Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS Family and Behavioral Health Services, Inc. – Interface Central
Gainesville, Florida

February 5-6, 2020

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Reviewer

Members

Ashley Davies - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services

Renette Crosby – Regional Monitor - Department of Juvenile Justice

Jason Ishley – Non-Residential Clinical Director – Capital City Youth Services

Joe Mabry – Residential Supervisor – Family Resources

Cyntoria Thomas – Program Manager - Thaise

Quality Improvement Review

CDS Family & Behavioral Health Services, Inc. – Interface Central – February 5-6, 2020
Lead Reviewer: Ashley Davies

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
- **NA** # Food Service Personnel
- **1** # Healthcare Staff
- **NA** # Maintenance Personnel
- _____ # 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
- 25 # Personnel /Volunteer Records
- **7** # Training Records
- **5** # Youth Records (Closed)
- 5 # Youth Records (Open)
- _____ # Other: _____

Surveys

- **5** # Youth
- 5 # 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

The program had a successful Summer Enrichment program where two (2) five-week sessions occurred, running for the entire summer. The sessions were designed to ensure that participants are exposed to community, cultural, and leisure/recreational activities that encouraged self-esteem development, cooperation, and exploration through presentations and tours. These activities focused on: enhanced social skill development, employment readiness skills, leadership preparedness skills, exploring the world where they live, and service for and in their community.

Youth participated in awareness field trips that exposed them to community resources, events, and activities. Some of the many field trips included the CADE Museum, University of Florida tours including the football stadium, skyboxes, and behind the scenes athletic areas of the Stephen C. O'Connell Center, the Alachua County Solid Waste and Resource Departments, Santa Fe Teaching Zoo, Marjorie Kinnan Rawlings Park, Veterans Memorial Park, and the Humane Society.

Motivational and educational speakers provided the youth with self-esteem, health, and educational planning information. A few of the speakers included the Alachua County Sheriff, Gainesville Health and Fitness Center exercise professional, Sickle Cell lecturer, Professional Motivational speakers, Recycle/Reuse Staff, staff from Planned Parenthood, and Peaceful Path Domestic Program.

Program led activities included recreational activities, trivia challenges, knowledge is power, cooking, and craft sessions.

Each session ended with a graduation ceremony which included a dinner celebrating with the participant's family and friends as they shared the many experiences and accomplishments made over the summer.

Standard 1: Management Accountability

Overview

CDS Family and Behavioral Health Services, Inc. – Interface Central is managed by a chief executive officer and chief operating officer who oversee a coordinator and residential supervisor. The coordinator and residential supervisor are responsible for the day-to-day operations at the shelter. At the time of the review, there was one and a quarter youth care worker positions vacant. These positions were being covered by part-time and PRN staff until they could be filled. There was also a case manager position vacant in the Stop Now and Plan (SNAP) program; however, an individual had been identified for hire and was scheduled to begin work on the Tuesday following the review. The non-residential program was fully staffed.

The agency is still working on raising money to build a new shelter. The program has been in the current location for thirty-one years. Two of the biggest challenges the program faces at the current location is lack of space and the age of the building.

The program collects and reviews data from various sources on a monthly basis. All data collection is shared and reviewed with management and staff during monthly meetings. Any improvements or corrective actions needed are implemented at this time. The agency also submits a monthly packet to the Board of Directors. The packet includes all outcome data and a review of any incidents that happened at the shelter during that month. The program also provides the Board with a summary of program updates for the month. This packet is reviewed during the monthly Board meeting. Data entry and collection is reviewed monthly during the management team meetings. The Data Department for the agency will print out monthly JJIS and NETMIS reports. These reports are reviewed with all management staff during the meeting to ensure data accuracy.

All indicators in standard one were rated satisfactory with the only exception noted in indicator 1.04 Training Requirements. The exception noted in indicator 1.04 was due to one staff not receiving Serving LGBTQ Youth training and also completing the DJJ Skill Pro Child Abuse Reporting training late. All other indicators in standard two were rated satisfactory with no deficiencies.

Standard 2: Intervention and Case Management

Overview

CDS Family & Behavioral Health Services, Inc. – Interface Central provides residential and non-residential counseling and case management services over three counties, Alachua, Gilchrest, and Levy, across Circuit 8.

The regional coordinator, who is a Licensed Mental Health Counselor (LMHC), oversees both programs. The residential counseling program consists of two master's level counselors.

The non-residential counseling program is housed off-site. The non-residential program consists of six counselors. Out of the six counselors one is a Licensed Mental Health Counselor (LMHC), two are master's level counselors, two are bachelor's level counselors, and one is a Doctor of Philosophy. One of the bachelor's level counselors is also a Licensed Mental Health Counselor Intern.

The non-residential program offers Stop Now and Plan (SNAP) services. SNAP services are provided by a SNAP supervisor and SNAP in Schools lead. The regional coordinator oversees SNAP services. The program has provided staff secure, domestic violence, and probation respite services. The program has not had any examples of Domestic Minor Sex Trafficking or Family and Youth Respite Aftercare Services (FYRAC) youth in the last year. This site also does not provide Intensive Case Management Services. The program is currently maintaining paper files.

All indicators in standard two were rated satisfactory with no exceptions or deficiencies noted.

Standard 3: Shelter Care

Overview

CDS Family & Behavioral Health Services, Inc. – Interface Central residential program is led by a residential supervisor and a senior youth care worker who oversee seventeen youth care workers. The shelter runs three shifts. At the time of the review there was one and a quarter youth care worker positions vacant.

Other than some minor remodeling in the shelter to fit two additional offices for staff, there were no other major upgrades or physical changes to the shelter.

The shelter follows a daily schedule that allows time for school, homework, reading, meals, recreation, and sleeping. The schedule is posted in all common areas throughout the shelter.

The shelter utilizes the FACE System (Facilitating Activity & Communication Effectively) with the intent of increasing youth involvement in the program. Behavioral Expectation forms are reviewed between staff and youth so there is a clear plan designed for each youth to progress. The FACE System is comprised of three phases: Assessment, Daily, and Achievement. The youth are able to maneuver through the phases, gaining privileges based on their compliance with rules and through demonstrating that they are mastering their targeted skills. Youth are provided with an orientation packet at intake explaining in detail the Behavior Management System (FACE).

CDS Family & Behavioral Health Services, Inc. – Interface Central is licensed by the Department of Children and families for twenty beds. The agency serves both CINS/FINS and DCF program participants. At the time of the review the shelter had eight CINS/FINS youth.

All indicators in standard three were rated satisfactory with the only exception noted in indicator 3.06 Staff and Supervision. The exception noted in 3.06 was due to eight instances in the last six months where observations of the youth while sleeping were done beyond the fifteen-minute requirement. All other indicators in standard three were rated satisfactory with no deficiencies.

Standard 4: Mental Health/Health Services

Overview

The residential counseling services in the shelter are overseen by the regional coordinator who is a Licensed Mental Health Counselor (LMHC). Services are provided by two, master's level, residential counselors.

All youth are screened for suicide at intake using the six approved questions on the CINS Intake Assessment form. If youth receive a positive screening they are placed on sight and sound supervision until seen and assessed by a qualified mental health professional. All staff receive training on suicide prevention.

Health services are overseen by a part-time registered nurse (RN). The RN is on-site seven days a week for a total of twenty hours a week. The RN will distribute all medications when on-site and trained youth care workers will distribute medications when the RN is not on-site. The RN provides various trainings for staff, including Medication Administration. All staff are CPR and first aid certified.

All medications in the facility are stored in the Pyxis Med-Station 4000 Medication Cabinet. The shift leader completes a weekly inventory of all medications on-site. Youth care workers complete shift-to-shift inventories of all controlled medications and maintain perpetual inventories of all other medications. The shelter does not maintain any over-the-counter medications.

All indicators in standard four were rated satisfactory with the only exception noted in indicator 4.03 Medications. The exception noted in 4.03 was due to discrepancies not being cleared out by the end of the staff members shift. All other indicators in standard four were rated satisfactory with no deficiencies.

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)** The agency has two policies in place to address background screening requirements, P-1025 Background Check, Reference Check, Fingerprinting for Personnel, Volunteers, or Interns, and P-1285 Pre-employment Suitability Assessment. The policies were last reviewed on January 23, 2020 by the Chief Operations Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were thirteen new staff hired since the last on-site Quality Improvement review. All thirteen staff documented a background screening, with an eligible rating, was completed prior to the staff's hire date. All five applicable staff also documented a pre-employment suitability assessment, using the Criteria assessment, was completed prior to being hired and documented a favorable rating. All thirteen staff documented proof of E-Verify obtained from Department of Homeland Security.	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		
						There was one five-year re-screening required during the review period. The rescreening was completed prior to the expired prints expiration date on the employee's clearinghouse profile. There were eleven volunteers or interns during the review period. All eleven documented a background screening, with an eligible rating, was completed prior to the individuals start date. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and submitted to the Department of Juvenile Justice Background Screening Unit on January 8, 2020.	
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 provider has four policies in place to address the Provision of an Abuse Free Environment. The policies and procedures are P-1044 Florida Abuse Reporting, P-1105 Complaint/Grievance Process for Participants or Companions with Disabilities, P-1128 Rule Violations, and P-1212 Standards of Conduct. The policies were last reviewed on January 23, 2020 Chief Operations Officer.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☒	☐	☐	☐	☐	The program has a code of conduct that prohibits the use of physical abuse, profanity, threats, and intimidation. There is signage throughout the program to reflect that all youth are accepted regardless of sexual orientation, gender identity, or gender expression. The program has postings for the Florida Abuse Hotline in the living areas, dining areas, shelter area, poster boards, study areas, and in hallways. The program has a process in place for documenting child abuse hotline calls and maintains a logbook on the calls. The program has a policy in place to address actions that will be taken regarding incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force. A review of incidents reported to the Department's Central Communications Center did not include any allegations of abuse or neglect by staff. The program provides an accessible and responsive grievance process for youth to provide feedback and address complaints. Forms were visible and available on each dorm as well as a locked grievance box in the common area. The lead case manager has the key to the grievance box. A review	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						of the grievances indicates they are resolved within seventy-two hours by management. Grievances are maintained on file for a minimum of one year.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) The agency has a policy for Incident Reporting, P-1045 Incident Reporting Procedures. The policy was last reviewed January 23, 2020 by the Chief Operation Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A review of the program's notifications to the Department's Central Communication Center (CCC) revealed all six reportable incidents were called in no later than two hours or within two hours of the program learning of the incident. The program has significant documentation regarding follow up tasks/special instructions as required by the CCC. All incidents, reportable and unreportable, are documented in the program logs and are documented on incident reporting forms. The forms were reviewed and signed by a program supervisor/director.	No exceptions
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 agency has a policy in place titled P-1030 Training Policy to address the	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						requirements of this indicator. The policy was last reviewed on January 23, 2020 by the Chief Operations Officer.	
RATING	☐	☒	☐	☐	☐	There were three trainings files reviewed for first year training requirements. One staff had completed their first year of training and documented 164.5 hours of training. All required trainings were completed with the exception of Serving LGBTQ Youth and the DJJ Skill Pro training for Child Abuse Reporting was completed late. The second staff reviewed had four months left in their training cycle. This staff had 113.75 hours of training and was on track to receive all required trainings. The third staff reviewed documented 50.5 hours of training and was still in the first 120 days of training. This staff was on track to receive all required trainings. There were four staff training files reviewed for annual training requirements. The program tracks annual training by fiscal year so all four staff were still in their annual training cycle. The staff documented between 9 and 13.5 hours of training so far with 5 months left in the training cycle to receive additional training hours. All three staff had already completed some the required trainings. The program has an annual training plan in place which outlines training	One staff did not receive Serving LGBTQ Youth training and also completed the DJJ Skill Pro Child Abuse Reporting training late.

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		
						requirements for the first 120 days of employment, for the first year of employment, and for employees beyond the first year. Each staff has a training file which contains an annual tracking form, all supporting documentation for every training completed, and any certifications the staff may have.	
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) The agency has a policy in place titled P-1049 Risk Management Plan that addresses the requirements of this indicator. The policy was last reviewed on January 23, 2020 by the Chief Operations Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The annual CDS performance and risk management report from the past fiscal year was reviewed. The report included performance analysis data from participant satisfaction surveys, demographics of all participants, performance and projections, monthly shelter utilization, outreach, risk, and issue distribution. Other areas addressed included annual data collection of screenings, admissions, discharges,	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		
						emergency shelter participants, NetMIS data entry, medical emergencies, incident summary report, and personnel summaries. A performance improvement and risk management report are developed every fiscal year. The data is captured using graphs, charts, spreadsheets, and in written forms. This information is also captured and analyzed monthly. Monthly data is collected for participant performance based on contracted deliverables, incidents, accidents, and grievances. The program conducts quarterly participant, peer, and supervisor reviews on two open and two closed files. A report is created from this data and shared with program staff. All data collection is shared and reviewed with management and staff monthly as documented in meeting minutes and agendas reviewed for the past six months. Any improvements or corrective actions needed are implemented at this time. The agency also submits a monthly packet to the Board of Directors for each program operated by the agency. The packet includes all outcome data and a	

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		
						review of any incidents that happened at the shelter during that month. Each program also provides the Board with a summary of program updates for the month. This packet is reviewed during the Board meeting as evidenced by meeting minutes. Data entry and collection is reviewed monthly during the management team meetings. The Data Department for the agency will print out monthly JJIS and NETMIS reports. These reports are reviewed with all management staff during the meeting to ensure data accuracy. Any changes that need to be made are made at that time.	
1.06: Client Transportation **Policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						☒ YES ☐ NO (explain) The agency has a policy in place for client transportation requirements titled P-1013 Vehicle Use and Safety Inspection. The policy was last reviewed on January 23, 2020 by the Chief Operations Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has a transportation policy with drivers appointed by administrative personnel. The policy does not prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip. Approved program drivers	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						are documented as having a valid Florida driver's license and are covered under company insurance policy. The third party can be an approved volunteer, intern, agency staff, or other youth. The program's policy includes exceptions in the event that a third party is not present in the vehicle while transporting. In the event that a third party cannot be obtained for transport, the program's supervisor or managerial personnel can consider the client's history, evaluation, and recent behavior. In the event of a single driver transporting a single client, there is evidence that the program supervisor is aware prior to transport and consent is documented accordingly per policy. A review of vehicle logs includes name and initials of the driver, the date and time, mileage, number of passengers, purpose of the travel and location. Logs reviewed for the last six months were filled out in their entirety. All single client transports documented a supervisor's approval was obtained prior to the transport taking place.	
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 two policies in place to address the requirements of outreach	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		
						services, P-1050 Outreach Plan for Targeting Youth for Program Services and P-1053 Roles and Responsibilities – Prevention Outreach. The policies were last reviewed on January 23, 2020 by the Chief Operations Officer.	
RATING	☒	☐	☐	☐	☐	Outreach services was presented to over 600 youth in the community through the combined efforts of Safe Place presentations and outreach events. In addition to presenting to youth and families, Outreach also held targeted trainings for school staff and human services professionals. These trainings provided adults information on Safe Place, CDS programs, and the referral system for services. Outreach's main dissemination activities revolved around increasing the organization's online footprint as more families and youth look to the internet for referrals to programs. Outreach focused on redesigning and updating the organization's website and increasing social media presence and following. Outreach was featured in Our Town magazine with an article highlighting CDS. Outreach also marketed services in an advertisement published in the Pride Community Center of North Central Florida's PRIDE Guide which is distributed across the county. Outreach attended over sixty events during this reporting period. Outreach has focused on building strong relationships with local	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		
						organizations, businesses, and alliances. They attended a myriad of individual meetings with local businesses that have resulted in partnerships and increased involvement from the local community and expanded service offerings to participants. Outreach attended a series of trainings emphasizing diversity, inclusion, and current trends in youth development. In the last six months there was documentation of staff attending the Alachua County Juvenile Justice Council meeting in September and November 2019. Staff attended the Circuit 8 Board Meeting in November 2019. The program has current, up-to-date, Cooperative Service Agreements with Meridian Behavioral Healthcare, Alachua County Coalition Against Human Trafficking, Alachua County Health Promotion and Wellness Coalition, Child Advocacy Center of Gainesville, Alachua County Sheriff's Office, Levy County Prevention Coalition, Gilchrist County Schools, The School Board of Alachua County to participate in the implementation of the Too Good for Drugs and Too Good for Violence programs, and a Universal Agreement for Emergency Disaster Shelter for Florida Network Member Agencies.	

STANDARD 2: INTERVENTION AND CASE MANAGEMENT

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Two – Intervention and Case Management							
2.01: Screening and Intake							
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☒ YES ☐ NO (explain) The agency has three different policies to address the requirements of this indicator. The policies titled P-1112 Intake/Assessment, P- 1113 Screening for Eligibility and Target Population, and P-1115 24-Hour Telephone Access were all last reviewed on August 1st, 2019 by the Chief Operations Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five residential files (two open and three closed) and five non-residential files (three open and two closed) reviewed. All ten files reviewed documented the eligibility screening was completed within seven calendar days of the referral. All ten files documented the parent/guardian received the following in writing: available service options, rights and responsibilities of youth and parents/guardians and, a parent/guardian brochure.	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		
						All files indicated that the parents/guardians and youth have access to possible actions occurring through involvement with CINS/FINS services and grievance procedures.	
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) The agency has a policy titled P-1019 Needs Assessment that addresses the requirements of the indicator. The policy was last reviewed August 1st, 2019 by the Chief Operations Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five residential files (two open and three closed) and five non-residential files (three open and two closed) reviewed. In all five residential files, the Needs Assessment was initiated within 72 hours of admission. All ten files documented that the Needs Assessment was completed within two to three face-to-face contacts after the initial intake. The Needs Assessments were conducted by a bachelor's or master's level staff member.	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		
						All ten Needs Assessments included a supervisor review signature upon completion. None of the youth were identified with an elevated risk of suicide as a result of the Needs Assessment.	
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) The agency has a policy titled P-1162 Individual Plan that addresses the requirements of the indicator. The policy was last reviewed August 1st, 2019 by the Chief Operations Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five residential files (two open and three closed) and five non-residential files (three open and two closed) reviewed. All ten files had the Case/Service Plan developed within seven working days of Needs Assessment. All ten Plans documented individualized and prioritized need(s) and goal(s) identified by the Needs Assessment, the service type, frequency, and location for services, the person(s) responsible, the target date(s) for completion, and the date the plan was initiated. Actual completion dates were documented in the four closed files.	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		
						All ten Plans had youth, parent/guardian, counselor, and supervisor signatures. All applicable thirty, sixty, and ninety-day reviews were completed as required.	
2.04: Case Management and Service Delivery							
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) The agency has a policy titled P-1163 Case Management, Counseling, and Service Delivery to address the requirements of the indicator. The policy was last reviewed on August 1st, 2019 by the Chief Operations Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five residential files (two open and three closed) and five non-residential files (three open and two closed) reviewed. All ten files had a Counselor/Case Manager assigned, established referral needs, coordinated referrals to services based upon the on-going assessment of the youth's/family's problems and needs, coordinated service plan implementation, monitored youth's/family's progress in services, and provided support for families. None of the files were applicable for monitoring out-of-home placement.	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		
						All ten files referred the youth/family for additional services when appropriate and provided case monitoring and review of court orders, as needed. Referrals to Case Staffing were made if needed, and the Counselor/Case Manager accompanied the family to court and other meetings when needed. These efforts were noted in emails, progress notes, and meeting summaries. All closed files provided case termination notes. All closed files also documented thirty-day follow-ups were completed as required. None of the files were due for a sixty-day follow-up.	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) The agency has a policy titled P-1046 Case Management, Counseling, and Service Delivery to address the requirements of the indicator. The policy was last reviewed on August 1st, 2019 by the Chief Operations Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five residential files (two open and three closed) and five non-residential files (three open and two closed) reviewed. All ten files documented the youth's presenting problems were addressed in the Needs Assessment, in the initial	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		
						Case/Service Plan, and in the Case/Service Plan reviews. Case notes were maintained for all counseling services provided and documented the youth's progress. All ten files had on-going clinical reviews of case records and staff performance. All ten files documented the youth and families received counseling services in accordance with the Case/Service Plan and that individual/family counseling was provided. All five residential files indicated that group counseling sessions were provided at least five days a week, if not more. The counseling sessions documented the following: at least thirty minutes in length, clear leader or facilitator, and clear and relevant topic.	
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) The agency has three different policies in place to address this indicator, P-1157 Case Staffing Committee: Plan of Services, P-1159 Case Staffing Committee: Review and Committee Composition, and P-1160 Case Staffing Committee: Parent/Guardian Request.	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		
						The policies were reviewed on August 1st, 2019 by the Chief Operations Officer.	
RATING	☐	☐	☒	☐	☐	The program has only had one case staffing file since the last review. This file was just opened on February 3, 2020, two days prior to the on-site review so we were not able to review case staffing process for this file as the notifications and actual staffing have not been held yet.	No exceptions
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) The agency has a policy in place titled P-1046 Youth Case Records that addresses the requirements of the indicator. The policy was last reviewed on August 1st, 2019 by the Chief Operations Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five residential files (two open and three closed) and five non-residential files (three open and two closed) reviewed. Each youth had an official case record. All files were labeled “confidential” and maintained in a neat and orderly manner. All files at the residential program were observed to be kept in the staff office, in a locked file cabinet that was marked "confidential".	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		
						All non-residential files were transported in a locked, opaque container marked "confidential".	
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) The agency has a policy titled P-1284 Sexual Orientation, Gender Identity, Gender Expression that addresses the requirements of the indicator. The policy was last reviewed on January 23, 2020 by the Chief Operations Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The shelter has the SOGIE policy posted in the visitor lobby area of the facility for all visitors to read and review. At admission, the counselor reviews the information in the SOGIE policy with the youth and asks the youth their preferred gender pronoun to be used. This is all documented on the last page of the Intake Assessment form by the counselor. The shelter has signage located throughout the shelter indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Signage is located in the computer lab, both male and female dorms, staff office, dining room, and a bulletin board was created in the hallway with various SOGIE postings. There is a	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						posting next to the youth alert board in the staff office for staff to review reminding them of proper documentation and use of gender pronouns for all youth.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☒ YES ☐ NO (explain) The agency has six policies addressing the requirements of special populations, P-1249 Staff Secure Shelter – Program Overview, P-1248 Staff Secure Shelter Services, P-1282 Domestic Minor Sex Trafficking, P-1267 Domestic Violence Respite, P-1279 Probation Respite, P-1283 Family/Youth Respite Aftercare Services (FYRAC). These policies were last reviewed on January 23, 2020 by the Chief Operations Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has not had any examples of Domestic Minor Sex Trafficking or Family and Youth Respite Aftercare Services (FYRAC) youth in the last year. This site also does not provide Intensive Case Management Services. The program had one Staff Secure youth in the last year. This youth was admitted to a different CINS/FINS shelter; however, housed at this shelter. The in-depth orientation took place at the other shelter. This youth was court ordered into Staff Secure services. Supervision of the 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		
						was assigned to one staff member each shift; this was noted in the logbook at the beginning of each shift. Throughout each shift an update on the youth would be given by the assigned staff member. Written reports were provided to the court regarding the youth's progress. There were three Domestic Violence (DV) cases reviewed. All three youth had a pending DV charge and did not meet criteria for secure detention. Data was entered into JJIS within twenty-four hours of admission and seventy-two hours of release. None of the youth stayed in the program longer than twenty-one days. All case plans reflected goals focusing on anger management and family coping skills. All other services provide were consistent with all other general CINS/FINS program requirements. There was one Probation Respite file reviewed. The file documented the referral came from DJJ Probation. Data was entered into JJIS and NetMIS within twenty-four hours of admission and seventy-two hours of release. The length of stay was no more than fourteen to thirty days. All case management and counseling needs were addressed. All other services provided were consistent	

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		
						with all other general CINS/FINS program requirements.	
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) The agency has five policies to address SNAP services, P-1286 SNAP Intake, P-1287 SNAP Group Delivery, P-1288 SNAP Fidelity Adherence Monitoring, P-1289 SNAP Discharge Requirements, and P-1290 SNAP in Schools. All policies were reviewed on January 23, 2020 by the Chief Operations Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were eight files reviewed four open and four closed for SNAP Clinical Groups. All eight files documented the youth were screened to determine eligibility using the NETMIS screening form and the SNAP Brief Intake Screening form. All youth had consent signed by the parent prior to receiving services. All eight files documented the Needs Assessment was initiated at intake. All eight files documented the Pre-Child Behavior Checklist, the TOPSE assessment, and the PAT assessment were completed at intake. In five of the eight files the Pre-Teacher Report form was completed. In the remaining three files the form was not completed; however, each file documented the form was given to the teacher to complete and also documented	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		
						follow-up attempts to get the form back from the teacher. In the four closed files the Post-Child Behavior Checklist, TOPSE assessment, and PAT assessment were completed at discharge. Three of the four files documented the Post-Teacher Report form was completed. The fourth file documented the form was given to the teacher to complete and documented follow-up attempts to get the form back. All four files documented a SNAP Discharge Report Summary was completed. The last 13-week session of SNAP in Schools was reviewed. The session included three different classrooms. There were weekly attendance sheets with all the youth names and signature of the teacher and SNAP facilitator for all 13 weeks in all three classrooms. The class Shoot for Your Goal sheet was completed for each classroom. One of the sheets was not signed by the facilitator or teacher. The facilitator reported this was because a youth in the class kept ripping the sheet off the wall and tearing it up so the facilitator had to replace the sheet multiple times during the 13 weeks and the last time it was replaced there were no signatures on the sheet. Pre and Post evaluations were completed for a majority	

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		
						of the youth in each class. The facilitator reported the youth are given the option to complete these and are not required to so some did not complete one and some youth who did complete one chose not to put their name on it. Pre and Post evaluations were completed for each teacher in all three classrooms. There was one Fidelity Adherence Checklist completed for each classroom during the 13-week session.	

STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Three – Shelter Care							
3.01 Shelter Environment **The shelter's environment is safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development.**							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						☒ YES ☐ NO (explain) The agency has two policies in place to address the requirements of the indicator P-1122 Leisure Activities Program (LEAP), and P-1137 Faith Based Activities. The policies were reviewed on January 23, 2020 by Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A review of the facility and site revealed the furnishings are in good repair and the program is free of insect infestation. The grounds are landscaped and well maintained. The bathrooms and shower areas are clean and functional. There was no evidence of graffiti on the walls, doors, or windows, lighting was adequate for tasks performed throughout all areas. The exterior areas were free of debris and grounds were free of hazards. Dumpsters and garbage cans are covered. All doors to the program and staff vehicles were secure. A check of program vehicles concluded they were equipped with major safety equipment including first aid kit, fire	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						extinguisher, flashlight, glass breaker, seat belt cutter, and air bag deflator. In and out access is limited to staff members and key control is in compliance. Detailed maps and egress plans of the facility were available throughout the building. General client rules, grievance forms, abuse hotline number and other related notices are posted. DJJ Incident Reporting number is available in the parent packet as well as the youth orientation packet. The program has a current DCF Child Care License displayed in the facility, effective date April 2019. The interior areas were free of contraband and hazardous metal/foreign objects. All chemicals are listed, approved for use, inventoried, stored securely, and Material Safety Data Sheets (MSDS) are maintained on each item (located with chemicals in the broom room off of the kitchen). The washer/dryer were operational and were free of lint. Each youth had their own bed and clean linens and blanket. The youth have a safe secure place to store their belongings. Property of value is kept in the control room in locked area. Annual facility fire inspection was conducted on January 30, 2020 and the program is in compliance. The program completes a minimum of one fire drill per month within two minutes. The program had drills July 18, 2019, August 13, 2019, September 16, 2019, October 2,	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						2019, November 24, 2019, and December 5, 2019. The program completes a mock emergency drill per shift per quarter which included: July 2019 Threatening drill, August 2019 Utility failure, September 2019 Bomb threat, October 2019 Natural disaster, November 2019 Medical emergency, December 2019 Threatening drill. The program had an annual fire safety equipment inspection on January 30, 2020 and all extinguishers, sprinklers, alarm systems, and the kitchen overhead hood is up to date. The agency received a Satisfactory Residential Group Care Inspection on February 5, 2020 from Department of Health. The program has a current Satisfactory Food Service inspection report from the Department of Heath dated October 14, 2019, and the food menus were posted, current and signed by Licensed Dietician. A review of the kitchen revealed all cold food properly stored, marked and labeled and dry storage was clean, and food properly stored. The refrigerators were clean and maintained and all the small and medium sized appliance were operable and clean. The youth are engaged in meaningful, structed activities seven days a week during awake hours. The youth receive at least one hour of physical activity daily. Youth are provided the opportunity to participate in a variety of faith-based activities. Documentation was available of	

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		
						faith-based opportunities for youth at the program. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth were observed during this review working on schoolwork in class area. Books were visible on the dorms in the common area. Daily programming schedule is posted throughout the program in common areas, dining hall, class area, and hallways.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) The agency has a written policy in place for Program Orientation, P-1114, Admission/Intake and Participation Orientation. The policy was last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five files reviewed, three closed files and two open files. In all the files reviewed the youth received an orientation to the program on the same date of admission to the program. The orientation process was comprehensive. The youth received a handbook and disciplinary actions, grievance procedures, and emergency procedures were explained. Contraband rules were reviewed and explained. The facility was	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		
						toured, and a layout map provided, and youth was assigned a room. Suicide prevention, abuse, and alert notification was explained, and the youth initials and signature were available in all five files reviewed.	
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) The agency has a policy in place titled P-1116 Youth Room Assignment that addresses the requirements of this indicator. The policy was last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five files reviewed, two open and three closed. Each youth file documented a process for youth room assignment to include the initial classification of youth, with consideration given to potential safety and security concerns. The youth intake form documents a review of youth history, status and exposure to trauma, age, gender, history of violence, disability, physical stature, gang affiliation, suicide risk, sexually aggressive behavior, and gender identification. Collateral contacts and initial interactions and observations of the youth were documented. Based upon the findings, youth are assigned to a bed within the appropriate male or female	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		
						dorm. All applicable alerts were documented.	
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) The agency has a policy in place titled P-1149 Log Books that addresses the requirements of the indicator. The policy was last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	Logbooks were reviewed for the last six months. It was evident that all safety and security concerns were documented and highlighted appropriately. All entries were brief, legible, and written in ink. All entries included the date, time, names of youth and staff involved, a brief statement, and signature of person making the entry. Any errors were properly corrected with one line drawn through and marked with initials. Supervisors reviewed the logbook for the previous two shifts and shift staff were documenting their review each shift to ensure they were up to date on any pertinent information within the past two to three shifts. The Program Director reviewed the logbook at least weekly documenting a note chronologically indicating dates reviewed and any	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		
						recommendations. Supervision and resident counts were documented clearly with youths first and last name at each shift. Visitation and home visits were documented clearly.	
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The agency has several policies in place to address Behavior Management Strategies. Policies P-1222, P-1123, P-1125, P-1126, P-1127 and P-1128 were last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The FACE System is comprised of three phases: Assessment, Daily, and Achievement. The youth are able to maneuver through the phases, gaining privileges based on their compliance with rules and through demonstrating that they are mastering their targeted skills. Youth are provided with an orientation packet at intake explaining in detail the Behavior Management System (FACE). There were five files reviewed and there was documentation in each file in the form of a signature indicating that each youth was given this information. There were five staff training files reviewed. Documentation was found in each file indicating that staff was trained in	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		
						the Behavior Management System (FACE) during the orientation training period. There was one staff interviewed and this staff was able to thoroughly outline the Behavior Management System (FACE) and its policy, giving clear examples of how it's implemented with the youth. The staff had an excellent understanding of the process and explained how staff uses points or incentives to encourage positive behavior, as well as negative points to address negative behavior. The staff also reiterated that the FACE system encourages the youth to earn above the minimum goals reinforcing the youth's achievement with more privileges.	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) The agency has two policies to address Staffing and Youth Supervision. Policies P-1121 and P-1133 were last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☐	☒	☐	☐	☐	The shelter has the staff schedule posted in the staff office accessible to all staff. There is protocol in place to ensure that there is coverage if staff calls in or if there is a vacancy on the schedule. The schedule indicates that the staffing ratio is met and there is a minimum of two staff	There were eight instances during the months of October, November, and early December where bed checks exceeded the fifteen-minute requirement.

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		
						on the overnight shifts. The schedule was verified by cross referencing it with the logbook. The bed checks are done by two methods. The shelter has handheld scanners. There are barcodes in the dorm rooms that are scanned, and it is electronically entered into the shelter's system. Those reports can be printed off. If the scanners are not used, then staff documents bed checks manually. There is a form that is filled out by staff when a check is done. For each bed check, the time is noted, what the youth was doing, and the staff's initials are documented. The staff doing the check then signs the bottom. Bed checks were reviewed for the last six months. There were eight instances noted during the months of October, November, and early December where bed checks exceeded the fifteen-minute requirement. On December 11, 2019 the supervisor and coordinator held a meeting with all direct care staff to address this issue. A written Bed Check Report form was then implemented to be filled out each night documenting if all bed checks were completed and if any were missed or late, and the reasons why. Since this form was implemented in December bed checks reviewed during the months of January	

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		
						and February were done within the required fifteen-minute time frame. Video surveillance reviewed also confirmed bed checks were being completed as documented.	
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) The agency has a policy in place to address the Video Surveillance System. Policy P-1280 was last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A written notice is conspicuously posted on the premises, for the purpose of security, at the entrance where visitors sign in and in the foyer. Cameras are in the interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. There are sixteen cameras throughout the facility, inside and outside all of which are visible to anyone. Cameras are not placed in bedrooms or bathrooms. Video system stores recording well beyond the thirty-day requirement. System records date, time, location, and is visible in color. Cameras continue to record during a power outage. There are two designated reviewers who can access the video surveillance system, the Residential Supervisor and Regional	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		
						Coordinator. The Regional Coordinator has mobile access as well. The Residential Supervisor conducts supervisory reviews of random overnight shifts a minimum of every fourteen days as evidenced in reviewing documentation at the beginning of each logbook. Each logbook covers a two-week period. A third party is able to view stored video footage upon request in person or by downloading the footage to a thumb drive.	

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

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 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)** The agency has a policy titled P-1117 Preliminary Physical Health Screening and a policy titled P-1119 Medical Follow-Up, to address the requirements of this indicator. These policies were last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five files reviewed, two open and three closed. Of the five files reviewed, all contained the Intake Assessment form with all health screening sections completed on the day of admission. Three of the five files reviewed documented the youth were on medications. The medications were listed, as well as, the reasons for the medications. Four of the files documented the youth had some type of allergies. The Intake Assessment form was reviewed by the RN within five working days in all five files. The program has procedures in place for follow-up medical care if it is needed.	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		
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)** The agency has a policy titled P-1144 Suicide Assessment and a policy titled P-1247 Mental Health, Substance Abuse, and Suicide Risk Screening to address the requirements of this indicator. These policies were last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were three files reviewed on youth who had been placed on suicide precautions in the last six months. Two files were closed, and one was open. All three youth were placed on suicide precautions at intake due to issues identified during the screening process. All three youth were placed on sight and sound supervision. All three youth were seen and assessed, by a master's level counselor, within twenty-four hours. All three files documented a suicide risk assessment was completed by a master's level counselor and documented consultation with the LMHC and program director. Both the LMHC and program director signed the assessments prior to the youth being removed from suicide precautions. The youth were placed on normal supervision. All three youth had thirty-minute observations documented the entire time on suicide precautions.	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		
						The shelter employs two master's level counselors who complete all suicide risk assessments on youth in the shelter. Both staff have received training to complete the assessments and are supervised by the agency's Non-Residential Regional Coordinator is a Licensed Mental Health Counselor (LMHC). Both counselors consult with the LMHC prior to removing any youth from suicide precautions.	
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ **YES** ☐ **NO (explain)** The agency has a policy to address Medication. Policy P-1120 was last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☐	☒	☐	☐	☐	It was observed that all medications are stored in the Pyxis Med-Station 4000. The nurse confirmed this by opening the cabinets, and medications were observed all within their individual compartments. The agency maintains a minimum of two Super-Users for the Med-Station. The agency does not accept youth with injectable medications aside from EPI pens which are stored separately from oral/topical medications. All staff have been trained on the use of the EPI pen. Medications requiring refrigeration are stored in a secure refrigerator used only for that purpose and the temperature was	Medication discrepancies were not being cleared out by the end of the staff members shift.

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		
						within Florida Network guidelines. Narcotics and controlled medications are stored in the Med-Station, and it was noted they are in a separate drawer than non-controlled medications. It was observed that shift-to-shift counts are being completed and inventory is maintained for controlled substances. The program does not maintain syringes or sharps on site, so there is no inventory documentation. It is also noted the program does not keep, or distribute, over-the-counter medications. The nurse verified she distributes medications when on site, and the delivery process is consistent with FL Network guidelines.	
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)** The agency has a policy in place to address the Medical/Mental Health Alert Process. Policy P-1119 was last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	Upon intake to services a youth is screened for medical, mental health, suicide risk, substance use, medications, allergies, and any other limitations/impairments. The agency has processes in place to alert staff to these various issues. In regard to medications, the agency keeps a binder in the control room with medication information sheets,	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		
						and common side effects are noted on medication forms. Alerts are noted on the spine of the youth's file, and at other locations in the agency. The agency has twenty-one coded alerts that include Sight & Sound, limited contact with parents, no contact allowed, runaway history, bed assignment concerns, allergies, diet restrictions, medication, medical conditions, mental health condition, physical limitations, mental limitations, fire setting history, suicide risk history, sexual acting out history, substance use history, staff secure, DV Respite, self-harm behaviors, and sleeping arrangements. There were five files reviewed and four out of the five had at least one alert. All the files had clear documentation of the alert(s).	
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** The agency has a policy in place to address Episodic/Emergency Care. Policy P-1166 was last reviewed on January 23, 2020 by the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There have been three off-site emergency care events in the last six months. The shelter maintains an Emergency and Episodic Care Log that documents the date, youth involved, service needed, if the parent was notified, notification to the CCC, and discharge instructions. There	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		
						was also an incident report completed for each event that documented a more detailed explanation of the incident, all notifications, and discharge instructions. Each incident was also found documented in the program logbook. The shelter has completed a Medical Emergency Drill on each shift for the last quarter. First aid kits are located in the staff office and in both of the vans. The kits are checked weekly for expiration dates and replenished as needed. The shelter has both a knife for life and wire cutters in the staff office. All staff had current first aid and CPR certifications.	

FLORIDA NETWORK
of youth and family services

Florida Network for Youth and Family Services
Compliance Monitoring Report for

CDS – Interface Central
1400 Northwest 29th Road
Gainesville, FL 32605
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 CDS Family and Behavioral Health Services, Inc. – Interface Central for the FY 2019-2020 at its program office located at 1400 Northwest 29th Road, Gainesville, 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. CDS Family and Behavioral Health Services, Inc. – Interface Central 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 Ashley Davies, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from CDS Family and Behavioral Health Services, Inc. – Interface Central present for the entrance interview were: Tracey Ousley, COO; Jessica Bechtold, Regional Coordinator; Evelitza Soto, SNAP Supervisor; Gonzellas Whitter, Residential Supervisor; Cassandra Mccray, Regional Coordinator; and Naomi Thompson, Residential Counselor. The last onsite QI visit was conducted January 16 – 17, 2019.

In general, the Reviewer found that CDS Family and Behavioral Health Services, Inc. – Interface Central is in compliance with specific contract requirements. **CDS Family and Behavioral Health Services, Inc. – Interface Central received an overall compliance rating of 100% for achieving full compliance with eleven indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit; however, no recommendation was made for an indicator rated as conditionally acceptable.

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 02-05-2020

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central						**Monitor Name: Ashley Davies, Lead Reviewer**	
Contract Type : CINS/FINS						**Region/Office: 1400 NW 29th Rd., Gainesville, FL**	
Service Description: Comprehensive Onsite Compliance Monitoring						**Site Visit Date(s): February 5 - 6, 2020**	
	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)**
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.	☐	☐	☒	☐	☐	Interview: The program currently has at least two staff members certified as DJJ QI Peer reviewers. One of the staff members has participated as peer reviewer this season.	**No recommendation or Corrective Action.**
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**	☐	☐	☒	☐	☐	Documentation: The agency provided a list of eight contracts for FY2019- 2020. The list includes: the contract #, the agency, the contact, the address, service, start and end dates, date executed, and annual amount. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed had current contract/agreement dates.	**No recommendation or Corrective Action.**
Limits of Coverage	☐	☐	☒	☐	☐	Documentation:	**No recommendation or Corrective Action.**

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 1400 NW 29th Rd., Gainesville, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): February 5 - 6, 2020	
	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		
a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						General Liability through Berkshire Hathaway Specialty Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, $20,000 individual medical, $1,000,000 personal & adv injury, and $1,000,000 employee benefits, effective 1/10/20-1/10/21. Automobile insurance through Berkshire Hathaway Specialty Insurance Company, for combined single limits of $1,000,000, and PIP Basic for $10,000. Policy effective for 1/10/2020-1/10/2021. An umbrella liability policy through Berkshire Hathaway Specialty Insurance Company, for $1,000,000 each/aggregate. Workers Compensation through Bridgefield Casualty Insurance Company for $500,000 each accident. Effective 5/1/19 – 5/1/20. Abuse and Molestation coverage through Berkshire Hathaway Specialty	

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 1400 NW 29th Rd., Gainesville, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): February 5 - 6, 2020	
	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)
						Insurance Company for $1,000,000 each and $3,000,000 aggregate. Effective 1/10/20 – 1/10/21. Professional Liability Coverage through Berkshire Hathaway Specialty Insurance Company for $1,000,000 each and $3,000,000 aggregate. Effective 1/10/20 – 1/10/21. Florida Network is listed on the Worker's Compensation certificate as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	**N/A –** During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency had a set of 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,	**No recommendation or Corrective Action.**

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 1400 NW 29th Rd., Gainesville, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): February 5 - 6, 2020	
	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)
						property and equipment, debt and other liabilities. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls.	
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: Detailed General Ledger for the current FY, through 2/3/2020. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the shelter and each program separately.	**No recommendation or Corrective Action.**
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**	☐	☐	☒	☐	☐	Observation/Documentation: the agency since the last onsite program review in January 2019. Reviewed petty cash Policy and Procedure was conducted. The Petty Cash fund does not exceed the established minimum. Petty cash is stored in a locked box in the administrative assistant's office. All receipts are submitted to the main office for reimbursement as needed. Reimbursement comes in the form of a check made out to the Administrative Assistant, who will then cash it and place money in petty cash box.	**No recommendation or Corrective Action.**

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 1400 NW 29th Rd., Gainesville, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): February 5 - 6, 2020	
	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)
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: Reviewed Bank Statements and Bank Reconciliations for the past six months for one account held with Renasant Bank. Financial Statements are reported on a monthly basis and were found to be current. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month and are documented by two signatures. Invoices are submitted on a monthly basis with supporting documentation.	**No recommendation or Corrective Action.**
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**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
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 documentation in bank statements that payroll taxes are paid each payroll period to the IRS, for the last six months.	**No recommendation or Corrective Action.**

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 1400 NW 29th Rd., Gainesville, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): February 5 - 6, 2020	
	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)
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 a year-to-date report for the current fiscal year. The report shows Actual, Budget, and Variance with Total Revenue Over Expense. A review of these documents was conducted. Variances in budget are monitored on a regular basis and are discussed with the Board by the Budget and Financial Committee. If changes need to be made to the budget, then the individual shelter is notified.	**No recommendation or Corrective Action.**
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 June 30, 2019 and 2018 was completed by James Moore & Co., P.L. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor. A copy of the audit was submitted to the FNYFS.	**No recommendation or Corrective Action.**
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	☐	☐	☒	☐	☐	Documentation: Policies and procedures for Back-up, IT Confidentiality Standards, Virus Protection, Data Integrity, Record Elimination, Uses and Disclosures of Confidential and Protected Health	**No recommendation or Corrective Action.**

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 1400 NW 29th Rd., Gainesville, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): February 5 - 6, 2020	
	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)
documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**						Information. The Medical Manager performs daily back-ups at 2am and prints summary receipt. Back-up tape is replaced every morning. Accounting data files are backed-up every night. Other critical servers, microcomputers and laptops complete scheduled back-ups on a secured portable hard drive.	

CONCLUSION

CDS Family and Behavioral Health Services, Inc. – Interface Central has met the requirements for the CINS/FINS contract as a result of full compliance with eleven applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the thirteen indicators were not applicable because: 1) the provider does not have any outstanding corrective action item(s) cited by an external funding source, and 2) does not have any current inventory purchased with DJJ/FN Funds. Consequently, t**he overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

SUMMARY OF RECOMMENDATIONS

Recommendation
There were no recommendations as a result of this review.

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