Florida Network for Youth and Family Services
Compliance Monitoring Report for

CHS WaveCREST
4520 Selvitz Road,
Fort Pierce, FL 34981

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for CHS WaveCREST for the FY 2019-2020 at its program office located at 4520 Selvitz Road, Fort Pierce, 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. CHS WaveCREST 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 CHS WaveCREST present for the entrance interview were: Sabrina Sampson, Executive Director; Kristi Walsh, Director of Program Operations; and Kelly Barnett, Residential Supervisor. The last onsite QI visit was conducted May 8 – 9, 2019.

In general, the Reviewer found that CHS WaveCREST is in compliance with specific contract requirements. **CHS WaveCREST 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 11-06-2019

Agency Name: CHS WaveCREST	**Monitor Name: Ashley Davies, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 4520 Selvitz Road, Fort Pierce, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): November 6 - 7, 2019**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The program currently has at least two staff members certified as DJJ QI Peer reviewers. One of the peers has participated on a review 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 five additional contracts for FY2019 - 2020 for the shelter. The list includes: the funder, service provided, and contract start and end dates. 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 a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's	☐	☐	☒	☐	☐	Documentation: General Liability through Alliance of Nonprofits for Insurance, for limits of	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						coverage $1,000,000 each $3,000,000 aggregate with medical expenses of $5,000 for any one person, effective 7/1/2019-7/1/2020. Workers Compensation through United Wisconsin Insurance Co., with limits of $1,000,000 each/aggregate, effective - 7/1/2019-7/1/2020. Automobile insurance through Alliance of Nonprofits for Ins., for combined single limit of $1,000,000, effective for 7/1/2019-7/1/2020. Florida Network is listed as certificate holder on all certificates of coverage.	
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: Fiscal Policies and Procedures are contained in the agency's Accounting Procedures Manual with a recent revision date of 1/1/16 and review date off 1/1/2017. The procedures	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for accounts receivable, cash management, contributions, accounts payable, purchasing, and payroll.	
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 (Standard) for Period: 07-19 through 09-19 (Present). The agency maintains a detailed general ledger with corresponding source documents. General ledger is structured to track all funding sources.	**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: No change in practice was reported for the agency since the last onsite program review in May 2019. Petty cash is maintained and reconciled by the Secretary monthly or as needed. The reconciliation is accompanied by a log including the date, vendor, amount, account, and sub-account for each activity.	**No recommendation or Corrective Action.**

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						Policies and procedures are maintained in the Fiscal Manual under the Cash Management section. The maximum petty cash account for WaveCREST shelter is $400. The fund is kept locked up in the Administrative Secretary's office. Requests for petty cash are informal but are accompanied by an up-to-date log of activities and receipt that is maintained by the custodian.	
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: Reviewed Bank Statements and Bank Reconciliations for July 2019 – September 2019 for the program's Payroll account held with Fifth Third Bank. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month. The bank statements were all found to be reconciled within four weeks of receipt and were signed by the Analyst and Controller.	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						Financial Statements are reported on a monthly basis and were found to be current. Vendor files and invoices are maintained in the agency's corporate office.	
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 submitted a Tax Ledger as evidence of payroll taxes paid for the period as well as 941 Tax filings for the second and third Quarters of 2019. The tax payments were submitted to the IRS for Federal and FICA taxes. CHS is exempt from filing Form 940 (FUTA); instead it files Form 941 quarterly. CHS does not file Form 1098 as this is related to mortgage interest statements issued by financial institutions.	**No recommendation or Corrective Action.**

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Report shows program budget and variances with YTD net surplus for the current fiscal year ending in September 2019. Variances in budget are monitored on a regular basis and approved by the Program Director and management.	**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 RSM US LLP. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor. Per the Shelter Manager, 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 documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Policy and Procedure number: CHS1017 addresses: Access to Consumer Information and Records and Confidentiality of Consumer Information and Records. There are security procedures in place for laptops.	**No recommendation or Corrective Action.**

CONCLUSION

CHS WaveCREST 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.

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CHS - WaveCREST
Residential Program

November 6 - 7, 2019

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	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	Failed
3.07 Video Surveillance System	Satisfactory

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 14.29%

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:96.55%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 3.45%

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, Consultant-Forefront LLC, Florida Network of Youth and Family Services

Shakela Minns, Regional Monitor, Department of Juvenile Justice

Terence Washington, Prevention Program Director, Mount Bethel

Pam Palmer, Director of Residential Services, SMA Beach House

Raylene Coe, Street Outreach Coordinator, Crosswinds

Quality Improvement Review

CHS - WaveCREST – November 6 - 7, 2019
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
- **1** # Program Supervisors
- **NA** # Food Service Personnel
- **1** # Healthcare Staff
- **NA** # Maintenance Personnel
- **NA** # 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
- **2** # MH/SA Records
- 5 # Personnel /Volunteer Records
- **5** # Training Records
- **5** # Youth Records (Closed)
- 5 # Youth Records (Open)
- **NA** # Other: _____

Surveys

- **4** # Youth
- 4 # Direct Care Staff
- **0** # Other: **NA**

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 agency is implementing a step pay increase for Youth Care Specialists. The employees pay will increase at set increments of continued employment. At the end of their first year of employment a Youth Care Specialist will be a $12/hour. Non-residential staff will receive a $2,000 starting increase. The agency is hoping this will help increase retention rates and decrease turnover rates.

The shelter is in the process of hooking up to the city septic system. St. Lucie County has agreed to pay the $75,000 it will cost as a capital improvement for the shelter.

Standard 1: Management Accountability

Overview

CHS WaveCREST is managed by an Executive Director and a Director of Program Operations. Day-to-day activities in the youth shelter are managed by a Residential Supervisor. At the time of the review there were four vacant Youth Care Specialist's positions, one vacant Food Service Manager position, and one vacant Outreach Counselor position.

The shelter has a failing septic system and is in the process of hooking up to the city septic system. The city has agreed to pay the $75,000 it will cost for the shelter to hook up to city water. The shelter also received a new hot water heater about a month prior to the on-site review.

At the time of the review the shelter had one vehicle in the shop for needed repairs.

The shelter has had on-going issues hiring qualified staff. Delays in the background screening process, driving records, hours, and pay have all contributed to the hiring issues.

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

Standard 2: Intervention and Case Management

Overview

CHS WaveCREST provides residential and non-residential counseling and case management services across four counties, Indian River, Okeechobee, Martin, and St. Lucie, in Circuit 19.

The residential counseling program consists of a Program Supervisor who is a Licensed Clinical Social Worker (LCSW) who oversees one Counselor II.

The non-residential counseling program consists of a CINS/FINS Non-Residential Supervisor who is a Licensed Mental Health Counselor (LMHC) who oversees four Outreach Counselors. At the time of the on-site review one of the Outreach Counselor positions was vacant.

The non-residential program also offers Family/Youth Respite Aftercare services (FYRAC) and Stop Now and Plan (SNAP) services. Intensive Case Management (ICM) services are not offered at this location.

The residential program has provided domestic violence and probation respite services. At the time of the review the program had not provided any staff secure or domestic minor sex trafficking services. The agency is currently maintaining paper files.

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

Standard 3: Shelter Care

Overview

CHS WaveCREST residential program is led by a Residential Supervisor. The shelter runs three shifts. Each shift is staffed with Youth Care Specialists (YCS). There are currently four full-time and one part-time YCS staff. There were two full-time and two relief YCS positions vacant.

The building occupied by the shelter program is over forty years old and is leased by Children's Home Society from St. Lucie County. The shelter consists of a large day room with two hallways extending from each side of the dayroom. One hallway houses the male sleeping rooms and the other hallway houses the female sleeping rooms. Each hallway has five bedrooms with four bedrooms housing two youth and the fifth bedroom housing three youth. This gives the program the flexibility to accommodate more youth of one gender when necessary.

All indicators in standard three were rated satisfactory with the exception of indicator 3.06 Staffing and Youth Supervision which was rated a failed. There was a deficiency noted in indicator 3.04 Log Books due to a few instances staff signed in the log book but did not indicate a review of the previous two shifts; however, this deficiency did not result in an exception. Exceptions noted in 3.06 were due only one staff being present on the overnight shift a majority of the last six months. All other indicators in standard three were rated satisfactory with no deficiencies or exceptions.

Standard 4: Mental Health/Health Services

Overview

The residential counseling services in the shelter are provided by the Program Supervisor who is a Licensed Clinical Social Worker (LCSW) who oversees one Counselor II.

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 at least twenty hours each week. The RN will distribute all medications when on-site and trained Youth Care Specialists (YCS) will distribute medications when the RN is not on-site.

All staff are trained on the medication distribution process and the Pyxis Med-Station 4000 Medication Cabinet at hire. Refresher training is provided for as needed.

All medications in the facility are stored in the Pyxis Med-Station 4000 Medication Cabinet. The RN completes a weekly inventory of all medications on-site. YCS complete shift-to-shift inventories of all controlled medications and maintain perpetual inventories of all other medications.

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

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 a policy in place titled CHS/7101 Background Screening of Employees/Volunteers, Annual Affidavit of Compliance with Good Moral Character & Annual Abuse Registry Clearance. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	There was one newly hired staff who was reviewed for a background screening completed prior to hire. The background screening was completed prior to hire with an eligible rating. The staff also had a pre-employment suitability assessment completed, using the Berke Assessment. There was documentation of E-Verify obtained from the Department of Homeland Security. There were no staff eligible for a five-year rescreening. The Affidavit of Annual Compliance was completed and submitted to the Department of Juvenile Justice Background Screening Unit via email on	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		
						November 6, 2019, prior to the January 31, 2020 deadline.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ YES ☐ NO (explain) The agency has a policy in place titled CHS/7102 Providing an Abuse Free Environment. The policy was last reviewed September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation. There are many signs throughout the shelter to reflect that all youth are accepted regardless of sexual orientation, gender identity, or gender expression. There are also many postings throughout the shelter with information regarding the Florida Abuse Hotline. The program has a process in place for documenting any child abuse hotline calls. During the last six months there has not been any incidents of physical, psychological abuse, verbal intimidation, use of profanity, or excessive force to review. The program does; however, have a policy written for management to take immediate action if any of the above issues were to occur. The program provides an accessible, as well as responsive grievance process for youth to provide feedback and address complaints. The locked grievance box is	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		
						available to youth in the common area. The direct care workers do not handle the complaint/grievance documents, only the supervisor. During the review period the program did not have any grievances that needed to be resolved within seventy-two hours by management; however, there is a written policy. The program 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 in place titled CHS/7103 Incident Reporting. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	A review of the Department's Central Communication Center (CCC) daily report found the program had a total of nine reportable incidents. All incidents were reported no later than two hours after the reportable incident occurred, or within two hours of the program learning of the incident. When applicable, the program completed follow-up communication task or special instructions as required by the CCC. All reviewed reportable incidents were documented in the program's log book. All incidents were documented in the program's electronic reporting system and were reviewed and signed by the supervisor or director electronically.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
1.04: 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 CHS/7104 Training Requirements. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	There were two staff training files reviewed for first year training requirements. Both staff had exceeded the required 80 hours of training for the first year of employment. The first staff had 104.75 training hours and had completed all but two of the required trainings. This staff still has approximately nine months left in their training cycle to receive these trainings. The second staff had 103 training hours and had completed all required trainings. This staff still had approximately two and a half months left in their training cycle to receive additional trainings. There were three staff training files reviewed for annual training requirements. The three staff documented 36.75, 61.50, and 43.25, of the required 40 hours of annual training, for 2019. All three staff still have until December 31, 2019 to receive additional trainings. All three staff have already competed all required trainings.	No exceptions
1.05: Analyzing and Reporting Information							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
The program 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 CHS/7105 Analyzing and Reporting Information. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	The agency's Quality Management department completes a quarterly review of case files and emails the program the results of that review. The residential supervisor reviews the results and discusses the findings during the next staff meeting. Any corrective actions or improvements needed are discussed during the meeting. Incidents, accidents, and grievances are reviewed monthly during the staff meetings. Customer satisfaction data is reviewed electronically since surveys are completed electronically now. This information is shared with staff during monthly meetings. NetMIS data reports and JJIS reports are reviewed monthly by the data coordinator and administrative assistant to ensure accuracy of data entry.	No exceptions
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)	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 agency has a policy in place titled CHS/7106 Client Transportation. The policy was last reviewed September 23, 2019 by the Director of Program Operations.	
RATING	☒	☐	☐	☐	☐	The program has implemented a transportation policy with drivers approved by administrative personnel. The approved agency drivers are documented as having a valid Florida driver license and are covered under company insurance policy. The agency's transportation policy prohibits transporting a client without maintaining at least one other passenger in the vehicle during the trip. The 3rd party is an approved volunteer, intern agency staff, or youth. The agency transportation policy included exceptions if a 3rd party is not present in the vehicle while transporting. If a 3rd party cannot be obtained for transport the agency supervisor considers the clients history, evaluation, and recent behaviors. The Travel Log forms were reviewed from 6/3/19 – 11/5/19. There is evidence that the program supervisor is aware prior to transport and consent is given when a single driver was transporting a single youth. The Travel Log provides documentation of use of vehicle that notes name of driver, date, time, mileage, number of passengers, purpose of travel, and location.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
1.07: Outreach Services **The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) The agency has a policy in place titled CHS/7107 Outreach and Interagency Agreements. The policy was last reviewed September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	The agency attends numerous outreach and prevention events, totaling seventy-one events thus far since 5/9/19. The minutes of the events are being provided by the agency. There is evidence that a representative of the agency attended each event, and in some cases facilitated the event. The agency has lead staff members such as Director of Program Operations and Director of Outreach that are designated to participate in local DJJ Board and Council meetings. There were minutes of the meetings, as well as other documentation of attendance. The program maintains written agreements, in a binder, with other community partners which includes services provided and a comprehensive referral process.	No exceptions

STANDARD 2: INTERVENTION AND CASE MANAGEMENT

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Two – Intervention and Case Management							
2.01: Screening and Intake							
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☒ YES ☐ NO (explain) The agency has a policy in place titled CHS/7201 Screening Eligibility for Services and Intake Assessment. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	There were ten files reviewed five non-residential (two open and three closed) and five residential (two open and three closed). In all ten files the eligibility screening was completed within seven calendar days of referral. All ten files contained a signed document indicating that the parent and/or guardian received written information about service options, rights and responsibilities, the parent handbook, and CIN/FINS brochure explaining possible actions that could occur from participation in the program and grievance procedures.	No exceptions
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain)	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The agency has a policy in place titled CHS/7202 Needs Assessment. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	
RATING	☒	☐	☐	☐	☐	There were ten files reviewed five non-residential (two open and three closed) and five residential (two open and three closed). All five residential files contained a Needs Assessment that was completed within twenty-four hours of intake and each of the five non-residential files contained a Needs Assessment completed the same day as admission. In all ten files reviewed, each Need Assessment was completed and signed by a bachelor's or master's level staff member and contained a supervisor's review signature. None of the youth in any of the ten files reviewed were identified with an elevated risk of suicide.	No exceptions
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) The agency has a policy in place titled CHS/7203 Case/Service Plans. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	There were ten files reviewed five non-residential (two open and three closed) and five residential (two open and three closed). All ten files contained a Case/Service Plan dated and initiated the same day as the youth's intake date. This	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		
						exceeds the indicator's requirement for development of the Case/Service Plan within seven working days of the Needs Assessment. Each Case/Service Plan reviewed contained individualized and prioritized needs and goals as identified in the Needs Assessment and provided service type, frequency, location, and person responsible. All applicable Case/Service Plans had target completion dates or actual completion dates. All ten also contained signatures or notations that parents acknowledged and agreed to the terms of the Case/Service Plan and/or any subsequent reviews. Each of the Case/Service Plans were signed by the counselor and supervisor as were subsequent updates/reviews. All five residential files documented a progress review was completed and signed or acknowledged by the parent, youth, counselor, and supervisor at seven- and twenty-one-day intervals. The five non-residential files documented progress reviews of the Case/Service Plan occurred at thirty, sixty, and ninety days and every six months thereafter, as applicable. Each of these reviews also contained signatures or documented acknowledgement from the parent/guardian and youth, as well as the signature of the assigned counselor and supervisor.	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
2.04: 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 in place titled CHS/7204 Case Management and Service Delivery. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	There were ten files reviewed five non-residential (two open and three closed) and five residential (two open and three closed). All ten files documented a counselor was assigned to the youth at intake. The counselor completing the Needs Assessment also signed the Case/Service Plan indicating that the goals and services to be provided were reviewed with the parent/guardian and youth. The files reviewed contained parent/guardian signatures on every Case/Service Plan acknowledging their agreement to engage in the process of assisting the program. In every instance where the parent/guardian and/or youth were unavailable to sign reviews of the Case/Service Plan, the counselor documented efforts and/or verbal consent. The files reviewed contained chronological notes in addition to the Case/Service Plan reviews which indicate on-going case management to monitor progress, adjust goals, provide assistance and support, and make referrals to	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		
						additional services as needed. Although there were no referrals for case staffing's or for judicial intervention in any of the ten files reviewed, it appears from the program's policy that the assigned counselor would be the staff person making such referrals and would accompany the youth and parents to any court hearings or related appointments, as well as continue progress monitoring and reporting. The six closed files reflect that the counselor assigned performed case termination and timely follow ups with the parent/guardian.	
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 in place titled CHS/7205 Counseling Services. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	There were ten files reviewed five non-residential (two open and three closed) and five residential (two open and three closed). Each of the ten files reviewed contained an individualized Needs Assessment on each youth. In each of the files reviewed, the Case/Service Plan appropriately addressed youth's presenting problems. All files documented timely reviews of the Case/Service Plan and dated notations when goals were met.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Signature of the counselor's supervisor on reviews indicated that the program has an on-going internal process for clinical review of case records and staff performance. Each of the ten files contained case management and/or chronological notes by the assigned counselor and follow up documentation, as applicable. The program's binder for shelter group counseling was reviewed for the dates June 1, 2019 through July 30, 2019 and October 1, 2019 through November 5, 2019. Based on this review, the program shows that it is providing group counseling at least five days per week to residential shelter youth. Each group session sign-in sheet lists the date and time of the session, the length of the session, and is titled with the relevant topic and name the facilitator. Each residential youth participating in the group session sign the sheet themselves and the counselor's notes in each of the five residential youth files reviewed correlate to the group sessions. The five non-residential files reviewed contained documentation in the form of chronological and/or case management notes when individual and/or family counseling services were provided.	
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain)	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The agency has a policy in place titled CHS/7206 Case Staffing Committee. The policy was last reviewed September 23, 2019 by the Director of Program Operations.	
RATING	☐	☐	☒	☐	☐	The program did not have any case staffing's during the review period. An interview with the counselor confirmed the agency has a process in place to conduct the case staffing and petition process when needed. There is an established case staffing committee with required members.	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 CHS/7207 Youth Records. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	There were ten files reviewed five non-residential (two open and three closed) and five residential (two open and three closed). Each of the ten files were clearly labeled as "confidential" in red ink and maintained in a neat and orderly manner. The container used to transport files is solid, opaque, and marked confidential. Files are stored in a secured cabinet in the assigned counselor's office when open and in a locked cabinet behind a locked door when closed.	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		
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 in place titled CHS/7210 Sexual Orientation, Gender Identity, Gender Expression (SOGIGE). The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	The shelter has signage located throughout the building including in the boy's hallway, the girl's hallway, the staff office, the dayroom, the kitchen, the counselor's office, the intake office, and the lobby indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression. The screening form used at intake asks the youth which gender they identify with and their LGBTQ youth pronoun preference. A review of five staff training files revealed all five staff had received training on policy CHS/7210 Sexual Orientation, Gender Identity, Gender Expression (SOGIGE).	No exceptions
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 a policy in place titled CHS/7211 Special Populations. The policy was last reviewed September 23, 2019 by the Director of Program Operations.	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 agency did not have any examples of Staff Secure, Domestic Minor Sex Trafficking, or Family and Youth Respite Aftercare Services (FYRAC) since the last on-site Quality Improvement review. The agency also does not provide Intensive Case Management Services (ICMS) at this location. There were two Domestic Violence (DV) cases reviewed. Both 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. Neither youth stayed in the program longer than twenty-one days. Both 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 were two Probation Respite files reviewed. Both files 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 with all other general CINS/FINS program requirements.	No Exceptions
2.10: STOP NOW AND PLAN (SNAP)							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☒ YES ☐ NO (explain) The agency has a policy in place titled CHS/7212 Stop Now and Plan (SNAP). The policy was last reviewed on September 23, 2019 by the director of program operations.	No exceptions
RATING	☒	☐	☐	☐	☐	There were four SNAP files reviewed, two open and two closed. All four files documented the youth were screened at intake. There was a signed consent form in each file signed by the parent. A Needs Assessment was completed at intake in each file. A pre-Child Behavior Checklist (CBCL) was completed at intake in each file. A pre-Teacher Report Form (TRF) was also completed in each file. A pre-TOPSE assessment was completed at intake in two of the files and the other two files documented the EARL was completed. A Prevention Assessment Tool (PAT) was completed at intake in each file. For the two closed files a post-CBCL, a post-TRF, a post-TOPSE and a post-PAT was completed. A SNAP Discharge Report Summary was completed in both closed files. There was one session for SNAP in Schools reviewed. Weekly attendance sheets with the youths' name and signature of the teacher and SNAP facilitator were documented for all thirteen sessions. The Class Shoot for Your Goal	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		
						sheet was completed. A pre-evaluation for the teacher and each youth was not completed due to a late start and the school would not allow any extra time or days for the pre-evaluations to be completed. A post-evaluation for the teacher and each youth was completed. There was one Fidelity Adherence Checklist completed.	

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 a policy in place titled CHS/7301 Shelter Environment. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	An observation of the facility found the program furnishing is in reasonable repair, free of insect infestation based upon observation and the Residential Group Care inspection. All bathrooms and showers were sanitized and functional during the time of the site visit. There was no graffiti or contraband/unauthorized items found, lighting was adequate, exterior areas were free of debris, grounds were free of hazards, the dumpster and trash cans were covered, and all doors including staff vehicles were secure. An observation of the program's van confirmed the vehicle was equipped with all required equipment in accordance to the program's policy. An interview with the program manager in comparison with	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						the logbook confirmed access is limited to staff members and key control was in compliance. The program maintains a detailed maps and egress plans in various areas throughout the facility. General client rules, grievance forms, Florida Abuse Hotline information, The Department of Juvenile Justice Central Communication Center (CCC) number, and other related notices were posted. The program has a current Department of Children and Families (DCF) Child Care License displayed with an effective date of February 28, 2019 and an expiration date of February 27, 2020. An observation of the chemical binder found Safety Data Sheets (MSDS) as well as weekly tracking logs of all chemicals. The program utilizes a generic form to track all chemical quantities. At the time of the site visit, the washer and dryer were operational, each youth has their own individual bed, linen, pillow, and blanket. An observation of the pantry found all items were secured in a locked safe in the program's pantry. A review of supporting documentation confirmed the program annual fire inspection was conducted on January 31, 2019. Reviewed documentation also confirmed service for all equipment inspections were completed June 17, 2019, September 18, 2019 and, October 15, 2019. A review of the program's drill book found fire drills were conducted at 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		
						minimum three times a month except in July and August drills were conducted twice. The program still exceeded the requirement. The program conducted emergency mock drills June 14, 2019, July 31, 2019, August 29, 2019, September 27, 2019, and October 31, 2019. The program maintains a combined current Satisfactory Residential Group Care inspection report and Satisfactory Food Service inspection report from the Department of Health dated February 8, 2019. Food menus signed by a licensed Dietician were observed posted on the bulletin board inside of the kitchen. All food was properly stored and labeled in the refrigerator and pantry. An observation of the refrigerator and freezer were clean and maintained at required temperature. The freezers temperature was zero and the refrigerator temperatures were between thirty-seven and forty. An observation of the program's schedule posted throughout the facility confirmed youth engage in meaningful structured activities seven days a week with minimal idle time. All youth receive one hour of physical activity and are provided the opportunity to participate in a variety of faith-based activities. All youth are allowed time to complete homework and quiet time for reading.	
3.02: Program Orientation							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) The agency has a policy in place titled CHS/7302 Program Orientation. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	There were two open and three closed residential youth files reviewed for program orientation. All youth received a handbook and were provided orientation within twenty-four hours of being admitted into the program. Each file contained an orientation check list initialed and signed by the youth and staff. The orientation checklist covered disciplinary action, grievance procedure, emergency/disaster procedure, contraband rules, physical/ facility layout map, room assignments, daily activity, and the Florida Abuse Hotline number. When applicable suicide prevention alert notification was discussed. Four youth's intake documentation included the parent/guardian and youth signature. One youth's intake documentation included the youth's signature and noted the parent participated by phone.	No exceptions
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain)	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 agency has a policy in place titled CHS/7303 Youth Room Assignment. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	
RATING	☒	☐	☐	☐	☐	The program has a process in place which includes an initial classification of the youth. A review of two open and three closed residential youth files was conducted for youth room assignments. Each youth's history, status, and exposure to trauma were considered prior to room assignments. The program's classification factors included age, gender, history of violence, disabilities, gang affiliation, gender identification, physical and sexual aggression level, suicide risk, and collateral contracts when applicable. All youth files documented applicable alerts pertaining to the youth. Initial interactions and observations were reviewed.	No exceptions
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 CHS/7304 Logbook Requirements. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☐	☒	☐	☐	☐	The provider has a process in place to monitor daily activities, events, and other major occurrences. A review of the program's logbook found safety and	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		
						security issues were highlighted, all entries were brief and legibly written in ink. Supervision counts, medication administration, visitation, and home visits were documented. All entries included dates, times, youth and staff involved, a brief statement, and the name and signature of the staff making the entries. There was no use of whiteout or recording errors. Supervisory staff reviewed the logbooks for previous shifts by signing and dating the logbook. Direct care staff signed and date acknowledging reviewing the previous shifts. However, there were a few instances where the staff just signed but did not indicate they reviewed the previous two shifts. The Program Director reviewed the logbook weekly in accordance to the policy.	
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The agency has a policy in place titled CHS/7305 Behavior Management Strategies. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has a detailed hand-written Behavior Management Strategies (BMS) in place. The BMS is explained to all youth during the intake process and is also outlined in the resident's handbook. The written description of the BMS	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		
						includes positive incentives used by the program, appropriate interventions used by the program to teach the youth new behaviors and help the youth understand the natural consequences for their actions, and behavioral interventions are applied immediately with certainty, and reflect the severity of the behavior. The BMS also outlines consequences for violation of the program rules are applied logically and consistently, the program uses a variety of rewards/incentives to encourage participation and completion of the program, the BMS promotes order, safety, security, respect, fairness, and protection of youth rights, and the BMS provides constructive discipline which encourages youth to meet behavior expectations. The BMS provides positive reinforcement and recognition; constructive dialogue and peaceful resolution and minimizes separation of youth from the general population. Additionally, the BMS disciplinary measures do not deny the youth regular meals, snacks, clothing, sleep, physical or mental health services, educational services, exercise, correspondence privileges, and contact with parent/guardian, attorney, or juvenile probation officer (JPO). A review of two open and three closed files confirmed the program's practice. All reviewed staff training files found the staff were trained in	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						the theory and practice of administering BMS rewards and consequences. Supervisors are trained to monitor the use of behavioral interventions by their staff to include the use of point based and level-based interventions.	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) The agency has a policy in place titled CHS/7306 Staffing and Youth Supervision. The policy was last reviewed on September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☐	☒	☐	☐	☐	Staff schedules were reviewed for the last six months. Ratio requirements were met with one staff to six youth during the awake hours. However, during sleeping hours, although ratio requirements were met with one staff to twelve youth, there were not two staff on duty during sleeping hours the majority of the last six months. During the month June 2019 there were between two and four nights a week with only one staff on duty during the sleeping hours. After June 2019 the shelter had two staff members quit suddenly and unexpectedly and another staff member go out on FMLA. This resulted in overnight shifts during the months of July, August, and most of September having only one staff on duty for a six-hour time frame, from 12am until 6am. During this	There have not been at least two staff members on duty at all times on the overnight shift during the majority of the last six months. From the last week in September until the time of the on-site quality improvement review there were between two and four overnight shifts each week, with a gap of four hours, with only one staff on duty.

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		
						time there were seven different individuals who completed a Berke Assessment and scored high enough to be contacted for an interview. Out of those seven individuals, two declined the interview, two declined the position due to hours and pay, one was rejected by human resources due to their driving record, one individual was hired on September 27, 2019; however, accepted a job somewhere else on October 24, 2019 due to the background screening process taking so long. There was one individual out of the seven that was actually hired and stayed. This individual was offered the position on June 26, 2019 but did not start working at the shelter until August 4, 2019 due to the delays in the background screening process between the Department of Juvenile Justice and the Department of Children and Families. This person helped fill ratio requirements on the overnight shift; however, due to the other vacant positions not being filled the program still struggled to have two staff members present on the overnight shift until the end of September. From the last week in September until the time of the on-site quality improvement review there were between two and four overnight shifts each week, with a gap of four hours, with only one staff on duty. Staff from the 4pm – 12am shift have been staying over two extra hours to help with the overnight shift,	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						bringing the gap of having only one staff member on duty down from six hours to four hours. In addition, the residential supervisor, the counselor, and two staff members from another program operated by the agency were helping to fill the ratio requirements and reduce the frequency of having only one staff on duty during the overnight shifts. At the time of the review the shelter had one full-time staff hired and scheduled to start work the Monday following the review. There was one full-time and one part-time staff going through the hiring process and waiting on background screenings to come back. There were also two other individuals who had just completed the Berke Assessment and were candidates for an interview. Staff observe the youth at least every fifteen minutes, during the sleeping periods. Staff actually exceed the fifteen-minute requirement by observing the youth every ten minutes or less. Documentation in the logbook confirmed the staff compete the bed checks at least every ten minutes. A review of three random nights of video surveillance also confirmed staff completing the bed checks at least every ten minutes. The residential supervisor reviews the video surveillance from the overnight shifts at least weekly to ensure the checks are being done appropriately. This review is documented	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						on a log along with the dates and time frames for that review.	
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 titled CHS/7307 Video Surveillance System. The policy was last reviewed September 23, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has a written notice that is conspicuously posted on the premises at the entrance of the shelter. 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 no cameras in the bathrooms or sleeping quarters. The system can capture and retain video photographic images up to thirty-eight days. The camera system can record date, time, location, and maintain resolution that enables facial recognition. Per supervisor, the camera system has a backup battery that can operate several hours during a power outage. The program has a list of designated personnel who can access the video surveillance system. The camera log and logbook entries were reviewed both revealed that a supervisor is reviewing video consistently at a minimum of once	No exceptions

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						every fourteen days. The program has a process in place for third party review of recordings if needed.	

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

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 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 in place titled CHS/7401 Healthcare Admission Screening. The policy was last reviewed on October 1, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	There were a total of five files reviewed, three open and two closed. All five files documented a healthcare screening was completed on the day of admission. Four out the five files documented the nurse reviewed the healthcare screening forms within the required time frames. One youth was only in the shelter five hours and left before the nurse was able to review the forms. All five youth documented either a medical condition, a mental health condition, medications, allergies, and/or a chronic condition. Two out of the five files documented the youth needed coordination of the parents for follow up appointments and both files had documentation that the appointments were made.	No exceptions
4.02 Suicide Prevention **There is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.**							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled CHS/7402 Suicide Prevention. The policy was last reviewed on October 1, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	There were only two closed files available for review, for the last six months, of youth who had been placed on suicide precautions. Both youth were screened during the initial intake process. Both suicide screenings were reviewed and signed by the supervisor. Both youth were placed on sight and sound supervision. Both youth were assessed by a qualified mental health professional within twenty-four hours and were appropriately removed from suicide precautions and placed on standard supervision. Staff documented the youth's behavior at ten-minute intervals the entire time while on suicide precautions.	No exceptions
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 in place titled CHS/7403 Medications. The policy was last reviewed on October 1, 2019 by the Director of Program Operations.	No exceptions
RATING	☒	☐	☐	☐	☐	The shelter has a Registered Nurse (RN) who is on-site at least twenty hours each week. All medications were observed to be stored in the Pyxis Med-Station 4000 Medication Cabinet which is not	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		
						accessible to the youth. The shelter maintains a list of staff authorized to administer medications and four of those staff are documented as Super Users. The shelter currently does not accept youth on injectable medications, except for Epi-pens. It was observed that oral medications were stored separately from topical medications. In reviewing six staff training files, all non-licensed staff were trained on how to use an Epi-pen. The Agency did not have any medications that required refrigeration, but they did have a secure refrigerator that is only used for medications. The temperature was recorded at forty degrees which is within the required range. The refrigerator had a double lock, one on the outside and one on the inside. It was observed that narcotics and controlled medications are stored in the Med-Station. Shift-to-shift counts (verified by a witness) and were conducted for all controlled substances. A perpetual inventory with running balances is also maintained for all medications. Only designated staff delineated in writing have access to secured medications, with limited access to controlled substances. The shelter currently does not have any syringes but does have the means to secure them, provide the necessary counts weekly, and document the inventories if necessary. Razors are inventoried and logged with each use.	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Over-the-counter medications that are assessed regularly are inventoried weekly and the counts are logged in the Over-the-counter Medication Logbook. The shelter uses a Medication Log Record (MLR) to document all medications given. Four of the five youth files reviewed documented the youth were on medications. Each file documented the MLR was completed in its entirety and all medications were given as prescribed. The RN completes a monthly review of medication management practice via the Pyxis Med-Station reports and verifies medications utilizing pharmacy verification which is an approved practice by the Florida Network. It was confirmed during an interview with the RN that when the nurse is on-site medication processes are conducted by the RN. In reviewing the discrepancy audit report that is completed by the RN monthly, it confirmed that discrepancies are cleared at the end of each shift.	
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 titled CHS/7404 Medical/Mental Health Alerts. The policy was last reviewed on October 1, 2019 by the Director of Program Operations.	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	☒	☐	☐	☐	☐	There were five files reviewed, three open and two closed. All five files documented the youth had a medical or mental health condition requiring an alert. All five files had an alert sticker on the outside of the file and a yellow general alert form in the front of the file. In all five files the alerts documented precautions concerning medications prescribed, medical and mental health conditions as well as run risk, aggressive behaviors, criminal history, gang affiliations, susceptibility to victimization, physical disabilities, and substance abuse issues. In all five files the alerts included sufficient information concerning the youth's medical condition, allergies, common side effects to medications, food and medications that are contraindicated, and other pertinent mental health treatment information, documented in the youth's Mental/Medical Healthcare Follow-up Notes for staff to review. Alerts were also documented in the chronological entries and progress notes in all five files. In reviewing the logbooks and the program alert board, all alerts were properly documented and easy to find by staff.	No exceptions
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled CHS/7405 Episodic/Emergency Care. 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		
						policy was last reviewed on October 1, 2019 by the Director of Program Operations.	
RATING	☒	☐	☐	☐	☐	There have been two instances of off-site emergency medical care in the past six months. Both incidents were documented in the youth's file and also on an incident report. Both incidents were also reported to the Central Communications Center (CCC). Documentation reviewed in both files documented medical clearance as well as discharge instructions. Both incidents documented the parents were notified. Both incidents were also documented in the logbook. In reviewing the training files for six staff, all contained training for emergency medical procedures. It was observed that the agency had a knife-for-life and a wire cutter easily accessible to staff. It was observed that the agency had an AED and first aid kits located in the group room, staff office, kitchen, and two portable kits for the vans.	No exceptions