
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)	N/A

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	Limited
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Video Surveillance System	Satisfactory

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.29%
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	Limited
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

Percent of indicators rated Satisfactory: 80.00%
Percent of indicators rated Limited: 20.00%
Percent of indicators rated Failed: 0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory: 89.29%
Percent of indicators rated Limited: 10.71%
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

Tamara Mahl-Adkins – Regional QI Monitor, Department of Juvenile Justice

Nitara LaTouche - Consultant-Forefront LLC

Chaniqua Rembert – Intake Specialist, Hillsborough County Children Services

Fatima Rogers – Program Director, Thaise, Orlando

Quality Improvement Review

Boys Town – October 9-10, 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
- **1** # Case Managers
- **2** # Program Supervisors
- **N/A** # Food Service Personnel
- _____ # Healthcare Staff
- **N/A** # 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
- **5** # Health Records
- **5** # MH/SA Records
- **12** # Personnel /Volunteer Records
- **6** # Training Records
- **22** # Youth Records (Closed)
- **2** # 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

Boys Town of Central Florida (Boys Town) is located in Oviedo, Florida. The program is an affiliate of its national non-profit agency Father Flanagan's Boys Home with headquarters located in the Village of Boys Town, Omaha, Nebraska. Boys Town provides a variety of services from its main campus as well as in the surrounding community. Services include: intervention and assessment; treatment family homes; in-home family services (IHFS); a national hotline; free online resources; parenting; project Safe Place; and comprehensive behavioral health clinic; and behavioral assessments. Community support services enable children and parents to tap in to a wide variety of resources from agency experts or through direct specialized services. The Boys Town National Hotline® (800-448-3000) is a free resource and counseling service that assists youth and parents 24/7, year round, nationwide. Boys Town Press® produces books, audio products, DVDs, display materials and other resources to assist children, parents, caregivers, educators and other professionals. YourLifeYourVoice.org is a special website that enables and encourages teens to share their problems and concerns in positive ways and provides access to immediate help in a crisis.

The following programmatic updates and highlights since the last Quality Improvement review in December 2018 were reported to the QI team during the visit:

Agency

- The program has provided 927 residential bed days since the last Florida Network visit
- Non-residential admissions are currently at 108%
- The agency is in the process of establishing a cooperative agreement with Seminole County Public Schools to offer social skills groups in the school system.
- Embrace Families (Community Based Care) has granted a rate increase to Boys Town in July 2019.
- An inaugural celebration of Father Flanagan's birthday by staff and youth was implemented this year and will continue as an annual employee team building and campus wide togetherness activity.
- Employee of the Quarter and the Wall of Excellence has been implemented to highlight and recognize staff's outstanding performance.
- Upcoming events: Annual Candy Cane 5K, Annual Christmas Tree Lighting, British Car Show.

Staff Updates

- IHFS staff promotions: Rochelle Davis was promoted to Program Support Coordinator and Bethania Rivera to Youth Care Supervisor.
- IHFS Director celebrates 10 years with Boys Town
- CINS staff, Mariel Guerrero (Bi-lingual CINS Family Consultant) attained her 4th certification with Boys Town

Standard 1: Management Accountability

Overview

Narrative

Boys Town of Central Florida, Inc. is under the leadership of a management team that consists of an Executive Director, Senior Director of Program Operations, Psychiatrist, Program Support Coordinator, Clinical Support Coordinator, Shelter Program Director, and IHFS Director. Based on the organization chart reviewed during the visit, the Intervention and Assessment Center, also known as the youth shelter, is staffed by 19 Youth Care Workers (YCW), four of which are on call staff. At the time of the onsite visit there were no youth care positions vacant. There were no significant or major administrative or programmatic changes since the last onsite review and the program has not reported any major challenges, incidents, administrative review, or current external investigation.

Boys Town has a Quality Management Council (QMC) made up of staff from all programs that meets monthly to review data from Monthly Risk Management Reports and monthly scorecards (program, financial, audit and development data). "Red flags" or changes in the number or severity of incidents are identified through the committees' reports and critical success factors are reviewed; whenever necessary, a plan is created to reduce future incidents/risks. The Program Support Coordinator is responsible for compiling and distributing all the data into a "risk management assessment" for the programs to review. The agency uses the Plan, Do, Check, Act (PDCA) model as one of its tools for identifying and monitoring significant issues. Data is reviewed with all staff during monthly team meetings and goals are developed for any priority issues.

The following indicators in standard 1 were rated satisfactory with exceptions for: 1.01 Background Screening, 1.03 – Incident Reporting, 1.04-Training Requirements, and 1.06-Transportation. The exception noted in 1.01 was one 5-yr rescreening that was not conducted during the required timeframe. The exception noted in 1.03 was due to one incident being reported outside of the 2-hour timeframe requirement and 2 incidents could not be verified as being reviewed and signed off on by the supervisor due to missing signature and 1 form missing altogether. The exceptions noted in 1.06 was due to 16 instances where the log had missing information for single transportation of youth or the form did not clearly indicate supervisor approval prior to transportation. Indicator 1.04 resulted in a limited rating which was due to 1 new hire staff missing 1 training within the 120-day requirement, 1 staff missed 2 trainings being completed within the first-year timeframe, and 2 annual staff were missing 5 DJJ SkillPro trainings as part of

the annual requirements. All other indicators were rated satisfactory with no deficiencies.

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Standard 2: Intervention and Case Management

Overview
Rating Narrative

Boys Town provides both residential and non-residential counseling and case management services to youth and families in need of services in Seminole County. The non-residential counseling program is housed in the administrative building on the Boys Town campus. The IHFS non-residential program staff consists of an IHFS director (MSW), an IHFS supervisor (BA degree), three IHFS diversion consultants, two IHFS CINS/FINS consultants, and an Administrative Assistant. The agency also has a licensed mental health counselor (LMHC) coordinator as well as a LMHC clinical support specialist to provide licensed supervision. Out of the six consultants, one of the CINS/FINS consultants has a master's degree and the remaining five are bachelor's level. None of the counseling positions were vacant at the time of the review.

Boys Town non-residential program does not offer Intensive Case Management (ICM) and Stop Now and Plan (SNAP) services. SNAP services are provided by the local Seminole County Sheriff office. At the time of the review the program had not provided any staff secure, domestic minor sex trafficking, or Family and Youth Respite Aftercare (FYRAC) services. However, the program has provided domestic violence and probation respite services.

The agency is currently maintaining paper files but youth records are maintained in a neat and orderly manner and needs assessments are typed.

All indicators in standard two were rated satisfactory with the exception of indicators 2.08-SOGIE and 2.09-Special Populations. The exception in 2.08 was due to 6 of the 11 applicable new staff not having documentation to support knowledge of Florida Network 5.08 policy for SOGIE. The exception in 2.09 was a result of data entry into Netmis within 72 hours of discharge not being completed on time for 2 DV youth. Also, no JJIS data entry was made for 1 youth who did not have a prior JJIS record and CINS/FINS staff did not create the JJIS record. All other indicators in standard two were rated satisfactory with no deficiencies.

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Standard 3: Shelter Care

Overview

Rating Narrative

Boys Town provides both residential and non-residential services to dependency, status offenders and other youth and families in need of services in Seminole County. The shelter program is operated around three shifts and is staffed by a program director, 2 youth care supervisors, and 19 YCW staff. Additional support staff include: a certified county teacher, an administrative assistant and part time RN nurse. The Boys Town shelter is licensed by DCF for eighteen beds and is located on a large, attractive campus in Oviedo, FL which is located Northeast of Orlando in Seminole County, Central Florida.

The program has adequate space for all indoor and outdoor activities and is equipped with two separate wings for males and females. These areas are separated by a large dining area, conference room, kitchen, and classroom. There is also a "boy's lounge" and a girl's "dream room" for activities, social interaction, and relaxation. The dormitories, kitchen, restrooms, classroom, and common areas were observed to be clean during the visit. Each bedroom is furnished with two or three beds with separate pillows and bed covering, dressers, and closets for youth belongings. Youth have access to a large yard for outdoor activities. During the tour, beautiful inspirational and artistic wall posters and pictures adorned the walls of the facility. At the time of the review there were no CINS/FINS youth in the shelter.

The agency uses the nationally recognized "Boys Town Model" behavior management system consistent with all Boys Town programs across the Country. The strategies and techniques of the Boys Town model are designed to help youth grow and learn, especially in the area of social interaction. There are five competencies for social and emotional learning that frame the social skills curriculum: self-awareness, self-management, social awareness, relationship skills and responsible decision making.

All indicators in standard three were rated satisfactory with the exception of indicator 3.04-Log Book that received a limited rating. The limited rating is a result of consistent deficiencies in the logbooks with staff writing the time and the date per entry, documentation of some entries which appeared to be pre-populated, failure to document the youth's name as required, and frequently not recording errors with a single line, "void" written in error, and signed and date by staff making the correction. Some errors were scribbled out with initials and no date; others had only a line through it without "void" written.

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Standard 4: Mental Health/Health Services

Overview
Rating Narrative

The residential counseling services in the shelter are overseen by the clinical support coordinator who is a Licensed Mental Health Counselor. There are designated trained youth care workers complete screening, CINS/FINS Intake, and child ecological and bio-social assessment. All Boys Town direct care staff members employed at the Intervention and Assessment Center are trained on the suicide risk screening process and utilize the CINS Intake form to initially screen for potential risks prior to placing all youth on sight and sound supervision status. The agency's direct care staff members also have access to two (2) licensed clinicians and a contracted psychiatrist on an as needed basis.

At the time of the QI review, the provider had a licensed part time registered nurse (RN) who was hired three months prior to provide services on-site. The agency has a list of the duties assigned to the registered nurse including: 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.

During the tour of the facility, medications were observed to be stored in a locked room in their own separate containers in a specific drawer in the Pyxis Med Station 4000. All medications including injectables are stored in separate containers in 1 of 5 possible drawers in Med Station. Topical and/or injectable 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 Boys Town of Central Florida has screening systems and processes to detect general health and mental health risks presented by prospective youth. This process requires that each youth that meets CINS/FINS eligibility requirements be screened by staff members for the severity of potential health and mental health issues. The agency also utilizes the SPS Suicide Risk Assessment instrument that is conducted on youth that indicate a positive on the CINS Intake form. Boys Town also operates a Behavioral Health Clinic that offers a wide range of outpatient services for children of all ages. Individual therapy, family therapy and psychological evaluations are available for children and young adults (up to age 22) who are experiencing any of a wide variety of problems, including ADHD, school difficulties, emotional issues, and noncompliance and relationship concerns.

All indicators in standard four were rated satisfactory with the exception of 4.02-Suicide Prevention and 4.03- Medications. The exception noted in 4.02 was due to the provider's policy not stating the correct time frame for the assessment of suicide risk to

be completed between Friday evening and Monday morning and does not have a time frame regarding the observation during one-to-one or constant supervision, as well as what documentation should be included in the observation documents. In addition, some of the thirty minute precautionary checks were not documented in the logbook in the four files reviewed for youth on constant sight and sound. A limited rating was applied to 4.03 as a result of several issues identified during the review with regards to the following: staff not consistently signing the bottom of the medication log when giving medications; the current policy does not require shift to shift count to be verified by a witness as required by the indicator and there isn't always a witness to verify shift-to-shift counts for controlled substances; missing documentation in the file regarding why youth on ibuprofen was receiving the medication; missing perpetual inventories; maintaining extra prescribed medications in other storage area outside of the Pyxis Med Station and not maintaining an inventory on these medication; no documentation of monthly reviews of medication management via Knowledge Portal; and having 2 staff distribute medication with no evidence of medication training.

STANDARD 1: MANAGEMENT ACCOUNTABILITY

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) IAP 19 - Background Checks and Re-Screenings was last reviewed and signed by the executive director (ED) on January 21, 2019.	No exceptions
RATING	☐	☒	☐	☐	☐	A total of fourteen (14) background screening files were reviewed for twelve (12) new staff and two (2) 5-year re-screened staff. The program did not have any volunteers who met the criteria for background screening during the QI visit. All twelve (12) new employees were background screened prior to hire date with eligibility documented through the Background Screening Clearinghouse. Two of the program staff met the criteria for 5-year re-screening. One of the two staff was re-screened by DJJ prior to the 5-year anniversary. The program has a signed and notarized Annual Affidavit of Compliance with Level 2 Screening Standards that was complete and notarized on January 8, 2019 and sent to the Background Screening Unit on January 22, 2019, prior to the January 31st deadline. Boys Town uses the Hiring Manager Interview (HMI) pre-assessment tool to determine eligibility rating for employment. The selection process for hiring employees is designed to ensure safety for clients in compliance with Federal and State statutes and regulations. An eligible pass rate for a youth care worker is a minimum of 26 and 24 for an In Home Consultant. All ten applicable new staff were screened using the HMI prior to hire with evidence of pass rates greater than 24.	**Exception** One of two eligible 5-yr rescreening's was not conducted during the required timeframe. The DJJ 5-year re-screening was not completed for the past two 5-year anniversary periods for one of eligible employee (DOH 8/01/04). The last 5-year re-screening on file is for August 2009. Upon notification, the business manager submitted the 5-year re-screening request to DJJ BSU; an eligibility determination date of 10/11/2019 was obtained and provided to the reviewer.

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain: Deficiency Identified	Rating: Explain: No Eligible Items For Review	Rating: Explain: No Practice	Rating: Explain: 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)
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 agency has the following policies to meet this indicator: • Client Contact and Communication, IAP55 approved by the ED 9/30/19 • Websites and Social Media, # 13025, reviewed on 9/17/18 but not signed by ED • Code of Ethics and Professional Conduct, # 13275, reviewed on 10/8/18 but not signed by ED • Standards of conduct for Program Staff, IAP 31, reviewed, approved and signed by ED 1/21/19. • Recreational and cultural enrichment activities, IAP 23, reviewed, approved and signed by ED 1/21/19. • Grievance, IAP 22 which was revised 9/30/19 and approved and signed by ED 10/2/19. All policies meet the requirements for the indicator except for one item that was discussed with program leadership.	**Exception** The program policy missed language specifying that 'physical abuse' is prohibited and that 'youth are not deprived of basic needs, such as food, clothing, shelter, medical care and security'.
RATING	☒	☐	☐	☐	☐	The program displays hanging folders with blank 'grievance forms' for the youth to have access to complete and there is a locked box in the dining room/ common area. Direct care workers do not handle the grievances and all resolved grievances remain with the youth's file. Reviewed 7 grievances for the month of September, 1 for June, and 3 for April. The total of 11 grievances ranged from grievances against another youth, grievances related to concerns related to staff, space and environment, a lost item, and miscommunication or misunderstandings between youth receiving discipline for behavior. 2 reports were towards a particular staff and they were investigated by the program supervisor reviewing the camera the following day. Additionally, no concerns were noted when cameras were reviewed onsite during 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 of another peer. All grievances except 1 were reviewed and followed up within the 72 hour timeframe requirement. The grievance was related to points and it was dated 2/4/19 but signed off on by both youth and administrator on 4/2/19. The administrator noted follow up regarding the inquiry when staff returned on 4/5/19 so it is unclear if the initial date was a typo. During a walkthrough of the shelter, it was observed that signage was posted throughout to reflect all youth are welcome. The program has a process in place to document child abuse calls on the 'incident report' forms and the 'child abuse' forms.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☐ YES ☒ NO (explain) Incident Reporting and Risk Management Reporting policy I&A Protocol 21 was last reviewed and signed by the ED January 21, 2019. Additional supplemental policies to support this indicator are as follows: Child Abuse/Neglect Reporting, policy # IAP Protocol 24, last revised and signed by ED January 20, 2017; Reporting Abuse and Neglect, policy# 9150, last reviewed July 23, 2018 but was not signed by the ED; and In-home Family Services and Intervention and Assessment Services Procedures, policy #9525, last reviewed on September 28, 2015 but not signed by the ED.	**Exception** I&A Protocol 21 does not specifically address completing follow-up communication and tasks required by the CCC; however, program provided a copy of a DJJ document 'FAQ' that includes this information.
RATING	☐	☒	☐	☐	☐	10 out of 11 incidents were reported to the CCC within the required 2-hour timeframe. The program log indicates when some incidents occur with youth but don't always specify the youth's name and indicate when CCC is called. 1 out of 11 incidents reviewed did require communication and follow up. The program completed follow-up as required by the CCC. Incidents are not consistently documented in program log with youth's name, time and dates the CCC report is made or notated as to when the youth is taken off campus but this information was included in the	**Exceptions** 1 incident was reported late notifying the CCC outside of the 2-hour timeframe as required per policy by approximately 1 hour. The program log did not evidence when the youth was taken offsite to hospital, however, they documented when youth returned.

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain: Deficiency Identified	Rating: Explain: No Eligible Items For Review	Rating: Explain: No Practice	Rating: Explain: 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)
						incident reporting form. Example: Incident on 6/2/19 had a completed form and documented when the youth reported passing out in the shower at 7:45pm and supervisor, PD, and family was notified at 8:45pm via phone. Staff had to transport youth to hospital at 9:15pm and the program logbook documented when they returned to shelter at 11:55pm but staff did not document when youth was originally taken to hospital or highlighted as a medical concern. CCC was notified at 12:25am. Incidents are documented on the agency's 'CCC Call Incident Report' form and allows for the staff completing the form to indicate the type of incident, youth's name, date and time of incident, date and time CCC was called, staff that reported the incident, if the incident was accepted by CCC and the case number assigned. Additionally, the form includes the option to explain the reason when a CCC report was not accepted. 9 out of 11 incident report forms indicated that the incident was reviewed and signed by a program supervisor or director.	It was observed that 2 incidents were missing evidence of supervisor review and signature on incident reporting form. 1 signature was unable to be verified due to the signature page of the incident report missing. 1 incident form was missing the evidence of supervisor signature.
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 program has a policy titled, Training Requirements, policy # IAP 37, and the policy was reviewed January 21, 2019 and approved by the ED. The policy meets the indicator requirements.	It was noted that the training course 'cultural humility' is not listed in its policy but the policy does require 'Diversity' in its policy, which is the training equivalent for this program.
RATING	☐	☒	☐	☐	☐	The agency has an annual training plan that captures all required trainings for new hire staff, annual training, part-time staff, and non-licensed clinical staff. Each staff member has their own individual training file and includes an individual 'transcript report' for all staff.	**Exceptions** 3 new staff did not meet the full training hour requirement for suicide prevention of 2 hours. The training course titled 'Suicide Identification and Prevention' PSW-0032 only provides 1.5 hours.

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		
						This electronic transcript report captures all completed training and their applicable training hours. The agency has a robust orientation that takes place over a 2-week period at the corporate headquarters in Nebraska that provides training for all new hire staff and additional training for staff that are promoted into new leadership positions. 2 out of 3 staff files reviewed for new hire requirements met all of the 120-hour training requirements except for the 'suicide prevention' training course that was completed but not meet the 2 hours requirement. However, the agency provided curriculum that addresses suicide facts/myths, behavior warning signs, suicide identification and guidance for staff on how to address potential threats and concerns. 3 out 3 staff have achieved over the 80-hour training requirement and range in trainings hours from 109 hours, 112.25 hours and 119.75 hours at the time of review. 3 staff files were reviewed for training during the 1st year. 2 out of 3 staff completed most of their 1st year requirements well within the timeframe required. 1 staff was missing fire safety but still has 3 months to complete this. 1 out of 3 annual staff files reviewed contained all annual training requirements were met within the required timeframes. All 3 staff had training hours that exceeded the annual 40-hour requirement. 1 staff had exceeded the required training hours and had 90.75 hours, the other staff had 71.25 hours and 64 hours of training. There were no non-licensed mental health clinical shelter staff files that met the requirement for review at this time. The agency provided correspondence sent on October 1, 2019 requesting trainings that are past due and an internal 'QMC Action	1 new hire training file reflected that staff completed the 'confidentiality' training after the required timeframe. 1 staff lacked evidence that 2 trainings were completed within the 1st year as required: Fire Safety Equipment and Cultural Humility. 2 out of 3 annual staff files reviewed were each missing 5 trainings for DJJ Skill Pro that are required: Suicide Prevention Part 1, Suicide Prevention Part 2, Prison Rape Elimination Act, Sexual Harassment and Human Trafficking.

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)
						Plan' to address staff out of compliance with training requirements and will be reviewed on 1/31/20 that is currently pending ED approval. This plan includes staff completing training on time, staff resolving compliance prompts that alert staff of any areas of non-compliance, and site leaders prioritizing training and supervising staff compliance.	
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) Program has two policies in place: 1) protocol 16, (IAP 53) – Data Collection, last revised 9/25/2019 and signed by ED 9/30/2019, and 2) protocol 6, (IAP 41) for Risk Management that was last reviewed, signed and dated by the Executive Director on 01/02/18.	No exceptions
RATING	☒	☐	☐	☐	☐	Boys Town has a Quality Management Council (QMC) made up of staff from all programs that meets monthly to review data from Monthly Risk Management Reports. The committee reviews the monthly scorecard (program, financial, audit and development data) and data from the various committees involved in the risk management process namely: Safety and Health; Staff and Program Requirements; Youth and Family Records Review; and Service Review. "Red Flags" –identified through the committee, reports, or critical success factors are reviewed and a plan is created to reduce future incidents/risks. The Program Support Coordinator is responsible for compiling all the data into a "risk management assessment" for distribution to the Program Directors for review. The agency uses the Plan, Do, Check, Act (PDCA) model as one of its tools for identifying and monitoring significant issues. Peer record reviews are conducted for the residential and non-residential CINS/FINS programs separately on a quarterly basis by the record review committee. Peer record reviews were conducted quarterly by the Youth and Family Records Review and Service Review committee members for the 3rd and 4th quarter of FY 2018-	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		
						2019 as follows: I&A program: March 2019 (5 files) and June 2019 (6 files); and for the IHFS program: February 2019 (5 files) and May 2019 (5 files). Record reviews for the 1st quarter FY2019-2020 were underway during the QI visit. Detailed reports of the case record reviews are included on the agenda for the QMC meeting including significant findings, data analysis, and report summary/recommendations. Risk management meeting minutes for the months of April- August 2019 reviewed demonstrate activities and meetings held regarding: compliance with licensing; abuse calls reported; grievances; safety holds; incidents/accidents; and medication errors. The Safety Committee conducts monthly analysis of the data and submits the necessary documentation to the QMC for discussion. Data is submitted to the Program Support Coordinator for compilation on a Risk Management Review report monthly. Consumer Satisfaction Surveys are completed a variety of ways: directly by CINS/FINS youth upon discharge; coordinated by the Compliance Specialist once per month with active youth in the residential programs; and by the Home Campus in Nebraska. Survey results are compiled monthly for the shelter and non-residential clients separately. A review of the monthly surveys completed by a total of 55 respondents in the I&A program during the past 6 months was conducted. Areas of concerns are identified and followed up with the program managers. Evidence of discussion of the results of the surveys at the monthly QMC meetings is documented on the agendas. Outcomes data for the program is monitored in a variety of ways and were observed to be included on the agency's Scorecard, Program Alignment Plans, and documentation of outcomes through client follow ups. Program outcomes are included on the monthly QMC meeting agenda and are discussed accordingly. The program support coordinator identifies issues that need to be addressed at these	

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		
						meetings and implements the PDCA process as needed. A copy of the 2019 Balanced Scorecard was reviewed that addresses specific areas, comparing current results with actual planned/expected and change in outcome as compared to the prior two years. NETMIS data is reviewed on a monthly basis by the program directors who correspond mainly via email to communicate areas of performance met/ deficient. Email documentation was reviewed demonstrating review and communication of the NETMIS data and a copy of the CINS/FINS Contract Performance report for 7/1/2019-8/31/2019 was provided to the reviewer for examination. Discrepancies and deficiencies are communicated verbally to the program directors during QMC meetings. In Home Family Services monthly staff meeting minutes was up to date with documentation of QM aggregated data being discussed with detailed action plans of any needed areas of improvements or changes needed from analysis. The Intervention and Assessment program conducted staff meetings for 7 out of the past 10 months; the agenda items were mostly related to shelter issues such as incidents, medication, monitoring youth, and occupancy. Data entered into JJIS and NETMIS will be reviewed, compared, and assessed with contract compliance outputs, outcomes, and target populations. Boys Town will conduct a diligent search prior to data entry to avoid duplication of records and to avoid errors, JJIS and NETMIS face sheets will be printed and compared for accuracy. Data issues will be reviewed at internal CINS/FINS meetings and if necessary by Boys Town QMC.	
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)	**Exception**

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 agency has a policy titled, Vehicle Maintenance, Use and Transportation of Youth, Policy # IAP Protocol 10, CINS FINS Protocol 2 that was approved by the ED on 1/21/19. The policy meets the indicator requirements.	The policy indicates they will strive to have a third party as a best practice but does not include language that states they 'prohibit transporting a client without maintaining at least 1 other passenger in the vehicle' as required per Florida Network policy. It was observed that the policy does not include specific language that the approved agency drivers are documented as having a 'Florida's driver's license'; however, it does include that they will be covered the agency insurance policy as required.
RATING	☐	☒	☐	☐	☐	The agency has a policy that indicates that all staff must successfully complete an 'Adult Driving Review' prior to transporting any youth and/or family member. There is an approved driver list that is maintained by the Program Director and it was verified they are covered under the company insurance policy. The program director considers a clients' history, evaluation and recent behavior if a 3rd party cannot be obtained for transport. The 3rd party would be an approved volunteer, intern agency staff, or other youth. It was observed that the program is using 2 different vehicle logs. The 'blue van' log includes date, time out, time in, staff name, mileage out, mileage in, gas level, # of youth present, business reason/destination, and supervisor approval with no clear indication of when the supervisor approved any single transports. The 'client transportation' log includes date, time, driver's name, number of passengers, start mileage, end mileage, purpose of travel, location, supervisor approval, and time of approval. The form doesn't clarify the return time back to the program and number of passengers. However, the program director (PD) explained that they enter all 'incidents' for youth in their internal	**Exceptions** There were several inconsistencies with completion of all sections of the transportation logs for the past 6 months of logs reviewed. The forms had incomplete or blank information for the following: number of passengers, documentation of drivers' name/initials, mileage, list purpose as 'outing' without more specific information, and/or location. There were 13 instances of single youth transport on the 'blue van' log that indicated the supervisor initialed that they approved the transport but there was no way to verify the approval occurred prior to transport due to the missing column for 'time of approval'. There were 3 instances on the 'client transportation' form that were blank for 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		
						system, which is entered for all youth leaving and returning to the facility that would capture this information. It was unclear which forms were the most recent being used by the agency but during interview with the Director it was advised they revised the form to include time out and time in and was aware the time of 'supervisor approval' would need to be added to the form if the 'blue van' log forms. The forms that do include 'time of approval' do not always indicate the time approval was given in AM or PM on all entries.	supervisor time of approval or the log indicated the approval was after the time the transportation occurred.
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 agency has a policy Interagency Agreements and Outreach Services, policy # IAP 49, last reviewed and approved by ED on January 21, 2019. The policy meets the requirements for this indicator.	No exceptions.
RATING	☒	☐	☐	☐	☐	The agency maintains a binder to house Advisory Board Meeting Minutes and verification of attendance. There was evidence reviewed to verify attendance at the DJJ Circuit and Advisory Board and Council Meeting and minutes for the months of June and April. The agency also provided email correspondence to request the meeting minutes for the month of August where the agency held a presentation. The agency maintains a list of Interagency Agreements including 30 different agencies that include a vast range of service provisions that prevention, early intervention programs, medical, educational, mental and/or substance abuse, and recreational and leisure.	No exceptions.

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) Screening Eligibility and Intake Assessment policy has been identified as Central Florida Practice CF I-16, with an approval/update date of 1/21/19 and signed by the ED.	No exceptions
RATING	☒	☐	☐	☐	☐	Five nonresidential files were reviewed; 4 files were closed and 1 was a currently opened file. All screenings were completed within seven (7) calendar days, all available service options were signed and identified as, the Boys Town Central Florida- Seminole County Quick Referral List. All rights and Responsibilities were acknowledged by signing the Consent for Services form indicating the clients Rights and Responsibility has been given to youth/family at time of admission. Each file indicated on the Table of Contents-CINS/FINS checklist section that all parents were given the Parent /Guardian Brochure by receipt of the Parent Handbook. The files also included the Families' and Children Rights and Responsibilities which provide the grievance procedure. Five residential closed files were also reviewed. Each file had a screening completed within 7 calendar days, available service options, right and responsibilities of youth and parents, parent and guardian brochure, possible actions occurring through involvement through CINS/FINS services-CINS petition/CINS adjudication, and grievance procedures were all signed upon admission by signing the Intervention and Assessment Placement Agreement, and the Fire Drill and Emergency Evacuation/Personal Articles/Orientation Procedures	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)
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) Needs Assessment policy is identified as IHFS Protocol I-17, with an approval date of 1/21/19 and signed by the ED.	No exceptions
RATING	☒	☐	☐	☐	☐	Five nonresidential files were reviewed; 4 files were closed and 1 was a current/open file. Five residential closed files were also reviewed. All residential files had an assessment which was identifiable and completed within 72 hours of admission. Each nonresidential needs assessment was completed within 2-3 face-to face contacts following the initial intake. All assessments were completed by a Bachelor's or Master's level staff, and the supervisor reviewed and signed all needs assessments. Youth who were identified as having an elevated risk of suicide based on their assessment were referred for an assessment of suicide risk to be conducted by or under the direct supervisor of a Licensed Mental Health Professional. It was observed that although the assessments were signed by the staff who conducted the assessment, the supervisor's signatures appeared to be signed in the range of 15 days, more than 30days, and at times more than 60 days after the initial assessment had been completed. After a detailed conversation with the supervisor, it was determined that the supervisor is conducting frequent consultation with the clinical staff.	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) Service Plans, Implementation, Review, and Revision policy has been identified as FFBH Policy CINS/FINS I-10/ IAP Protocol 38 with an approval/update date of 1/21/19 and signed by the ED.	No exceptions

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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	☒	☐	☐	☐	☐	Five nonresidential files were reviewed; 4 files were closed and 1 was a current/open file. Additionally, five residential closed files were reviewed. All files had a listed Case/Service Plan date, and the case/service plan was developed within the 7 working days of the needs assessment. All service plans had an identified prioritized need and goals identified by the needs assessment. Each service plan did indicate the type, frequency, person responsible, a target date, actual completion dates, signature of supervisor and counselor, and had the service plan/case plan-initiated date. One out of the 5 non-residential files was missing the signature of the youth and parent and indicated the service plan/case plan was mailed to the client. Two of the case/service plans were signed on time by the youth, parent, supervisor, and consultant. Two of the case/service plans were signed late with a note indicating on the service plan/case plan stating, "late due to FC error and consultant oversight."	No exceptions
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) Referrals to Community- Based Services/Youth Based Services policy has been identified as: # 13525 with a review date of 11/12/18 and signed by the ED.	No exceptions
RATING	☒	☐	☐	☐	☐	Five nonresidential files were reviewed; 4 files were closed and 1 was a current/open file. Also, 5 residential closed files were also reviewed. All files had a date of admission, had an assigned case manager, established referral needs, coordinated referrals for service, monitored youth/family progress in services, provided support for families, monitors out of home placement, refer to case staffing to address problem needs of the youth and families, accompanied	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		
						youth/ parent to court hearing and related appointments, referred the youth/family for additional services, provided case termination notes when appropriate or providing case monitoring and reviews court orders. Three of the 5 closed residential files reviewed had documentation to support 60 day follow ups were completed post case termination. Five out of the 5 nonresidential files had 30 day and 60 day follow ups.	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) Crisis Intervention Counseling and Access to Mental Health Services policy has been identified as IAP Protocol 4 with a review date of 1/21/19 and was signed by the ED.	No exceptions
RATING	☒	☐	☐	☐	☐	Five nonresidential files were reviewed; 4 files were closed and 1 was a current/open file. Five closed residential files were also reviewed. All files have an assessment, initial case/service plan, case service plan reviews, case management and follow up, case notes were maintained for all counseling services and documented youths' progress. The supervisor has an ongoing internal process that ensures clinical reviews of case records and staff performance. Youth and families can receive counseling service in accordance with their case/service plan, and thee program provides individual/family counseling. There were groups offered at least 5 days a week in the boys' residence; however, the girl's residence did not have a consistent group for 5 days a week. The group notes do indicate the group facilitator, relevant topics, youth participant, and duration of at least 30 mins.	No exceptions
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain)	No exceptions

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)
						The agency has a written policy and procedure for Case Staffing Committee/Central Florida policy with an effective date of 4/2/18.	
RATING	☒	☐	☐	☐	☐	The program has not had any case staffing since the last QI visit; however, the program has an established case staffing committee and has regular communication with the committee members as well as an internal procedure for the case staffing process, including a schedule for committee meetings.	No exceptions
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) Youth Record Contents policy has been identified as IAP Protocol 27 with a review date of 9/25/2019 and signed by ED.	No exceptions
RATING	☒	☐	☐	☐	☐	All nonresidential: records were marked confidential in the file cabinets. The cabinet was marked as confidential and all files were in a neat and orderly manner. When files are in transport they are placed in an opaque locked container that is marked confidential. Residential records were kept in a locked room; however, not all file cabinets were individually marked as confidential at the time of the review.	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) Sexual Orientation, Gender Identity, and Gender Expression policy IAP 54 was last revised on September 25, 2019 and signed by the ED.	No exceptions
RATING	☐	☒	☐	☐	☐	During a tour of the facility, “hate free zone” rainbow stickers were posted throughout the facility in all common areas including youth lounge, a poster board in the dormitories, and dining room, signifying youth are welcome and should feel safe regardless of sexual orientation, gender identity, and gender expression. The program also has printed material entitled I Deserve Respect, Support, and Safety	**Exception** 6 of the 11 applicable new staff did not have documentation to support knowledge of Florida Network 5.08 policy for SOGIE.

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		
						available for youth in staff offices. A binder is maintained in the shelter that contains the FN policy # 5.08 and a volunteer/visitor log indicating review and acknowledgement of the policy. Five of the eleven new staff were verified as receiving training in Florida Network policy #5.08. The program has not served any youth during the annual review period who met the criteria for the indicator. However, staff interviewed during the visit supported the agency's policy to treat youth with respect and ensure youth are addressed by pronouns, name, and gender they prefer and room assignment is made accordingly.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☒ YES ☐ NO (explain) Staff Secure and Special Populations policy IAP 26 and CINS/FINS Protocol 15 addressing Family and Youth Respite Aftercare Services (FYRAC) were last revised on January 21, 2019 and signed by the ED.	No exceptions
RATING	☐	☒	☐	☐	☐	Two applicable closed Domestic Violence Respite files were reviewed. Both files had a pending DV charge, were screened by the JAC, and did not meet criteria for secure detention. The length of stay did not exceed 21 days; case plans reflected goals that were appropriate such as aggression management, coping skills, etc. It was not necessary to transition the youth from DV Respite to CINS/FINS since the length of stay did not exceed 21 days. All other services provided to DV youth are consisted with the general CINS/FINS program service requirement. There were no Staff Secure, DMST, Probation Respite, or FYRAC clients served during this period but the agency does have appropriate policies and procedures in place regarding these special populations. Boys Town is not contracted to provide intensive case management services.	**Exception** Intake data entry into Netmis was verified for 2 DV youth within 24 hours. However, the data entry within 72 hours of discharge was not documented. No JJIS data entry was made for 1 youth. The youth was on civil citation and did not have a prior JJIS. However, CINS/FINS staff did not create a JJIS record.

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		
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)	Boys Town is not a SNAP provider.
RATING	☐	☐	☐	☐	☒	**N/A** Boys Town is not contracted to provide SNAP services.	**N/A**

STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain – Deficiency Identified	Rating: Explain – No Eligible Items For Review	Rating: Explain – No Practice	Rating: Explain – 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 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 agency has multiple policies that govern the provision of a safe shelter environment as follows: IAP 52, Shelter Services, approved by ED 8/15/18; IAP 14, Safety Inspection, approved by ED 5/31/18; IAP 9, Control & Use of Keys, approved by ED 5/31/18; IAP10, Vehicle Maintenance, Use and Transportation of Youth, approved by ED 8/13/18; IAP 20, flammable, Poisonous, and Toxic Control, approved by ED 1/2/18; IAP 32, Fire Drills, approved by ED 1/2/18; IAP 17, Fire Prevention, approved by ED 5/31/18; and IAP 23, Recreational and Cultural Enrichment Activities, approved by ED 1/2/18.	No exceptions
RATING	☒	☐	☐	☐	☐	**Facility and Site Inspection:** The shelter environment is safe, clean, neat and well maintained, with a few wear and tears in the furnishing. There's no graffiti on the walls, lighting was adequate, and garbage can(s) were covered. All doors in the facility were secured and access was limited to staff members with key control. Agency vehicles were locked and equipped with major safety equipment such as first aid kit, fire extinguisher, flashlight, glass breaker, seat belt cutter and air bag deflator. A visible sight of a detailed map and egress plans of the facility, as well as general client rules, grievance forms, and abuse hotline information was located on bulletin boards on boys and girls wing. Interior areas were clear of contraband, all chemicals that were listed were approved for use, and washers/dryers were operational. All 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		
						have their own bed with clean covered mattress, pillow, and linens. Agency had current DCF Child Care License displayed. **Fire Safety and Health Hazards** Annual fire inspection was conducted 09/27/19. Fire inspection indicated a few violations for the admin and shelter, which the fire inspector has given the facility 30 days to bring up to compliance, such as: update business and tax receipts; copy of state license; repair light under hood; fix switch for fan; repair light fixture at front entrance; fix tag on fire extinguisher on girls wing; secure fire extinguisher on girls wing; and keep pathway clear. Agency completes 1 fire drill per month within 2 minutes or less, and 1 mock emergency drill per shift per quarter. Agency has a current satisfactory Residential Group Care Inspection on 10/02/19, with a maintenance violation: girls' laundry room floor damaged; replace cut vinyl tiles; tighten loosen faucet in boys' hall; and repair vanities in girls' restrooms. Agency has a current satisfactory Food Service inspection report from the Department of Health. All food was properly stored, marked and labeled and dry storage/pantry area is cleaned. Refrigerators/freezers are cleaned and maintained at required temperatures. **Youth Engagement** Youth are engaged in meaningful structured programs and/or activities 7 days a week. At least 1 hour of physical activity is provided daily. Youth are provided the opportunity to participate in faith based activities. Daily programming includes homework, age appropriated programs books for reading and quiet time to read. Daily programs are accessible and publicly posted and accessible to both staff and youth.	
3.02: Program Orientation							

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		
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) Program Orientation and Classification policies have been identified as IAP Protocol 2 and IAP Protocol 42, respectively. The policies were last reviewed and approved by the ED on 01/21/19.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of 3 closed residential files were reviewed as the program did not have any current open/active CINS/FINS youth. All files reviewed demonstrated youth receiving a comprehensive orientation and handbook provided within 24 hours. Two (2) of three (3) of the residential files had clear suicide prevention alert notifications. All files that were reviewed demonstrated all program orientation requirements as outlined in the CINS/FINS policy manual. Signatures of youth with parent/guardian were obtained, daily activities were reviewed and the Abuse Hotline number was provided.	No exceptions
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) Classification policy has been identified as IAP Protocol 42. The policy was last reviewed and approved by the ED on 01/21/19.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of 3 closed residential files were reviewed. The program demonstrates the goal to protect youth through a classification system that ensures the most appropriate sleeping room assignment. Also, other classifications as outlined in the CINS/FINS standards has been demonstrated.	No exceptions
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) A logbook policy has been identified as IAP Protocol 11. The policy was last reviewed and approved by the ED on 01/21/19.	No exceptions

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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	☐	☒	☐	☐	☐	The agency uses a permanent, bound, log book to document daily activities, events, and other major occurrences with the youth and staff. It has been documented that all safety and security issues that could impact the youth and/or program are highlighted, brief, and legibly written in ink. Per the agency police, all entries should include: date and time of incident/activity/events; name of youth and staff involved and staff; brief statements providing pertinent information; and name and signature of person making the entry. However, the agency has a lot of inconsistencies with this task, along with all recording errors not being struck through with a single line with staff initial and date. The use of whiteout was prohibited. The supervisory staff reviews the logbook for the previous shifts; however, there's no evidence of the shifts reviewed because the supervisory entry does not include the dates reviewed. All direct care staff coming onto shift should review the logbook from the previous two shifts and include dates reviewed. Throughout the log book staff are not putting the date next to their log book entries, nor are they being consistent with highlighting their entries. The program director reviews the logbook every week, however the director does not record dates chronologically indicating date(s) that were reviewed. All supervision and resident count were documented, as well as visitation and home visits.	**Exception** Florida Network policy indicates that all entries should include, date and time of incident/activity/events, name of youth and staff involved and staff brief statements providing pertinent information, and name and signature of person making the entry. There were a lot of inconsistencies with staff writing the time and the date per entry. Also, real time entries were questionable as some entries appeared to be pre-populated. Throughout the logbook it has been reviewed that the youth's name isn't consistently written. Some staff will state the youth's name(s), other staff will put "youth". Per agency policy it indicates that all recording errors are struck through with a single line, "void" written in error, and signed and date by staff making the correction. The logbook has a lot of errors that were not struck through with a single line, with "void" written. Some errors were scribbled out with initials and no date, others had only a line through it without "void" written.
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) Behavioral Redirection and Safety Holds policy has been identified as IAP Protocol 39 as well as Youth Care Policy #13050, which is an	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain: Deficiency Identified	Rating: Explain: No Eligible Items For Review	Rating: Explain: No Practice	Rating: Explain: 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)
						agency wide policy. The policies were last reviewed and approved by the ED on 01/21/19.	
RATING	☒	☐	☐	☐	☐	The agency has a detailed written description of the BSM and it is explained during program orientation. The written description of the BSM strategies has a wide variety of positive incentives, appropriate interventions used to teach youth new behaviors and help youth understand natural consequences for their action, and behavioral interventions. The agency's BSM includes consequences for violations that's logical and consistent. The agency uses a variety of rewards/incentives. All staff and supervisory staff are trained in the theory of the BSM practice. Staff and supervisory staff engage in the following trainings: motivational system overview and point card mechanics; motivational system practice; observing and describing behaviors; principles of behaviors; and non-crisis intervention. IAP Protocol 39 provides feedback and evaluation of staff regarding their use of positive and negative consequences.	No exceptions
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) Security Youth Counts and Staffing Ratios policy IAP 18 was last reviewed and approved by the ED on 01/21/19.	No exceptions
RATING	☒	☐	☐	☐	☐	The agency has a process in place that ensures adequate safety and security of youth and staff. They agency maintains minimum staffing ratios as required by Florida Administrative Code. All overnight shifts consisted of a minimum of two (2) agency staff; schedule was posted and visible. Located next to the staff schedule is a roster that includes home telephone numbers of staff who may be available when additional coverage is needed. Staff observed youth at least every 15 minutes while they were sleeping in their room. The times were documented in real time; however the video time and times recorded were not the same due to a lag in time of the video system.	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		
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) Video Surveillance agency wide policy has been identified as Youth Care Policy #1395. The policy was effective as of 10/02/17.	No exceptions
RATING	☒	☐	☐	☐	☐	The agency has a system in operation 24 hours a day, 7 days a week communicated by a written notice that is conspicuously posted on the premises for the purpose of security. Cameras are located in the interior and exterior general locations of the shelter. All cameras are visible and no cameras are placed in bathroom or sleeping quarters. The video system can capture and retain video for a minimum of 30 days. System can record date, time and maintain resolution; however the time stated on the video is different from what the staff has written due to a lag in time with the video system. All cameras can operate during a power outage with the generator that's on campus. Supervisor conducts a review of the video recordings a minimum of once every 14 days and there's a process for third party review of videos for quality improvement visits and when investigation is pursued after an allegation of an incident.	No exceptions

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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)** Physical Health Screening policy IAP Protocol 28 was approved by the ED on January 21, 2019 addressing the requirements outlined in the indicator.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has a procedure including a thorough referral process and mechanism for necessary follow-up medical care for youth admitted with chronic medical conditions. Five closed files were reviewed. One youth was not on medication, but the other four were on medications. One youth had a medical condition, two had allergies, and none had recent injuries or illnesses, presence of pain or other physical distress at the time of admission. There was no observation of illness, injury, pain or physical distress. Four youths had scars, tattoos or other skin markings; the other youth did not. Four youths did not have any chronic medical condition, head injury in the previous two weeks, therefore no medical referral was documented, or parental involvement needed. One youth had diabetes, but no medical referral was needed due to it being a prior medical condition with current medication.	No exceptions
4.02 Suicide Prevention **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)**	**Exception** The QI indicator requires the suicide assessment be completed the morning of

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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 program has an At Risk Screening and Assessment policy, IAP Protocol 5, which was signed on January 21, 2019 by the ED addressing some of the requirements outlined in the indicator.	the first business day after the weekend; however, the provider's policy indicates the suicide assessment is to be completed within seventy-two hours of screening which can potentially occur beyond the required time frame. Additionally, the policy does not have a time frame regarding the observation occurring during one-to-one or constant supervision, as well as what documentation should be included in the observation documents.
RATING	☐	☒	☐	☐	☐	Five closed files were reviewed. All five youth received a suicide risk screening during the initial intake and screening process and the results were reviewed and signed by the supervisor and documented in the youths' files. One youth did not have a current risk for suicide but was placed on precautionary monitoring due to history. Four of the five youth were placed on constant sight and sound, the appropriate level of supervision based on the results of the suicide risk assessment. In two of the four files the youth was stepped down to precautionary monitoring by a master's level staff.	**Exceptions** Some of the thirty minute precautionary checks were not documented in the logbook in the four files reviewed for youth on constant sight and sound as follows: • April 25, 2019 the first thirty-minute check and the checks from 6:30 a.m. to 11:15 a.m. • March 12, 2019 -7 p.m. to 10 p.m. and March 13, 2019 - 7:30 a.m., 8 a.m., 12 p.m., 1 p.m., 2 p.m., 3 p.m. to 5 p.m. • May 31, 2019 starting at 4:30 p.m. through June 1, 2019 -7:30 a.m., as well as 8 a.m. to 9 a.m., 11 a.m., 12 p.m., 1 p.m., 2 p.m., 3 p.m. to 9:30 a.m. on June 2, 2019, 10 a.m., 12 p.m., 2 p.m. through 11:30 a.m. on June 3, 2019 • 7/23/19 starting at 6:30 p.m. to 10 p.m. There was no at-risk assessment completed when 2 of the 4 youth were stepped down to precautionary monitoring.

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Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain: Deficiency Identified	Rating: Explain: No Eligible Items For Review	Rating: Explain: No Practice	Rating: Explain: 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)
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☐ **YES** ☒ **NO (explain)** Medication Storage, Access, and Distribution policy and protocol, IAP Protocol 13, was signed on January 21, 2019 by the ED addressing some of the requirements outlined in the indicator. The policy also addressed the program not admitting youth with injectable medications, other than epi-pens. None of the youth reviewed had any injectable medications prescribed.	**Exception** The current policy does not require shift to shift count to be verified by a witness as required by the indicator.
RATING	☐	☒	☐	☐	☐	The program maintains three Super Users for the Med-Station (program director, and two senior youth care workers). The program maintains the youth prescription medications, as well currently used over-the-counter medications all separated in the Pyxis Medication Station in single locked containers which are only able to be opened when an authorized user uses their fingerprint to open the cart for a specific medication to distribute or inventory. The program had a locked medication refrigerator, which was currently empty and is only being used for medications; the temperature was forty degrees Fahrenheit, within the required storage temperature. The program's Pyxis medication cart provides a daily inventory of the over-the counter medications regularly used. When on site, the nurse conducts medication processes. The program conducts daily clearing of medication discrepancies. Five closed files were reviewed. One did not have any medications. The other four youth had medications and a medication distribution log for each medication they received. Two youth had a controlled substance prescribed and one had a perpetual inventory with running balances maintained. In three of the four records, the medications were verified at the time of admission; the other youth was receiving medications not accounted for at the time of admission. In three of the four records the medication delivery process was not consistent with the FNYFS medication management and distribution policy.	**Exceptions** Program staff indicated not everyone signs the bottom of the medication log even when giving medications. Also, when there is not a second person who is allowed to provide medications staff is unable to complete the shift-to-shift counts, since the Pyxis requires two staff fingerprints. Consequently, the morning medication log for Metformin on July 25, 2019 has the youth's initials but no staff/adult or time the youth received the medication. On June 10, 2019 the youth initialed the medication entry, but there was no staff initial. There were no signatures on the bottom of the medication log for the staff providing the medication on May 2019. Some shift-to-shift counts were missing on the medication log for a controlled substance for September 20/21/22/25/26/29 and 30, 2019. Similarly, shift-to-shift counts

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		
							were missing on the medication log for another controlled substance on June 20/22/23/25 and 26, 2019. One youth had a medication log for ibuprofen but there was no documentation in the file regarding why the youth was receiving the medication. The perpetual inventory was missing entries for June 2, 2019, duplicate dates for June 15, 2019, and voided for June 16, 2019. Contrary to the requirement that all medications including over the counter (OTC) controlled and non-controlled belonging to CINS/FINS clients during their shelter stay should be stored in the Pyxis Medication Station, and medication refills are to be stored in the Pyxis on the same cubie or in a separate cubie, the program maintains extra prescribed medications for youth in a double-locked cabinet in the front office, as well as some antacids, anti-itch cream and a pair of scissors with no inventory maintained of these items. The program was unable to state if monthly reviews of medication management report were conducted. There are two staff who initialed the medication logs, but the program was

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		
							unable to verify both staff were trained in medication distribution.
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)** Medic Alert Process and Medical/Mental Health Follow-up policy and protocol, IAP Protocol 3, was signed on January 21, 2019 by the ED addressing the requirements outlined in the indicator.	No exceptions
RATING	☒	☐	☐	☐	☐	Four youth files were reviewed. All four youths had mental health alerts at the time of admission, as well as two allergies. They were appropriately placed on the alert system, which includes precautions concerning prescribed medications, and medical/mental health conditions. The program has an alert board in the shelter's front office and when applicable alerts are documented including other essential information pertaining to the youth. The board is inaccessible to youth in the shelter.	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)** First Aid and Episodic/Emergency Care policy and protocol, IAP Protocol 16, was signed on January 21, 2019 by the ED addressing the requirements outlined in the indicator.	No exceptions
RATING	☒	☐	☐	☐	☐	Three closed files were reviewed. In all three files the youth was taken off-site requiring medical care, and the incident report was submitted. In two files, there was verification of discharge, receipt of instructions and/or medical clearance with no follow-up required; in one the parent/guardian was notified. In one the youth did not return to the program and in the other the youth was taken off-site by the parent/guardian. The program maintains an episodic emergency	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		
						medical and dental log. Staff are trained on emergency medical procedures. The program has three knife for life and wire cutters; one each in the front office, boys' file room and girls' electrical room. The program has five first aid kits with current supplies: one in each van for a total of two, one in the boys' file room, one in the girls' laundry room, and one in the front office.	

Florida Network for Youth and Family Services
Compliance Monitoring Report for

BOYS TOWN

975 Oklahoma Street
Oviedo, FL 32765

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the Boys Town CINS/FINS program for the FY 2019-2020 at its program office located at 975 Oklahoma Street, Oviedo, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Boys Town is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective for July 2019 through June 30, 2020.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewers. Agency representatives from Boys Town present for the entrance interview were: Greg Zbylut, Executive Director, Carmen Rodriguez, Business Manager; Rochelle Davis, Program Support Services Coordinator; Erica Vagle, Program Director (IHFS); Al McCray, Program Director; and Telma Favors, Senior Director of Program Operations; and Administrative Assistants and Jessica Whyte and Mackenzie Rosarius. The last onsite QI visit was conducted December 12, 2018.

In general, the Reviewer found that Boys Town is in compliance with specific contract requirements. **Boys Town received an overall compliance rating of 100% for achieving full compliance with all thirteen (13) indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit.

The following report represents the results of the in-depth evaluation of the provider's General Administrative performance, with all findings clearly documented. Copies of all completed tools utilized during the visit to determine these ratings will be maintained on file with the Reviewer. If any information or clarification is required, please contact Keith Carr by E-mail: keithcarr@forefrontllc.com

2019-2020 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 10-09-2019-2020

Agency Name: Boys Town	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 975 Oklahoma Street, Oviedo, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): October 9-10, 2019**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The provider currently has three (3) certified DJJ-QI Peer Reviewers: Melissa Quinn; Rochelle Davis; and Al McCray. Melissa Quinn and Susan Yang (prior employee) participated in QI Peer Reviews during the past FY.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	The agency maintains a list of 15 additional contracts for FY 2019-2020. The list includes: the company, contract number, contract expiration date, and contact information. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed during the QI visit had current contract/agreement dates.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's	☐	☐	☐	☒	☐	General Liability through Philadelphia Indemnity Insurance Company, for limits of coverage $1,000,000 each	

Agency Name: Boys Town						Monitor Name: Marcia Tavares	
Contract Type : CINS/FINS						Region/Office: 975 Oklahoma Street, Oviedo, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): October 9-10, 2019	
	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						$3,000,000 aggregate, and medical expense for $5,000, effective 9/01/2019 – 9/01/2020. Automobile insurance through Philadelphia Indemnity Insurance company for combined limits of liability/property damage for $1,000,000. Policy effective date 9/01/2019 – 9/01/2020. Workers Compensation through Sentry Casualty Company with limits of $1,000,000 each/aggregate, effective 12/31/2018 – 12/31/2019 Umbrella liability through Philadelphia Indemnity Insurance Company with limits of $25,000,000 each/aggregate, effective 9/01/2019-9/01/2020. E&O – MPL – Primary through Philadelphia Indemnity Insurance Company for Professional Liability of $1,000,000 each and $3,000,000 aggregate, effective through 9/01/2019 – 9/01/2020. Florida Network is listed as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an	☐	☐	☒	☐	☐	During the Entrance Conference, the provider indicated that there are no	

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
external funding source (Fiscal or Non-Fiscal). **ON SITE**						outstanding corrective action item(s) cited by an external funding source.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	The agency maintains Accounting Policies and Procedures in place for: fiscal management, cash, petty cash, support, program service fees, revenue, and receivables, expenses for program and supporting services and accounts payable, payroll and related liabilities, governmental financial assistance programs, property and equipment, debt and other liabilities. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls and review dates are indicated for each procedure.	
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Boys Town provided a detailed General Ledger for accounts 81270 (IHFS) and 81240 (I&A) for the period January 1 – August 31, 2019. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program. It appears that the agency is allocating cost per each program separately from other funding sources. The GL uses a chart	

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Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): October 9-10, 2019	
	Explain Rating						
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						of accounts and each entry includes the type of transaction, date, document number, description, and budget/transaction activity.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Boys Town has procedures for petty cash. Petty cash is stored in a locked box in the Supervisors office. All receipts are submitted for accounting and requesting reimbursement as needed and the fund is reconciled. Reimbursement comes in the form of a check made out to the Program Director who will then cash it and place money in petty cash box. The fund does not exceed $150. In addition to petty cash, Supervisors and 3 of 4 Senior YCWs have purchasing cards.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation and Observation: Bank Statements and Bank Reconciliations were reviewed for the period March-August 2019 for two accounts, depository and disbursement, held with Bank of America. Financial Statements are reported on a monthly basis and were found to be current. Bank reconciliations are conducted within 2-3 weeks of the end of each month for	

Agency Name: Boys Town	Monitor Name: Marcia Tavares
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Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): October 9-10, 2019

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes — Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						the preceding month's activities. Invoices are submitted on a monthly basis with supporting documentation.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Boys Town maintains an inventory list of items purchased with DJJ funds. These items include 3 Surface Pro Laptops purchased in May 2016; inventory numbers are on file for each.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided evidence of payroll taxes being paid to the IRS as reported on 941s submitted for the 1st and 2nd quarters of 2019. The 941s document the amount of payroll taxes that were submitted for Federal and FICA taxes with no balance due.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided budget to actual year-to-date report as of September 13, 2019 for accounts 81240 and 81270. The report shows Actual, Budget, Over/Under, Annual Budget, and Balance Remaining. A review of these documents was conducted. Report shows program budget and variances with YTD net surplus. Variances in budget are monitored on a regular basis and are	

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						discussed with the Board.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending December 31, 2018 and 2017 was completed by KPMG LLP. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor. A letter dated July 3, 2019 stated the agency was in accordance with U.S. generally accepted accounting principles.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Review of the following policies and procedures: Confidentiality and Privacy, Information Management, Storage, Retention, Destruction, and Transfer of Files, Personnel Records and Information, Risk Management and Insurance, Technology Users' Security Responsibilities, Mobile Devices: Use	

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						and Security, and Acceptable Use of Boys Town Technology.	

CONCLUSION

Boys Town has met the requirements for the CINS/FINS contract as a result of full compliance with all thirteen (13) indicators of the Administrative and Fiscal Contract Monitoring Tool. Consequently, t**he overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, all of the indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

If required, the provider must submit a corrective action plan to address corrective actions cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.