Florida Network for Youth and Family Services
Compliance Monitoring Report for

Family Resources - Clearwater
1615 Union Street
Clearwater, FL 33755

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 Family Resources - Clearwater for the FY 2019-2020 at its program office located at 1615 Union Street, Clearwater, 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. Family Resources - Clearwater 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 Family Resources - Clearwater present for the entrance interview were: Beth Davis, Chief Executive Officer; Elizabeth Polifrone, Community Services Supervisor; and Erik Kline, Residential Supervisor. The last onsite QI visit was conducted February 5 – 6, 2019.

In general, the Reviewer found that Family Resources - Clearwater is in compliance with specific contract requirements. **Family Resources - Clearwater 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 10-23-2019

Agency Name: Family Resources - Clearwater	**Monitor Name: Ashley Davies, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1615 Union St., Clearwater, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): October 23 - 24, 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. None of the staff members have participated as peer reviewer this season but are scheduled to participate on reviews later in the 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 additional contracts for FY2019 - 2020 for the shelter and for the Family Counseling program. 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.**

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	Explain Rating					**Ratings Based Upon:**	**Notes**
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
Limits of Coverage 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**	☐	☐	☒	☐	☐	Documentation: General Liability through Alliance of Nonprofits for Ins. RRG, for limits of coverage $1,000,000 each $3,000,000 aggregate and medical expenses of $20,000 for any one person, effective 6/01/19 – 6/01/20. Workers Compensation through EVANSTON INS CO with limits of $2,000,000 each/aggregate, effective 6/1/19 – 6/1/20. Automobile insurance through Alliance of Nonprofits for Ins. RRG with an umbrella policy through Alliance of Nonprofits for Ins. RRG for combined limits of $1,000,000 effective for 6/1/19 – 6/1/20. Directors and Officers Liability insurance through Alliance of Nonprofits for Ins. RRG for a limit of liability of $1,000,00/$2,000,000 each/aggregate. Policy effective for 6/1/2019– 6/1/2020.	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						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: Fiscal Policies and Procedures are contained in Section F-Financial Management of the Administrative Standard Operating Manual. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. Procedures are included for general ledger, payroll, petty cash, computer backup, and other relevant financial processes. Polices were last reviewed in 2016 by the chief executive officer.	**No recommendation or Corrective Action.**
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. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program and non-residential program.	**No recommendation or Corrective Action.**

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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 February 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 secure locked location in the building. The Residential Supervisor reported all receipts are submitted to finance at the main office for reimbursement as needed. Reimbursement comes in the form of a check made out to the Residential Supervisor, who will then cash it and place money in petty cash box.	**No recommendation or Corrective Action.**
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 SunTrust. 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. Checks disbursed over $750 are signed by two	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						individuals with signing authority. Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files.	
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: The agency provided documentation for the last six months of payment of payroll taxes. Payroll taxes are paid weekly via electronic payment through the IRS. Electronic print out documents Tax form 941 was completed.	**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: Agency provided a Budget-to-Actual report for the current fiscal year. A review of these documents was conducted. Report shows program budget and actual with YTD actual, budget, variance, and %. Variances in budget are monitored on a regular basis and approved by 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 was completed by Assurance Dimensions. 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 documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Policies and procedures for Confidentiality/Release of Information, System Backup, and Disaster Recovery were reviewed. A daily back-up is performed on all information saved on various servers throughout the agency. Policies were last reviewed in 2016 by the chief executive officer.	**No recommendation or Corrective Action.**

CONCLUSION

Family Resources - Clearwater 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 Family Resources - Clearwater
Residential Program

October 23 – 24, 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	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, Consultant-Forefront LLC, Florida Network of Youth and Family Services

Felecia Goldstein, Regional Monitor, Department of Juvenile Justice

Erica Trendell, Counselor, Youth and Family Alternatives

Sheryl Kincy, Program Coordinator, Youth Advocate Program

Christine Morgan, Senior Youth Care Supervisor, Orange County Youth and Family Services

Quality Improvement Review

Family Resources - Clearwater – October 23 – 24, 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
- **4** # MH/SA Records
- 7 # Personnel /Volunteer Records
- **7** # Training Records
- **5** # Youth Records (Closed)
- 5 # Youth Records (Open)
- **NA** # Other: _____

Surveys

- **3** # Youth
- 3 # 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

Family Resources Clearwater was the recipient of the 2019 Florida Network Best Care Provider Award.

Youth and staff had a chance to attend six Tamp Bay Rays games and were provided a suite, with food and drink included, through the Tamp Bay Rays Home Run Club as well as attending Tampa Bay Rowdies and minor league baseball games.

The agency is going into their 50th year of service next year, 2020.

The agency received a 4-star rating for demonstrating strong financial health and commitment to accountability and transparency from Charity Navigator. This is the highest possible rating and indicates the organization adheres to sector best practices and executes its missions in a financially efficient way. This is the third year in a row the agency has received this rating and only 23% of the charities evaluated receive at least three consecutive 4-star evaluations indicating Family Resources outperforms most other charities in America.

Standard 1: Management Accountability

Overview

Family Resources Clearwater is managed by a vice president of residential services who oversees a shelter supervisor. At the time of the review there was one vacant cook position. Since the last on-site Quality Improvement review the program has brought on three new Youth Development Specialists (YDS), one full-time and two PRN. The program was able to hire and retain staff due to a significant pay increase that was approved by the agency for all YDS staff.

All indicators in standard one were rated satisfactory with 1 exception noted in 1.04 Training Requirements. There were deficiencies noted in indicators 1.03 Incident Reporting and 1.04 Training Requirements. The deficiency noted in 1.03 was due to one of the thirteen Central Communications Center (CCC) reportable incidents being reported outside the two-hour time frame until following day of staff having knowledge of the incident. This deficiency did not result in an exception. The exception noted in 1.04 was due to one staff not receiving two required trainings during the last completed training cycle.

Standard 2: Intervention and Case Management

Overview

Family Resources Clearwater provides residential and non-residential counseling and case management services across one county, Pinellas, in circuit six.

The residential counseling program consists of one counselor who is a Licensed Mental Health Counselor (LMHC) and a bachelor's level case manager. The residential counseling program is overseen by the vice president of residential services.

The non-residential counseling program is housed on-site with offices in the same building as the youth shelter. The non-residential program consists of three master's level counselors. One of the counselor's is a registered intern working towards a Licensed Clinical Social Worker (LCSW). The non-residential counseling program is overseen by a community services supervisor who is a LCSW.

The non-residential program also offers Family/Youth Respite Aftercare Services (FYRAC). Intensive Case Management (ICM) services and Stop Now and Plan (SNAP) 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, with the exception of indicator 2.10 Stop Now and Plan (SNAP), were rated satisfactory with no exceptions or deficiencies noted. Indicator 2.10 was rated not applicable as the agency does not provide SNAP services at this location.

Standard 3: Shelter Care

Overview

Family Resources Clearwater residential program is led by a residential supervisor. The shelter runs three shifts. Each shift is staffed with Youth Development Specialists (YDS). There are currently six full-time, four part-time, and four on-call YDS staff.

During the summer months the shelter finished another successful summer implementing the “Hello my name is, World Traveler” curriculum. The curriculum enables the youth to study ten different countries throughout the summer, at a weeks’ time, and offers educational instruction on the countries cultural aspects as well as trying different ethnic dishes from across the world. The youth created travel journals and passports that allowed them to record their experiences on a daily basis.

Family Resources Clearwater continues to teach life skills to the youth through a curriculum known as Operations iPath. Operations iPath is a socio-economic program designed to help each youth step into the shoes of a fictional character. Each character has an identity including an early life and a current situation. Some have corresponding documents, employment, education, credit cards, and bank accounts. All characters have: bills, curveballs, and choices to make. The focus of iPath is to get participants considering how their current path dictates future choices and how those choices dictate other paths that may or may not be beneficial to their goals.

The youth shelter consists of a large dayroom surrounded by four bedrooms. Each bedroom has three beds and a bathroom with a shower. A local artist has come in and painted the bedroom walls of each room with artwork that comfort and inspires the youth. At the time of the review there were seven CINS/FINS youth in the shelter.

All indicators in standard three were rated satisfactory with exceptions noted in indicators 3.01 Shelter Environment and 3.04 Log Books. Exceptions noted in 3.01 were due to several chemicals being used and stored that are not on the current month’s inventory sheet. Exceptions noted in 3.04 were due to logbook entries including the staff’s initials and not the name and signature of the person making the entry and the

program director or designee reviewing the logbooks weekly by putting a stamp at the top of the page with their initials and date and not a chronological entry. 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 provided by one counselor who is a Licensed Mental Health Counselor (LMHC) and one bachelor's level case manager. The counselor and case manager are overseen by the shelter supervisor and vice president of residential services.

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 approximately two hours in the morning and two hours in the evening. The RN will distribute all medications when on-site and trained Youth Development Specialist (YDS) will distribute medications when the RN is not on-site.

The RN provides training for all newly hired staff on the medication distribution process and the Pyxis Med-Station 4000 Medication Cabinet. 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. YDS 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 1.01 Background Screening of Employees and Volunteers. The policy was last reviewed in April 2019 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five newly hired staff who were reviewed for a background screening completed prior to hire. All five documented a background screening was completed prior to hire with an eligible rating. All five staff also had a pre-employment suitability assessment completed, using the Berke Assessment, with a rating of “high”. All five newly hired staff had documentation of E-Verify obtained from the Department of Homeland Security. There were two staff eligible for a five-year rescreening and the rescreening’s were completed as required. The Affidavit of Annual Compliance was completed and submitted on January 29, 2019.	No exceptions
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in 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		
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 1.02 Provision of an Abuse Free Environment. The policy was last reviewed in March of 2017 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has a code of conduct that all staff sign at hire prohibiting the use of physical abuse, profanity, threats, or intimidation. The program has signage to reflect that all youth are accepted regardless of sexual orientation, gender identity, or gender expression. The program also has postings of the Florida Abuse Hotline. The program has a process in place to document all child abuse hotline calls in an incident report. The program has a locked grievance box and blank grievance forms in youth common area. The grievance box is checked daily by the residential supervisor. There was one grievance filed by a youth on April 16, 2019 to report that a staff raised his voice at him because he touched a clipboard and did not allow him to use the bathroom. The residential supervisor responded to the grievance on April 17, 2019 and the youth signed the grievance form to indicate his agreement with how staff adequately handled his grievance.	No exceptions
1.03: Incident Reporting							

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 1.03						☒ YES ☐ NO (explain) The agency has a policy in place titled 1.03 Incident Reporting. The policy was last reviewed in July of 2017 by the chief executive officer.	No exceptions
RATING	☐	☒	☐	☐	☐	There were sixteen incident reports reviewed for the last six months. Out of those sixteen reports, fourteen were called into the Central Communications Center (CCC) and thirteen were accepted by the CCC as reportable incidents. Twelve of the thirteen incidents were reported to the CCC within two hours of knowledge of the incident. All incident reports were documented in the program logbook and all were documented on incident reporting forms. All incident reports were signed by a supervisor. All reports documented any follow-up communication tasks/special instructions required by the CCC were completed.	One incident was not reported until the day following staff having knowledge of the incident. This deficiency did not result in an exception.
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 1.04 Training Requirements. The policy was last reviewed in March 2017 by the chief executive officer. The agency also has an Annual Training Plan in place effective 7/01/2019 – 6/30/2020 that addresses all current training requirements.	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 three staff training files reviewed for first year training requirements. Two of the staff documented over the required eighty hours of training with 124.5 and 141. Both staff documented all required trainings were completed. The third staff documented over the eighty required hours also, with 123 hours and had all required trainings with the exception of one. However, this staff still had approximately three months in their training cycle left to receive this training. There were four staff training files reviewed for annual training requirements. One staff documented 32.25 hours with all required trainings completed and still has approximately one month left in their training cycle to reach the required forty hours of annual training. The next staff had over the required forty hours with 42.25 hours and documented all required training with the exception of two. This staff still had approximately one month left in their training cycle to complete the required trainings. The third staff documented over the required forty hours with forty-eight hours, for the last completed training cycle. This staff completed all required trainings. The fourth staff documented over the required forty hours with forty-six hours for the last competed training cycle. However, this	Exception: 1 out 4 annual staff was missing 2 required trainings for their annual training requirements.

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		
						staff did not compete two required trainings.	
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 1.05 Analyzing and Reporting Information. The policy was last reviewed in July of 2019 by the vice president of community services.	No exceptions
RATING	☒	☐	☐	☐	☐	The agency completes monthly reviews of case files. There were multiple reports provided of internal reviews of multiple case files each month. The reviews highlighted strengths and weakness of data collection and data entry, as well as the timeliness of signatures needed on documents. There are also monthly reviews of incidents, accidents, and grievances. There is an annual review of outcome data and customer satisfaction data. NetMIS data is reviewed monthly. Findings from these monthly reviews are discussed during the committee team meetings and through emails. A Continual Quality Improvement Worksheet is developed from the data gathered and shared with all staff. There were also copies of emails and screenshots to verify monthly quality checks of NetMIS 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		
						JJIS to help improve accuracy of data entry and collection.	
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 titled 1.10 Transportation. The policy was last updated in March 2017 and signed by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	All drivers are approved by administrative personnel. When transporting a youth at least one other passenger must be in the vehicle during the trip. Agency drivers all have a valid Florida driver's license and are covered under the company insurance policy. Approved third party riders include approved volunteers, interns, agency staff or another youth. There are provisions in the event that a third party is not available to include supervisor's consideration of the youth's history, evaluation, and recent behavior along with the driver's work performance and history. There is evidence of supervisory approval prior to transport. The last six months of the Travel Log's and logbook were reviewed. All trips were documented in the Travel Log with the departure date, initials of the driver and youth, destination, mileage, number of occupants, time leaving, anticipated time of arrival, actual time arrived, and ending mileage. They were all	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		
						signed off by a supervisor. The logbook contained documentation of all trips and supervisory approval was noted for all single client transportations.	
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 1.07 Outreach Services. The policy was last reviewed in March of 2017 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The agency provided verification of attendance to meetings with the Homeless Leadership Board, Pinellas Juvenile Assessment Center On-Site Partner's Meeting and DJJ's Circuit 6 Coordinator Meeting. The agency also provided an Outreach Report dated from April 1, 2019 - October 9, 2019 which reflected outreach initiatives for multiple events including: Community Programs Manager Meeting-Pinellas Sherriff's Office, YMCA Kids Day, UMA Community Resource Fair, and Youth Build. The program maintains written service agreements with community partners which include services provided. All agreements reviewed were current.	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 2.01 Screening and Intake The policy was last reviewed in July 2018 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	Out of ten files reviewed, five were non-residential (two open and three closed) and five were residential (two open and three closed). All ten files documented an eligibility screening within seven days of referral. All ten files documented the youth and parent/guardian received, in writing, available services options, rights and responsibilities, and brochure. All ten files also documented the youth and parent/guardian were provided information on possible actions occurring through involvement with CINS/FINS services and the grievance procedure.	No exceptions
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 in place titled 2.02 Needs Assessment The policy 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		
						last reviewed in March 2017 by the chief executive officer.	
RATING	☒	☐	☐	☐	☐	Out of ten files reviewed, five were non-residential (two open and three closed) and five were residential (two open and three closed). All ten files included a Needs Assessment initiated within seventy-two hours of admission or within two to three face-to-face contacts after intake. Two non-residential files were the only applicable files for an updated Needs Assessment if the most recent assessment is over six months old and both were completed. All ten files had Assessments that were conducted by a bachelor's or master's level staff member and signed by a supervisor upon review. In three of the ten files, the youth was identified with an elevated risk of suicide as a result of the Needs Assessment and in all three files the youth was referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional.	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 2.03 Case/service Plan. The policy was last reviewed in March 2017 by the chief executive 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	☒	☐	☐	☐	☐	Out of ten files reviewed, five were non-residential (two open and three closed) and five were residential (two open and three closed). Seven of the ten files reviewed documented a Service Plan was developed within seven working days of the Needs Assessment. Two files documented the Service Plan was completed after the seven working days; however, there was documentation that there was difficulty meeting with the family. The last file was a newer file and did not have a Service Plan completed yet. The nine Service Plans reviewed included individualized and prioritized needs and goals identified by the Needs Assessment, service type, frequency, location, person responsible, and target dates for completion. Of the ten files reviewed eight files include actual goal completion dates while the other two are still in the early active stage with one file not yet having a Service Plan completed. All nine of the Service Plans reviewed had the signature of the youth, parent/guardian, counselor and supervisor, and include a date the Service Plan was initiated. Of the ten files reviewed, five were not applicable for thirty-day reviews, four met criteria for being reviewed/revised every thirty days for the first three months and every six months thereafter, and the one file had not yet established a Service Plan.	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		
2.04: 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 2.04 Case Management and Service Delivery. The policy was last reviewed in March 2017 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	Out of ten files reviewed, five were non-residential (two open and three closed) and five were residential (two open and three closed). Of the ten files reviewed, all files were assigned a counselor/case manager. All nine applicable files establish referral needs and coordinated referrals to services based upon the ongoing assessment of the youth's/family's problems and needs, coordinated service plan implementation, monitored youth's/family's progress in service, and provided support to families. The one file that was not applicable had not yet developed a service plan. Five out of ten files were applicable and documented monitoring out-of-home placement. No files were applicable for referrals to case staffing committee or accompanying youth/guardian to court hearings and related appointments. Nine out of ten files referred the youth/family for additional services. The one file that did not, is a newer open file with only two meeting dates established. All ten files provided case monitoring and reviews 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		
						six applicable files all provided case termination notes. Of the ten files reviewed, four files were applicable for thirty- and sixty-day follow-ups and all were completed as required.	
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 2.05 Counseling Services. The policy was last reviewed in March 2017 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	Out of ten files reviewed, five were non-residential (two open and three closed) and five were residential (two open and three closed). All ten files reviewed documented coordination between the youth's presenting problems and the Needs Assessment, case management and follow ups, and case notes were maintained for all counseling services provided and documented youth's progress. Nine of the ten files documented coordination between the youth's presenting problems and the initial Service Plan and Service Plan review. The one file had not yet established a Service Plan. All ten files include an on-going process that ensures clinical reviews of case records and staff performance, youth and families received. Nine applicable files documented counseling services in accordance 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 Service Plan, and documentation that the program provides individual and family counseling. All five applicable residential files provide documentation that all youth are given the opportunity to participate in group counseling sessions which consist of a facilitator or leader and a relevant topic that is educational, informational, or developmental and are at least thirty minutes in length.	
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 a policy in place titled 2.06 Adjudication/Petition Process. The policy was last reviewed in March 2017 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There was one active case staffing file to review. The case was referred by the youth's CINS counselor who is also the committee chairperson. The family was notified no less than five working days prior to the staffing. There was a copy of the letter of notification that explained recommendations and reasons behind recommendations in the "Case Staffing" binder. Notification to the committee was no less than five days prior to the staffing, also included in the binder. The case staff included a local school district representative, DJJ representative or CINS/FINS provider, State Attorney's office, Mental Health representative, the youth, and the parent/guardian. As 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		
						result of the case staffing committee meeting, the youth and family were provided a new/revised plan for services. The program does work with the circuit court for judicial intervention for the youth/family and the counselor completed a review summary prior to the court hearing. The program has an established case staffing committee and has regular communication with the committee members. The program also has an internal procedure for the case staffing process, including a schedule for committee meetings.	
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 2.07 Youth Records. The policy was last reviewed in March 2017 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	All ten files reviewed were marked confidential and are kept in a secure file room, inside a locked file cabinet that is also labeled as confidential. The program uses an opaque locked container marked “confidential” when transporting files. All ten files that were reviewed were in a neat and orderly manner.	No exceptions
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain)	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 5.08 Sexual Orientation, Gender Identity & Gender Expression. The policy was last updated in August 2018 and signed by the chief executive officer.	
RATING	☒	☐	☐	☐	☐	The program did not have any youth who were included in the requirements for the SOGIGE indicator. However, the programs policy and procedure do indicate that the elements of the SOGIGE indicator are met by the program. The program did have signage posted in the common areas. Additionally, they have the "zines" around the facility as well. The programs intake assessment form was revised to include what gender the youth identifies with. All staff have been trained on the SOGIGE policy. Any new hires are trained on the policy as part of their first-year training requirements.	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 3.07 Special Populations. The policy was last reviewed in October 2018 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has not had any examples of Staff Secure youth or Domestic Minor Sex Trafficking youth in the last year. This site also does not provide Intensive Case Management Services. There were two Domestic Violence (DV) cases reviewed. Both youth had a pending DV charge 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		
						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. There was one file reviewed for Family and Youth Respite Aftercare Services (FYRAC). The youth was on probation and referred by DJJ. The referral was approved by the Florida Network. The initial intake session was face-to-face and included a gathering of family history and demographic information. The case plan was developed and signed by the youth and parent. An orientation was also provided. Group sessions were sixty minutes in length and focused on strengthening relationships	

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 preventing domestic violence. There were no more than eight youth in a session. The youth participated in services for sixty consecutive days.	
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) Not Applicable	The agency does not provide SNAP services at this location.
RATING	☐	☐	☐	☐	☒	Not Applicable	The agency does not provide SNAP services at this location.

STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain: Deficiency Identified	Rating: Explain: No Eligible Items For Review	Rating: Explain: No Practice	Rating: Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard Three – Shelter Care							
3.01 Shelter Environment **The shelter's environment is safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development.**							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						☒ YES ☐ NO (explain) The agency has a policy in place titled 3.01 Shelter Environment. The policy was last reviewed in March 2017 by the chief executive officer.	No exceptions
RATING	☐	☒	☐	☐	☐	The program's furnishings are in good repair and free from insect infestation. The grounds are landscaped, free of hazards and well maintained. Bathrooms and shower areas are clean and functional. No graffiti was seen during observations. Lighting is adequate for tasks and all doors including the vehicle was secure. Dumpster/garbage cans are covered. The program has one twelve-person passenger van which is equipped with major safety equipment as required. The key ring has a seat belt cutter and a window punch which also serves as an airbag deflator. The van also had one fire extinguisher which was recently inspected. The program has a policy and procedure addressing Key Control and this policy was last updated on June 2017	Exception: There are several chemicals being used and stored that are not on the current month's inventory sheet. Hand sanitizer although seen throughout the building is not on the current inventory it has been on and off the main list over the last few months.

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 approved by the CEO. The procedures indicate access to the building is limited to staff members and key control is in compliance. Detailed maps and egress plans of the facility are posted in each hallway and room. Additionally, the client rules, abuse hotline information, and DJJ incident reporting information is posted in the staff area/youth group room. Blank grievance forms are available on the wall of the youth group room underneath the locked grievance mailbox. The program has a current DCF Child Care license which expires December 15, 2019. During a tour of the program chemicals were seen in four main places: the laundry room, under the sink in the kitchen, in the broom closet, and in the main dining area closet. The program has documentation to show weekly counts of chemicals were being made but the staff wasn't initialing weekly just monthly. The program keeps a binder with all MSDS sheets in the cabinet behind the staff's desk. There is a sheet for all chemicals on site. The program is working on reorganizing their chemicals and updating the inventory to include all chemicals in the program (residential and non-residential).	

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		
						Interior areas did not have contraband and were free from hazardous unauthorized metal/foreign objects. The two washers and two dryers are operational and clean. Each youth has their own bed linens. Every Monday the program puts fresh linens on every bed (filled or vacant). They want youth who are admitted to come into a freshly made bed waiting for them. The program has lockers in a closet which can be locked and serve as a safe place for youth to keep their personal belongings. The Annual alarm test and inspection was completed on July 8, 2019 and no corrective action was needed. The Clearwater Fire and Rescue department completed the annual inspection on August 19, 2019 and a few items were recommended for repair. The department came back out on September 4, 2019 and indicated all corrections were made. The agency had a satisfactory Residential Group Care inspection report from the Department of Health on April 29, 2019. The kitchen hood was also inspected on June 20, 2019 with satisfactory results. Observations of the refrigerator and freezer were made. All items are operable and clean and all cold food is properly stored, marked and labeled, and dry storage/pantry area was clean. Upon further observation the refrigerator's temperature was around 36 degrees and	

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 freezer was negative 26. The program has all current food menus posted in the dining room. All menus were signed by a registered dietician on June 20, 2019. The agency completes a minimum of one fire drill per month within two minutes or less with exception. There were six out of the eighteen fire drills reviewed that documented a response time of over two minutes. However, corrective action was documented on each of the forms in response to the over two-minute time frame. The program also completed one mock emergency drill on every shift each quarter. All fire extinguishers are up to date and were last checked in September 2019. The program has an activity schedule for weekdays and weekends. Each weekday youth are engaged in activity from 5:40 a.m. to 10:00 p.m. and from 8:30 am to 11:00 p.m. on weekends. The schedule indicates one hour of recreation/physical activity is provided daily and non- punitive activities are available if youth do not want to participate in a faith-based activity. The program does not currently have a faith-based provider coming to the program to provide services; however, the youth's handbooks indicates youth can attend church with a parent or they can ask staff about the program taking them to church.	

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 schedule includes over an hour of time for youth to complete homework or read approved books. The daily schedule is posted in the program's main group/living area.	
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 two policies pertaining to this indicator. Policy 3.02 titled Orientation Process and policy 3.08 titled Grievance Process Policy were both reviewed in March 2017 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A review of three open and two closed youth files contained an orientation checklist which indicated the following twenty-two items were reviewed with the youth on the day of admission: • Program Rules • Daily Schedules • Youth rights • Room Assignments • Dress Code and hygiene • Behavior Management System (disciplinary action) • Contraband Policy • Emergency Procedures • Grievance Procedures • Visitation Schedule • Telephone Procedures • Health Services • Guardian Ad Litem	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		
						• Legal Services • Counseling Services • Tour of Shelter (physical layout) • Staff Introduction/roles • Read and sign youth Contract • Receive and read copy of youth handbook • Fire exits and extinguishers • Abuse Hotline numbers • Substance Abuse and Mental Health Office Phone Numbers All five records contained a completed Youth Orientation Checklist which were signed by the youth and a staff person, on the day of admission. Each of the youth files also included a Residential Safety Plan which indicates the youth agrees not to self-injure and to talk to a counselor or other staff if they are having any thoughts of suicide. Additionally, all of the youth Safety Plans, which were signed by the youth, parent, and a staff person on the youth's day of admission, indicate they will abide by program rules when it comes to their safety and the safety of youth and staff.	
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 3.03 Room Assignment. The policy was last reviewed in March 2017 by the chief executive 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	☒	☐	☐	☐	☐	Three open and two closed youth files were reviewed. The program utilizes the Residential CINS/FINS Intake Form to document the initial classification process and room assignment. All five files included this form. Each form included: 1. Review of youth's history and status and exposure to trauma 2. Age 3. Gender 4. History of Violence 5. Disabilities 6. Physical size/strength 7. Gang affiliation 8. Suicide risk 9. Sexually aggressive or reactive behavior 10. Gender identification All five youth were appropriately assigned to a room.	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 3.04 Logbooks. The policy was last reviewed in June 2018 by the chief executive officer.	No exceptions
RATING	☐	☒	☐	☐	☐	The program has a bound logbook which is the permanent record of the life of the program. Logbook entries for the last six months were reviewed. Entries which	Exception: The entries include the staff's initials and not the name and signature of the person making the entry. The program director or

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						could impact the security and safety of the youth and/or program are highlighted. All entries are brief and legibly written in ink and include the date and time of the incident, event or activity, names of youth and staff involved and a brief statement providing pertinent information to the reader. The entries include the staff's initials and not the name and signature of the person making the entry. Entries reflect reviews of the oncoming direct care staff and the oncoming supervisor.	designee is reviewing the logbooks weekly by putting a stamp at the top of the page with their initials and date; however, the requirement is for a note to be made chronologically indicating dates reviewed and if any corrections, recommendations, and/or follow-up is required.
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 3.05 Behavior Management Strategies. The policy was last reviewed in March 2017 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The written description of the BMS is included in each youth's handbook and it is described as the SafePlace2B Behavior Management System (BMS) and Advancing Youth Development (AYD). AYD is based on the principle that youth need to fully be involved in the processes that affect them. This also means they need opportunities to plan, evaluate and communicate with adults. When this happens, youth feel a sense of belonging, membership, empowerment and contribution.	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 BMS is a level system which helps the youth gain more rewards during their stay. Youth are graded each day in their ability to meet expectations in seven areas: 1. Morning chores and hygiene 2. School Attendance 3. Group Attendance 4. After Dinner Chores 5. Bedtime Hygiene 6. Respect 7. Safety Each day youth earn shelter dollars based on their level at the end of the day. Three dollars a day can be earned on leadership level, and two dollars a day for each day on citizenship level). No dollars can be earned on the orientation or ownership level. Each Friday youth can purchase items from the shelter store. The BMS has four levels: Leadership, Citizenship, Orientation, and Ownership). Rewards are commensurate with the level of performance. On the ownership level, consequences are given as well has information on how to get back to the citizenship level. After twenty-four hours on ownership, an ownership paper, which describes the incident, will be given to the program supervisor or the case manager and they will decide what assignment will be given to youth prior to earning back their citizenship level.	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						When youth are on the ownership level they do not gain incentives until they regain citizenship level. At no time does the program take earned shelter dollars from youth as a consequence, nor does the program utilizes room restriction, restraint or group punishment. The program does not deny youth meals, snacks, clothing, sleep, exercise, services or correspondence privileges as a means of discipline. Levels youth have achieved are documented on the program youth information board so each youth can see. A Behavior Grading Sheet is completed for each youth, every day and at the end of the day the total number of shelter dollars earned are documented. All grading sheets are maintained by staff in a binder on the unit. The program supervisor indicated if a staff needed feedback or additional training on the BMS implementation he would make sure it occurs. The program has a six-step approach for processing violation of programmatic values. Each step allows an opportunity for the youth to explain their perspective of the event, assist in taking responsibility and participate in suggesting appropriate consequences. A review of seven staff training files was conducted and each staff was trained in	

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 theory and practice of administering BMS rewards and consequences. The supervisors are trained to monitor the use of interventions by their staff to include the use of point-based and level-based interventions. A review of three youth open and two youth closed files verified each youth received a handbook. The BMS includes a wide variety of positive incentives used by the program. Incentives and privileges are described in the handbook and include but are not limited to items such as late bedtimes, extra phone calls/time, time with video game systems, getting to choose the chore they want, and outings.	
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 3.06 Staffing and Youth Supervision 3.06. The policy was last updated in August 2018 and signed by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The agency maintains a staff schedule that is prominently displayed in the intake area of the residential building for staff to see. The schedule maintains the appropriate ratio as required by Florida Administrative Code and contract including consistently maintaining two staff on overnight shifts. A staff overtime	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		
						rotation book including staff home phone numbers is also located in the intake office. In reviewing the logbook and Accountability binder staff are consistently documenting, in real time, that they are observing youth every fifteen minutes during sleep periods. A review of the video system over three random nightshifts shows consistent fifteen-minute checks by staff. These checks are done by opening the door and looking inside. At no time did a staff enter any of the rooms.	
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 4.13 Video Surveillance System 4.13. The policy was last updated in March 2017 and signed by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The video system is capable of storing forty-five days of images and is capable of recording during power outages. The system was reviewed and is able to record date, time and location, and the resolution enables facial recognition. Several samples of different overnight shifts were viewed. Cameras are visible in the hallways, recreation room, and other general locations as you walk through the building. There are no cameras in the sleeping quarters or bathrooms. Though no list is maintained, only supervisory staff can view the shelter remotely through	No exceptions

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						their phones. Supervisory reviews of the cameras, to include random overnight shifts, are conducted a minimum of every two weeks as was evidenced in a review of three months of the logbook. There is written notice placed prominently in the lobby of the shelter stating cameras are in use for security purposes. There is a process in place for third party review of video recordings upon request from program quality improvement visits and when an investigation is pursued after an allegation of an incident.	

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 4.01 Healthcare Admission Screening. The policy was last reviewed in March 2017 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five open residential files reviewed. All five youth had a healthcare screening completed on the day of admission. Three of the youth were on medications and names of the medications were documented. One youth was documented as having asthma and used an inhaler as needed. Two of the youth had different allergies documented. None of the youth had any recent injuries, illnesses, or pain. Four of the youth were documented as having scars or tattoos. There are procedures in place to involve the parent in any follow-up medical care needed for any chronic conditions.	No exceptions
4.02 Suicide Prevention **There is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.**							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled 4.02A Comprehensive Master Plan for Suicide Prevention and Response. 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 in October 2019 by the chief executive officer.	
RATING	☒	☐	☐	☐	☐	There were four files reviewed of youth placed on suicide precautions. All four youth were screened during the initial intake process. All suicide screenings were reviewed and signed by the supervisor. All four youth were placed on sight and sound supervision. All four 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 fifteen-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 three policies in place titled 4.03 Medications, 4.03A Medication Management and Distribution, and 4.03B Medication Disposal to address the requirements of this indictor. The polices were last reviewed in May 2017 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	All medications are stored in the Pyxis Med-Station 4000 Medication Cabinet which is located in a locked room inaccessible to youth. The program has four Super Users for the Med-Station. The program does not accept any youth who	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 prescribed injectable medications. Oral medications are stored separately from topical medications in the Med-Station. The program has a refrigerator that is used only for medications requiring refrigeration. The temperature of the refrigerator is checked weekly by the registered nurse. All controlled substances are counted shift-to-shift with two staff members present and documented on the youth's Medication Distribution Log (MDL). A perpetual inventory with running balances is also maintained on the MDL's for all medications. All medications stored in the Med-Station, including all over-the-counter (OTC) medications, are inventoried weekly by the registered nurse. Razors are secured in a locked box and are inventoried weekly and as used. The youth's individual MDL is used to document all medication distribution. The registered nurse runs weekly and monthly reports via the knowledge portal. All medications are verified at admission by calling the pharmacy or by the registered nurse. The registered nurse conducts all medication processes when on site. Medication discrepancies are cleared out after each shift. The delivery process of medication is consistent with the FNYFS Medication Management and Distribution Policy.	

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		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
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 4.04 Medical and Mental Health Alert Process. The policy was last reviewed in March 2017 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five open youth files reviewed. All five youth had some kind of medical or mental health condition, or food allergy. All five youth were appropriately placed in the program's alert system. The applicable color-coded dots were placed on the spine of the youth's file and alerts were documented on the dry erase board located in the dayroom of the shelter. The alert system includes precautions concerning prescribed medications and medical/mental health conditions. Staff can find this information documented in the youth's and on the youth's individual Medication Distribution Log (MDL).	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 4.05 Episodic/Emergency Care. The policy was last reviewed in March 2017 by the chief executive officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five instances of off-site emergency medical care. All five instances were documented on an incident report and reported to the Central	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		
						Communications Center (CCC). Four of the five instances documented the parent/guardian transported the youth for medical treatment. The fifth youth was transported by emergency medical services (EMS); however, there was documentation the guardian was notified and arrived at the shelter prior to the youth being transported. Four of the five youth returned to the program. Only one of the youth had any type of follow-up medical care and it was to take Tylenol for pain as needed. A daily log is maintained which documented all five events. There were seven staff training files reviewed and the staff were trained in first aid and CPR and emergency medical procedures. The knife-for-life and wire cutters are located in a cabinet in the dayroom. First aid kits were located in the dayroom and the vehicles.	