Florida Network for Youth and Family Services
Compliance Monitoring Report for

FAMILY RESOURCES – ST. PETERSBURG

3821 5th Avenue North
St. Petersburg, FL 33713

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Family Resources – St. Petersburg SafePlace2B CINS/FINS program for the FY 2019-2020 contract on January 15-16, 2020 at the 3821 5th Avenue North, St. Petersburg, Florida location. 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 is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct non-residential services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 2019 through June 30, 2020.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewers. Agency representatives from SafePlace2B present for the entrance interview were Lisa Davis, CEO; Nicole Leslie, Vice President Residential and RHY Services; Andrew Coble, Vice President Community Services; Joseph Mabry, Residential Supervisor; and Elizabeth Polifrone, Community Service Supervisor. Additional agency personnel present at the entrance conference are documented on the Entrance Conference Attendance Log. The last onsite QI visit was conducted October 24-25, 2018.

In general, the Reviewer found that the Family Resources – St. Petersburg's SafePlace2B program is in compliance with specific contract requirements. **Family Resources – St. Petersburg received an overall compliance rating of 91.7% for achieving full compliance with eleven (11) of the twelve (12) applicable indicators** of the Administrative and Fiscal Contract Monitoring Tool. One of the indicators was rated not applicable as the provider does not have any inventory purchased with Florida Network funds. There are no corrective actions cited but one (1) recommendation is made as a result of the monitoring visit.

The following report reflects the findings from the compliance monitoring tool used on site during the program review. These findings are an assessment of the provider's compliance with Administrative and Fiscal requirements of the CINS/FINS contract. A copy of the tool utilized during the visit and related documentation submitted by the provider are on file with the Reviewer. If any information or clarification is required, please contact Keith Carr by email to keithcarr@forefrontllc.net.

2019-2020 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 01-15-2019-2020

Agency Name: Family Resources – St. Petersburg	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 3821 5th Ave. North, St. Pete, FL 33713**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): January 15-16, 2020**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer **a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.**	☐	☐	☒	☐	☐	The agency currently has a total of eight certified DJJ-QI Peer Reviewers, two of which are located at the St. Petersburg office: Joe Mabry and Elizabeth Polifrone. Peers have been scheduled and/or participated in peer reviews for the current FY.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency provided a list of two contracts with DOH and JWB in addition to the FN for FY2019- 2020. 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.	
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	☐	☐	☐	☒	☐	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	

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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**						6/1/2019 – 6/1/2020 Workers Compensation through Evanston Insurance Company with limits of $2,000,000 each/aggregate, effective 6/1/2019 – 6/1/2020 Automobile insurance through Alliance of Nonprofits for Ins. RRG with combined single limits of $1,000,000, effective 6/1/2019 – 6/1/2020 An umbrella policy through Alliance of Nonprofits for Ins. RRG with limits of $4,000,000 each/aggregate, effective 6/1/2019 – 6/1/2020 Directors and Officers Liability insurance through Alliance of Nonprofits for Ins. RRG with limits of $1 million each/ $2 million aggregate, effective 6/1/2019 – 6/1/2020 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**	☐	☐	☒	☐	☐	During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by any external funding source.	
Fiscal Practice	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and	

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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**						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, purchasing process, financial management, budget process, capital assets, and other relevant financial processes.	
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: General ledger for July 1, 2019 – September 2019. The agency maintains a detailed general ledger with a chart of accounts. The general ledger is structured to track all funding sources separately; FN is identified as 105 on the GL and cost centers are 034 (shelter), 039 (counseling), and 014 (SNAP).	
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: Reviewed petty cash Policy and Procedure included in the Fiscal Manual. Petty cash is maintained by the Residential Supervisor and is stored in a secured cash box. The fund is $150 but a small amount usually $25 is kept in the shelter for YCW's to access for emergency items for the youth. Petty cash is reconciled at least monthly by the custodian. All receipts are submitted to	

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						finance at the main office for reimbursement as needed. Reimbursement comes in the form of a check made out to the designee who will then cash it and place money in petty cash box.	
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 the period June-November 2019 for one account held with SunTrust. Three of the six bank reconciliation posting journals reviewed were dated within six weeks of the bank statements for the preceding month and two of the three has one signature of approval. The remaining 3 bank reconciliations were dated greater than 6 weeks of the respective bank statements and were not signed. Checks disbursed over $750 are signed by two individuals with signing authority. Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files.	**Recommendation: 1)** Ensure all bank reconciliations are completed within 6 weeks of receipt of the bank statements and are signed by the preparer and agency approval authority.
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**	☐	☐	☐	☐	☒	**Not applicable** No DJJ inventory	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a printout of tax payment transactions made through the Electronic Federal Tax Payment System (EFTPS) for the 3rd and 4th quarters 2019. Payroll taxes are paid bi-weekly via the electronic payment through the IRS. These reports demonstrate submission of payroll taxes and deposits on time.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided Budget to Actual statement for the FY2019 for the month ending 9/30/2019. A review of these documents was conducted. Report shows program budget and actual for the current month, YTD, as well as a comparison from last FY. Variances in budget are monitored on a regular basis and approved by management.	
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 Assurance Dimensions CPA and Associates in a report dated September 13, 2019. 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.	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
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, System abuse, System Monitoring, and Disaster Recovery were reviewed. Policies are located in the Administrative Standard Operating Manual throughout various sections of the manual. A daily back-up is performed on all information saved on various servers throughout the agency. The Residential Supervisor reported no employee had a laptop.	

CONCLUSION

Family Resources St. Petersburg has met the requirements for the CINS/FINS contract as a result of full compliance with eleven (11) of the twelve (12) applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One of the indicators was rated not applicable as the provider does not have any inventory purchased with Florida Network funds. Consequently, t**he overall compliance rate for this contract monitoring visit is 91.7%.** There are no corrective actions cited but one (1) recommendation is made as a result of the monitoring visit.

RECOMMENDATION (S)

Recommendation:1)
Ensure all bank reconciliations are completed within 6 weeks of receipt of the bank statements and are signed by the preparer and agency approval authority.

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.

Recommendation (1) made is a suggestion regarding fiscal issues observed during the review. This item does not necessarily require a written response.

Florida Network of Youth and Family Services Quality Improvement Program Report

Family Resources – St. Petersburg, Florida
Residential Program

January 15-16, 2020

Compliance Monitoring Services Provided by

FOREFRONT

Quality Improvement Review

Family Resources – January 15-16, 2020
Lead Reviewer: Marcia Tavares

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 71.43%
Percent of indicators rated Limited: 28.57%
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: 93.10%
Percent of indicators rated Limited: 6.90%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Reviewer

Members

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

Kara Brown - Department of Juvenile Justice

Shanna Baker – Thaise Educational Tours

Rochelle Davis – Boys Town

Julie Edison – Hillsborough County Children's Services

Quality Improvement Review

Family Resources – January 15-16, 2020
Lead Reviewer: Marcia Tavares

Methodology

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

Persons Interviewed

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

Documents Reviewed

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

Surveys

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

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

Rating Narrative

Family Resources, Inc. is a non-profit community-based corporation contracted with the Florida Network of Youth and Family Services (Florida Network) to operate Children in Need of Services/Families in Need of Services (CINS/FINS) residential and non-residential services to youth and families. The agency is also accredited by the Council on Accreditation effective through December 31, 2020. The central office is located in Pinellas Park, Florida and shelters are located in Clearwater, St. Petersburg, and Bradenton, Florida. This QI review was conducted at the St. Petersburg SafePlace 2B program located at 3821 5th Avenue North St. Petersburg. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, youth referred by the Juvenile Justice Court System for domestic violence and probation respite, Intensive Case Management, and Family and Youth Respite Aftercare Services.

During the past year, Family Resources SafePlace 2B began its campus expansion and started construction on the adjacent building. The renovated building will be the site of the agency's Safe Connection Resource Center and house a new family counseling center with four offices and street outreach program used as a drop-in location for homeless youth. Vacated space from the existing shelter building will be used to expand/separate youth activities geared toward opportunities for youth to earn privileges.

The agency is the recipient of a Juvenile Welfare Board grant for $50,000 that will used to purchase and install a new generator that can operate for 7 days, allowing the facility to become a new hurricane shelter for staff youth and families. The agency was also awarded between $50-$75,000 through Leadership St Petersburg to complete a renovation project which will add an outdoor area for youth recreation, shelter renovations, and new landscaping.

Continued relationships with community partners have resulted in opportunities for additional youth activities including an art camp facilitated by local artists. The program has also modified its leadership program to encourage participation and behavioral outcomes of its behavior modification system.

Standard 1: Management Accountability

Overview

Narrative

Family Resources Inc. is under the leadership of a management team that consists of a Chief Executive Officer, 2 Vice Presidents, a Senior Director of Quality Assurance, a Chief Grants Officer, a Chief Human Resources Officer, and a Chief Financial Officer. The residential component is overseen by the Vice President (VP) of residential and RHY Services and the non-residential component is overseen by the VP of community and clinical services. SafePlace 2B shelter is staffed by a residential supervisor, counseling and case management staff, Youth Development Specialists (YDS), a cook, part time nurse, and administrative assistant.

At the time of the QI visit, the program did not report any specific issues, problems, or current corrective actions with any funding sources. There were no vacancies reported for the CINS/FINS program; however, the SNAP program supervisor's position was vacant.

Family Resources has a comprehensive team model that allows every employee to be a member of at least one PQI team. The teams report basic data, goals, areas of concerns, and activities toward meeting goals, corrective action activities, and needs through reports on a monthly or quarterly basis. These are presented to a QI Council, comprised of senior and program management members, and representatives of all agency-wide teams. The QI Council, in turn, relates through the Strategic Planning Team to the Board of Directors. Feedback is provided at all stages.

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

- 1.01 – Background Screening: 1) one new hire's background screening was completed after the employee's hire date; 2) One direct care staff who interned with the agency prior to hire did not complete the Berke Assessment prior to hire.
- 1.03 -Incident Reporting: 4 of 16 CCC reportable incidents were not documented in the program logbook. One of the four was not logged due to staff confidentiality.

Indicators 1.04 and 1.06 were rated as Limited as follows:

- 1.04 –Training: the training requirement for completion of mandatory training topics within the first 120 days of hire was not met for 4 new staff. Also, one of the 4 in-service staff did not have a current certificate of completion for First Aid and one

non-licensed mental health clinical staff (DOH 5/7/19) file did meet the requirement for Assessment of Suicide Risk training by a licensed mental health professional.

- 1.06 – Transportation: Twenty-six individual client transport records were reviewed alongside program director. Twelve transports did not support prior approval. Seven of the 12 did not note prior approval in the logbook on days when single transport occurred. Five were transported prior to the written approval in the log. There were also deficiencies noted with documentation of transportation information including mileage, number of passengers, and date/time of trips.

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

Standard 2: Intervention and Case Management

Overview
Rating Narrative

Through a contract with the Florida Network, Family Resources, Inc. operates SafePlace 2B South Campus. The program, located in St. Petersburg, provides centralized intake and screening twenty-four hours per day, seven days per week, and every day of the year to youth and their families in Pinellas County. Staff are trained staff to determine the conduct screening and immediately assess the needs of the family and youth. Residential and non-residential counseling services are provided by Master's level counselors who conduct individual, family, and group services. Case management services are provided by Bachelor's level staff.

The counseling component consists of a total of three (3) counseling positions (two non-residential and one residential) and a LCSW clinical supervisor. The residential services include individual, family and group counseling, as well as case management and substance abuse prevention education. Referral and after care services begin upon the youth's admission into the program. The aftercare services consist of referrals for the youth to community resources, on-going counseling services and additional educational assistance. Youth Development Specialists are responsible for completing the admission paperwork, providing orientation to the youth, and supervising the youth while in the shelter. Non-residential services within the program include individual and family counseling; counseling staff provide counseling and case management services for truant and ungovernable youth while also linking youth and families to community resources.

Family Resources South is contracted to provide services for youth who meet the criteria for staff secure, domestic minor sex trafficking (DMST), domestic violence (DV), probation respite (PR), Intensive Case Management (ICM), Family and Youth Respite Aftercare Services (FYRAC), and SNAP services. Since the last QI review, the program has not served youth who meet the criteria for staff secure, DMST, or FYRAC youth. The agency is currently maintaining paper files and youth records are maintained in a neat and orderly manner.

The following indicators in standard 2 were rated satisfactory with exceptions:
- 2.03 – Case/Service Plan: the service plan was not initiated within 7 days of completion of the needs assessment in 1 of 5 non-residential files.
- 2.04 – Case Management/Service Delivery: the 30 day follow up for 1 non-residential file was late.
- 2.09 – Special Populations: Data entry into Netmis and JJIS was not completed

within 24 hours for 1 of 3 DV and 1 of 3 Probation Respite youth files reviewed. Also, 6 direct and 6 collateral contacts were not met consistently each month in 3 ICM case files reviewed. The CBCL was not completed within 14 days of the intake in 1 of 3 files. Self-Report Assessment was not completed at intake in 2 of the 3 files and repeated within 90 days in 2 of 3 files.

- 2.10 – SNAP: 1) Three of five Pre- Child Behavior Checklist's were not complete at the time of intake; 2) Three of five PAT's were not completed at the time of intake and one was not completed at discharge; 3) One Post- Child Behavior Checklist completed two days after discharge; 4) One SNAP in school class did not include a Class Shoot for Your Goal' sheet; and 5) No teacher pre-evaluation was completed.

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

Standard 3: Shelter Care

Overview
Rating Narrative

SafePlace2B is a youth shelter located in St. Petersburg that is licensed to serve eligible Department of Children and Families (DCF) and Children in Need of Services/Family in Needs of Services (CINS/FINS) youth. The shelter is licensed by DCF effective through December 2020. The agency operates 24 hours, 7 days a week and serves both residential and nonresidential youth.

The shelter program staff includes: a residential supervisor; five full-time, five part time, and five on call YDS; a part time nurse; and an administrative assistant. In addition, the clinical component has one residential counselor and a case manager. The program operates around three 8-hour shifts: 7am-3pm, 3-11pm, and 11pm-7am. Youth are engaged in meaningful, structured activities seven days a week. At least one hour of physical activity is provided daily. The program has one van used to transport youth.

During the QI visit, the parking lot was under re-construction. Improvements to the shelter environment are planned for the near future as the agency was awarded funds to add a new generator, add an outdoor area for youth, and install new landscaping.

The goals of the program's behavior management system are to increase positive interactions between the staff and the program residents, and to shape appropriate behavior through these interactions. The program provides structured daily opportunities for residents to earn points with very clear procedure on how this should be carried out and there are visible signs posted throughout the facility for the youth and staff. In addition, the behavior management procedure is included in the youth handbooks they receive upon arriving at the facility. The residential handbook also describes the level system and the consequences of good or poor behavior. Residents discuss levels achieved as a group each day. Staff, in discussion with the group, determines the level of performance off each item and designates a resident as being on one of the following levels: Orientation, Citizenship, Leadership, or Ownership. Rewards commensurate with the level of performance.

The following indicator in standard 3 was rated satisfactory with exception:

- 3.01 – Shelter Environment: The agency's Policy 1.06 does not notate the length of time required for fire drill evacuation and the evacuation time for two fire drills in December 2019 was 3 and 5 minutes, in excess of the 2 minutes required.

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

Standard 4: Mental Health/Health Services

Overview
Rating Narrative

The residential counseling services in the shelter are overseen by a Licensed Clinical Social Worker (LCSW) who serves as the clinical supervisor. The shelter staff are trained to screen, assess, and notify all staff of the conditions and risks of all youth admitted to both the residential and non-residential CINS/FINS programs.

The shelter provides risk screening and identification methods to detect youth referred to their program with mental health and/or health related risks. The shelter utilizes screening and a CINS Intake form to determine eligibility and presence of risks in the youth's past mental health status, as well as, their status at intake. Staff receiving the youth at the time of admission notifies the program supervisor, licensed supervisor, counselor and/or VP of any youth admitted with special needs, mental health issues, substance abuse issues, medical needs or security risk factors as well as those at risk of suicide. The licensed clinical professional makes recommendations regarding placement and supervision and reviews/conducts all assessments. The shelter uses an alert board and colored dot system to inform staff members on each shift of the health and mental health status of all youth in the residential youth program.

At the time of this QI review the program had a part-time licensed registered nurse (RN). In addition, trained shelter staff assists in the delivery of medication to all youth admitted to the residential youth program. The shelter has a detailed medication distribution system and utilizes the Pyxis Med-cart. The agency provides medication training to all direct care staff as well as training in CPR, first aid, fire safety, emergency drills, suicide prevention, and observation and intervention techniques. Shelter staff members are also required to notify parents/guardians if a resident has a health injury.

The agency maintains interagency agreements that describe and specify services, fees, scope and nature of cooperation, collaboration, and responsibilities of all agencies involved in providing program services identified as needed by parent and/or youth. Agreements are in place to assist with medical and mental health services for youth.

The following indicators in standard 4 were rated satisfactory with exceptions:

- Indicator 4.03- Medications: medication discrepancies are cleared weekly, not after each shift. Topical medications appeared to be stored in a locked box in a cabinet, not in the Pyxis Med-Station.
- Indicator 4.05 – Episodic Emergency Care: 1) there was no verification receipt of medical clearance in the file of one youth via discharge instructions upon return to the facility; 2) no aromatic spirits of ammonia was found in the first aid kit; 3)

inspection/inventory of first aid kit was completed on a monthly basis, rather than a weekly basis.

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

STANDARD 1: MANAGEMENT ACCOUNTABILITY

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☒ YES ☐ NO (explain) The provider has a policy and procedures #2.14 for Background Screening and pre-employment assessment that meets the requirement of the indicator. It was reviewed and approved April 1, 2019 by the Chief Executive Director.	No exceptions
RATING	☐	☒	☐	☐	☐	A total of fifteen background screening files were reviewed for fourteen new staff and one intern. All fourteen new employees were background screened and thirteen of the fourteen had evidence of a DJJ Clearinghouse/BSU approval prior to hire date. All of the new employees were e-verified and proof of employment authorization is on file for each employee. The program did not have any eligible 5-year re-screening for the review period. The program had one volunteer/intern who met the requirement for background screening. An eligible DJJ Clearinghouse approval was obtained prior to the intern's start date.	**Exception** One new hire's background screening was completed after the employee's hire date One direct care staff who interned with the agency prior to hire did not complete the Berke Assessment prior to hire.

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 provider completed the annual Affidavit of Good Moral Character and submitted it to the Department of Juvenile Justice Background Screening Unit via email on January 6, 2020, prior to the January 31, 2020 deadline. Proof of an email submission to DJJ BSU was reviewed. The agency uses the Berke pre-employment assessment (to determine suitability) for direct-care positions. Candidates must score medium or high in order to be considered for employment. The assessment was administered to fourteen new staff hired. Twelve of the fourteen staff received scores of medium or high on the Berke assessment. It was observed that 1 employee scored a "low" on the Berke Assessment which does not meet the agency's established criteria for hire and was hired with no documented protocol of exemption/deviation from policy.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02.						☐ YES ☒ NO (explain) The provider's policies and procedures for Provision of an Abuse Free Environment #1.02 and #3.08 (Grievance Process), were last reviewed March 2017 and August 2018, respectively. Both were approved by the CEO. Policy 3.08 does	**Exception** Policy #3.08 also indicates that "any staff may accept a written grievance from a client" which does not align with indicator 1.02 which states that "Direct Care workers shall not handle the complaint/grievance

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		
						not fully meet the requirements for this indicator.	document unless assistance requested by youth". The 72-hour timeline for resolution of grievances is not depicted in the policy as there are 2 levels (first is supervisor and second is management), each with a timeframe of 72 hours to resolve grievances.
RATING	☒	☐	☐	☐	☐	Upon review of the Human Resources Code of Conduct section A (Client Services) it specifies that the use of profanity and abusive language towards clients is prohibited. The program's orientation packet includes a Discipline and Behavioral Management policy that addresses staff being prohibited from engaging in physical abuse, threats and intimidation. Sections on Discrimination (Items A, B & C) and Workplace Violence (item B) address maintaining a safe workplace environment with respect to practices free from discrimination, harassment/sexual misconduct, and verbal and physical intimidation. A total of 16 signs demonstrating acceptance of all youth were observed posted throughout the facility. This includes all gender restroom signs. Eight staff training files were reviewed, and all staff received training on Child Abuse Recognition, Reporting and Prevention.	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		
						Abuse Hotline Call Logs were reviewed. Documentation showed a total of 16 calls made between June 2019 and January 2020. The identified reasons for calls were 1 sexual activity, 4 abandonment, 3 sexual abuse, 2 physical abuse, 1 emotional and/or physical abuse, 4 neglect and/or abandonment, and 1 inadequate supervision. During the facility tour 4 Abuse Hotlines signs were posted in inconspicuous areas. The program has an accessible grievance process. Three grievance boxes are mounted in the facility. This was observed during the facility tour as 1 locked box with blank forms without a posted grievance process sign was located in the shelter, one locked box with blank forms and a posted grievance process sign was located in the street outreach room, and one locked box with blank forms without a posted grievance process sign was located in the counseling area. The program's youth handbook outlines the grievance process. Per the residential supervisor, each youth receives a handbook on admission. Eleven grievances were reviewed. Ten of the eleven grievances were resolved by management within 72 hours. The residential supervisor reported there were no grievances filed within the last year other than those reviewed.	

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 residential supervisor also indicated there have been no incidents that required management to take immediate action to address incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) The provider has a policy and procedures #1.03 for Incident Reporting that meets the requirement of the indicator. It was approved July 2017 by the CEO. There is also a sub-policy #1.03A - CCC Incident Reporting that was approved by the CEO July 2019.	No exception
RATING	☐	☒	☐	☐	☐	DJJ CCC reports and the agency's incident reporting forms were reviewed. The incidents are typically reviewed by the program supervisor, vice president and risk management. They acknowledge receipt and review of the document by adding a typed electronic signature and in some instances handwritten initials. Fifteen of 16 CCC reports indicated that the CCC is being notified of incidents within the 2-hour window. The 1/3/20 incident report form and CCC report did not indicate the CCC reporting time;	**Exception** 4 of 16 CCC reportable incidents were not documented in the program logbook. One of the four was not logged due to staff confidentiality.

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		
						however, the logbook entry verified it was reported on time. Follow up tasks required by the CCC were completed by the agency.	
1.04: Training Requirements **Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☒ YES ☐ NO (explain) The provider has a policy and procedures #1.04 for Training that meets the requirement of the indicator. It was approved and signed by the CEO in March 2017.	No exception
RATING	☐	☒	☐	☐	☐	The training files of 4 first year direct care staff were reviewed. All 4 staff have been employed for more than 120 days; however, none of the 4 staff completed all of the trainings required during the first 120 days. Two of the 4 staff files showed they had completed all of the 120-day training topics required; however, there were a total of 5 topics completed beyond the 120-day timeframe. One of the 4 staff exceeded the 80 hours required annually and the remaining 3 were on target for completing the hours required. The training files of 4 in-service staff were reviewed. Two of the 4 exceeded the 40 training hours requited annually and the other two were on target for completing the required hours and 3 of the 4 had completed all required annual trainings.	**Exception (Limited Rating)** The training requirement for completion of mandatory training topics within the first 120 days of hire was not met for 4 new staff reviewed: ▪ None of the 4 staff completed Understanding Youth/Adolescent Development ▪ Two of the 4 were missing Suicide Prevention, CINS/FINS Core, and Signs and Symptoms of Mental Health and Substance Abuse training ▪ One of the 4 did not complete CPR and First Aid training due during the 120-day time frame ▪ One of the 4 did not complete MAB, Signs and Symptoms of Mental Health and Substance Abuse, and Behavior Management training due during the 120-day time frame

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)
						Two non-licensed clinical shelter staff files were reviewed for assessment of suicide risk training. One of the two files had evidence of completing 5 suicide risk assessments with written confirmation of completion by the licensed professional.	▪ One of the 4 was not CPR/First Aid certified One of the 4 in-service staff did not have a current certificate of completion for First Aid. One non-licensed mental health clinical staff (DOH 5/7/19) file did meet the requirement for Assessment of Suicide Risk training by a licensed mental health professional; as of the QI visit, none of the 5 required assessments were completed.
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) The program has a written policy and procedures #1.05, for Analyzing and Reporting Information which was last reviewed March 2017 and signed by the Chief Executive Officer. In addition, the agency has a comprehensive PQI Plan dated 2019 to ensure programs adhere to the highest quality standards with quality and integrity and that agency resources are effectively utilized.	No exceptions
RATING	☒	☐	☐	☐	☐	A review of peer record reviews for FY 19-20 was conducted. The record reviews were conducted monthly with quarterly summaries for all programs. The program documents compliance for each record as	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		
						well as deficiencies. Detailed reports of the case record reviews include: significant findings, data analysis, and report summary/recommendations. Summary reports include highlighted strengths observed, areas of improvement observed, action steps needed by supervisor, and a summary. A total of 30 residential and 42 non-residential records were reviewed between July and December 2019. Incident reports are reviewed and analyzed by the Risk Management Committee in terms of incident total by program; agency-wide incident totals by type; and incident type by program. The report also aggregates data for grievances and workers compensation. The Risk Management Committee completed a Risk Management Analysis for the 1st quarter 2019-2020. Survey results are tracked monthly for the shelter and non-residential clients separately and compiled into quarterly and an annual report. A copy of the annual risk management analysis report for 2018-2019 was reviewed. The data shows an increase in client satisfaction by the end of the 4th quarter with average score of 92%. Program outcomes data are documented monthly by each program, incorporating	

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 contract, Netmis, and program outcomes required by the Florida Network and DJJ QI. The reports of the outcomes data quarterly demonstrate the provider is capturing and monitoring outcome indicators for both the residential and non-residential program. Quarterly Impact Management Committee meetings are held to review/discuss the quarterly reports. The program conducts QI Mock Reviews with a team of directors, supervisors, and case managers. A sample of 5 files for each program is selected for the review. The review covers each indicator of the QI Standards and a final report is written that provides feedback on exceptions, concerns, methodology for improvement, person(s) responsible, time frame for implementation, whether or not a tracking form is required, and date of staff training. A review of the quality improvement calendar of events shows mock reviews are conducted quarterly during the 1st -3rd quarters at one program location each quarter. Senior leadership meets every Wednesday to discuss and review policies and procedures, data presentations, and fiscal information. Monthly team/staff minutes were reviewed for the review period and were found to have	

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		
						documentation of discussion by of information discussed regarding FN Netmis data, QI activities, reports, and areas identified as needing improvements or changes needed from analysis. Netmis and JJIS data quality checks are conducted twice per month at staff meetings.	
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 policy 1.08, for Agency Vehicles and 1.10 - Transportation Policy. The policies and procedures were last reviewed by the CEO in March 2017.	No exception
RATING	☐	☒	☐	☐	☐	The program transportation log for the past six months was reviewed. A random selection of sixteen transports logged as having open lines during the review period was further reviewed. The agency's procedures state that the program director will be notified of any single youth transports and director will evaluate the youth's history, personality, recent behaviors and length of stay within the program to determine if the single transport can be approved. Upon approval the trip will be documented clearly and an open phone line will be had during the entire trip with several check-in during the trip. In practice, the program director indicated that the approval signatures are	**Exception (Limited Rating)** The policy indicated that "the program director must be aware of or notified prior, to the practice of individual staff transporting a single youth". Contrary to the requirement, the program director indicated that the approval signatures are done after transports and a blanket approval is given for any single transports to be done during the day. The supervisor approval column on the transport log states that it should include the date and time. Date and time were not included in any of the entries.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						done after transports and a blanket approval is given for any single transports to be done during the day.	Transportation log does not reflect changes in the number of passengers during the trip. The log entries are not consistent as some staff do single entries as a round trip and other staff do multiple entries for round trip. The time of day not noted for most entries. Twenty-six individual client transport records were reviewed alongside program director. Twelve transports did not support prior approval. Seven of the 12 did not note prior approval in the logbook on days when single transport occurred. Five were transported prior to the written approval in the log.
1.07: Outreach Services **The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒YES ☐ NO (explain) The agency has a written policy and procedure that addresses the elements of indicator 1.07 for Outreach Services. The policies and procedures were last approved and signed by the CEO in March 2017.	No exception
RATING	☐	☒	☐	☐	☐	There are two lead staff designated to attend the DJJ Circuit meetings and other staff attend if one of the leads are unavailable.	This deficiency did not result in an exception: There are two DJJ Circuit meetings annually. Two meeting forms were observed in the file. One had a photo of a sign-in sheet documenting agency staff

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The agency does community outreach and completed 19 activities between June and December 2019. The agency maintains interagency agreements that describe and specify services, fees, scope and nature of cooperation, collaboration, and responsibilities of all agencies involved in providing program services identified as needed by parent and/or youth. Copies of all interagency agreements are maintained in a binder by the program representing services and resources available to youth and family. There are a total of 31 active interagency agreements with community partners.	participation; however, there was no proof of attendance provided for the second meeting.

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 program has a policy 2.01 in place that addresses the requirement for screening and intake. The policy was reviewed and signed in July 2018 by the CEO.	No exception
RATING	☒	☐	☐	☐	☐	A total of 10 files were reviewed for 5 residential files (2 open and 3 closed) and 5 non- residential files (2 opened and 3 closed). The eligibility screening was completed within 7 calendar days in 8 of the 10 files. In 2 of the open files the eligibility screening was not completed within 7 calendar days of the referral because the clients were put on a waiting list. Documentation supported youth and parents/guardians received; available service options; rights, responsibilities of youth and parent/guardian; possible action with CINS/FINS and the grievance procedure in writing.	No exception
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement						☒ YES ☐ NO (explain)	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
for Indicator 2.02						The program has a policy 2.02 in place that addresses Needs Assessment. The policy was reviewed and signed in July 2018 by the CEO.	
RATING	☒	☐	☐	☐	☐	Reviewed 2 open and 3 closed Residential files. Shelter youth: all 5 needs assessments were initiated within 72 hours of admission and completed within 2 to 3 face to face. The needs assessment is conducted by a BA or MA level Staff member. One youth was identified with an elevated risk of suicide as a result of needs assessment. The youth was referred for an assessment of suicide risk conducted by or under direct supervision of a licensed mental health professional. 5 non-residential files, 2 opened and 3 closed were reviewed. In one of the open cases there were 2 dates for the needs assessment 12/16/19 and 1/6/20. There were no additional issues or discrepancies regarding the assessment.	No exception
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) The program has a policy 2.03 in place that addresses Case/Service Plan. The policy was reviewed and signed in July 2018 by the CEO.	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☐	☒	☐	☐	☐	Reviewed 2 open and 3 closed residential files. All 5 files demonstrated the service plans were developed within 7 working days of the needs assessment. 5 non-residential files, 2 opened and 3 closed were reviewed. The service plan was initiated within the 7-day frame in 4 of 5 files. Two files didn't have completion dates because the files were still open. Service plans include: ▪ Individualized and prioritized needs and goals identified by the needs assessment ▪ Service, type, frequency, location, person responsible ▪ Target date for completion and actual completion date ▪ Signatures of the youth, parent/guardian, counselor and supervisor ▪ Date the plan was initiated	**Exception** The service plan was not initiated within 7 days of completion of the needs assessment in 1 of 5 non-residential files. The needs assessment was completed 12/16/19 but the service plan was not initiated until 1/6/2020.
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 program has a policy 2.04 in place that addresses Case Management and Service Delivery. The policy was reviewed and signed in July 2018 by the CEO.	No exception
RATING	☐	☒	☐	☐	☐	5 residential files and 5 non-residential files were reviewed. Each youth was assigned a Counselor/case manager. The	**Exception** The 30 day follow up for 1 non-residential file was late. The file closed 12/12/19 and follow up date of first attempt was 1/15/20.

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		
						Counselor/ case manager completes the following as applicable: ▪ establishes referral needs and coordinates referrals to services based upon the ongoing assessment of the youth's family problems and needs ▪ coordinates service plans implementation ▪ monitors youth's/family's progress in services ▪ monitors out of home placement (if necessary) ▪ provides support for families ▪ referrals to the case staffing to address problems and needs of the youth/family. ▪ refer the youth family for additional services when appropriate	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) The program has a policy 2.05 in place that addresses Counseling Services. The policy was reviewed and signed in July 2018 by the CEO.	No exception
RATING	☒	☐	☐	☐	☐	5 residential files and 5 non-residential files were reviewed. Youth and families receive counseling services in accordance with the youth's case/ service plan, to address needs identified during the assessment. Shelter program provides individual and family counseling. Group counseling	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						sessions are held a minimum of 5 days per week. Group sessions consist of: • Length of at least 30 minutes • Opportunity for youth engagement • clear and relevant topic (informational/ developmental/educational) • Clear leader or facilitator Non- residential program provides therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, or the local providers counseling office. In each file, the youth's presenting problem, such as truancy, anger, depression, and domestic violence, was addressed in the needs assessment, service plan and in the service plan reviews. There were case notes to document all services provided, as well as the youth's progress. There was an on-going internal process to ensure clinical reviews of case files; the supervisor and clinical director reviewed and signed to document their case review.	
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) The program has a policy 2.06 in place to address the Adjudication/Petition Process. The policy was reviewed and	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						signed in July 2018 by the program's chief executive officer.	
RATING	☒	☐	☐	☐	☐	2 case staffing files were reviewed. In both cases, the court initiated the case staffing and the staffing was held within 7 days. The program has an established case staffing committee, and has regular communication with committee members. The youth, family and case staffing committee are contacted within a minimum of five working days. The Case staffing Committee consisted of: a substance abuse representative, local school district, and law enforcement representative. As a result of the case staffing, the youth and family are provided a new or revised plan for services and a written report is provided to the parent/ guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations.	No exception
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) The program has a policy 2.07 in place to address Youth Records. The policy was reviewed and signed in July 2018 by the program's chief executive officer.	No exception
RATING	☒	☐	☐	☐	☐	All records reviewed were marked confidential. All records are kept in a secure room in a file cabinet that is marked confidential. When in transport, all	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Explain						
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						records are locked in the opaque container marked confidential. All records are maintained in a neat and orderly manner so that staff can quickly and easily access information.	
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) The agency has a written policy, 5.08, for Sexual Orientation, Gender Identity, and Gender Expression. The policy was last reviewed in July 2018 and signed by the CEO.	No exception
RATING	☒	☐	☐	☐	☐	During a tour of the facility, "hate free" and "safe place" rainbow signs were posted throughout the facility in all common areas signifying that youth are welcome and should feel safe regardless of sexual orientation, gender identity, and gender expression. The program also has printed material entitled I Deserve Respect, Support, and Safety accessible for youth in the lobby, staff offices, and on the tables in the day room. The program has not served any youth during the annual review period who met the criteria for the indicator. However, staff interviewed during the visit stated applicable youth are addressed by pronouns, name, and gender they prefer and room assignment is made accordingly. Four new staff training files reviewed verified training was received.	No exception

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)
						In-service staff reviewed the Florida Network policy 5.08 in a staff meeting.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☒ YES ☐ NO (explain) The program has written policies and procedures 3.07 for Special Populations, outlining services to Staff Secure, Domestic Minor Sex Trafficking, Domestic Violence Respite, Probation Respite Youth, Intensive Case Management, and Family/Youth Respite Aftercare services. The policy was last reviewed and signed by the CEO in July 2019.	No exception
RATING	☐	☒	☐	☐	☐	The program provides services to the special population youth relating to Staff Secure, Domestic Minor Sex Trafficking (DMST), Domestic Violence Respite, Probation Respite, Family/Youth Respite Aftercare Services (FYRAC) and ICM. During the review period, there were no applicable Staff Secure, FYRAC, or DMST youth placement in the program. A review of three youth records (1 open, 2 closed) for Domestic Violence Respite was conducted. Reviewed documentation found the youth were screened by the Juvenile Assessment Center (JAC) and had pending charges of Domestic Violence (DV), but does not meet criteria for secure detention. The youths' stay did	**Exceptions** Data entry into Netmis and JJIS was not completed within 24 hours for 1 of 3 DV and 1 of 3 Probation Respite youth files reviewed. 3 ICM case files reviewed. Direct and collateral contacts were not met as follows: File #1: 6 direct contacts were not completed in the 4 months reviewed and 6 collateral contacts were not met in 3 of 4 months reviewed File #2: 6 direct and 6 collateral contacts were not met in 2 of the 3 months reviewed File #3: 6 direct and 6 collateral contacts were not met in 1 of the 2 months reviewed.

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		
						not exceed the twenty-one day length of stay in the DV respite placement. The case plans included goals focusing on aggression management, family coping skills, and other interventions designed to reduce reoccurrence of violence in the home in all 3 cases. Reviewed documentation validated all services provided to domestic violence respite youth were consistent with all other general CINS/FINS program requirements. A review of three closed records found all three youth had a Probation Respite referral from Department of Juvenile Justice (DJJ). Reviewed documentation found the length of stay to be less than 30 days for all 3 youth, and approval to extend was not required. All case management and counseling needs were considered and addressed in the goals. Reviewed documentation validated all services provided to probation respite youth were consistent with all other general CINS/FINS program requirements. A review of three closed ICM youth records found all three youth had a referral from the case staffing. Reviewed documentation found 2 of 3 youth had the CBCL completed within 14 days of intake and 1 of 3 had evidence of an approved	CBCL was not completed within 14 days of the intake in 1 of 3 files Self-Report Assessment was not completed at intake in 2 of the 3 files and repeated within 90 days in 2 of 3 files

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		
						self-report assessment completed at intake. The case plan demonstrate a strength based trauma informed focus in all 3 files.	
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) Policies and procedures 4.25 SNAP Intake Requirements, 4.16 SNAP Group Delivery, 4.19 SNAP in Schools, 4.17 SNAP Fidelity Adherence Monitoring and 4.18 SNAP Discharge Requirements are reviewed and approved in July 2018 by CEO.	No exception
RATING	☐	☒	☐	☐	☐	Five youth files, four open, and one closed, for the SNAP program, were reviewed to verify the files contained required documentation. All five youth were screened, using both the NETMIS screening form and the SNAP Brief Intake screening form to determine eligibility and identify presenting problems. All five youth have a consent form signed by the parent/guardian on the day of intake, prior to receiving services. Five of five youth had a Needs Assessment initiated at intake. Five of five youth had a Pre- Child Behavior Checklist completed and placed in their file. Only two of these checklists were completed at the time of intake. Two of the checklists were completed the day	**Exceptions** Three of five Pre- Child Behavior Checklist's were not complete at the time of intake. Two were completed the next day (ES & ST) and one was completed two days later (RB). Three of five PAT's were not completed at the time of intake. One was completed the next day (GM), one was completed four days later (ST), and one was completed ten days later (RB). One Post- Child Behavior Checklist completed two days after discharge (HM). One PAT not completed at discharge, completed five days later (HM).

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		
						after intake and one of the checklists was completed two days after intake. The Pre- Teacher Report was completed, or documentation was in the file stating why it was unable to be completed for all five youth. A TOPSE assessment was completed at intake and placed in the files for all five youth. Two of five youth had a PAT assessment completed at intake and placed in the file. The other three youth had PAT's completed. One was completed one day after intake, one was completed four days after intake, and one was completed ten days after intake. One of one applicable file contained a Post- Child Behavior Checklist. The checklist was not completed at the time of discharge but was completed two days later. One of one applicable youth file contained documentation why a Post-Teacher Report Form was unable to be completed. One of one applicable youth had a TOPSE assessment completed at discharge and had a SNAP Discharge Summary Report. One of one applicable youth had a PAT assessment completed; however, it was complete five days after discharge, not at the time of discharge.	One SNAP for SCHOOLS class (Williams) did not include a Class Shoot for Your Goal' sheet. No teacher pre-evaluation for one class (Williams).

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		
						Documentation was reviewed for three SNAP in SCHOOLS classes. Two of the classes have completed eleven weeks and one class has completed three weeks. Documentation for all three classes included weekly attendance sheets for all sessions. All attendance sheets include youth names and signatures for the teacher and SNAP facilitator. Two of the three classes have Class Shoot for Your Goal' sheets. Both sheets are filled out and completed through week eleven. All three classes have pre evaluations completed for each youth. Two of the three classes have pre evaluations completed for the teacher. All three classes are currently in session, so no post evaluations have been completed. One Fidelity Adherence Checklist must be completed per classroom for the thirteen-week session cycle. All the three classes are still in session. The checklists for two of the classrooms have been completed.	

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 several clear and precise policies and procedures for this standard: 1.06 Comprehensive Safety and Emergency/Disaster Plan reviewed June 2017; 1.07 Flammable, Toxic, and Poisonous Control reviewed March 2017; 1.09 Key Control Reviewed June 2017; 1.09b Personal Belongings (staff) reviewed June 2017; 3.01 Shelter Environment reviewed March 2017; 3.09 Special Diets reviewed March 2017; 3.10 Youth Hygiene reviewed March 2017; 3.11 Visitation, Correspondence, Telephone Calls reviewed March 2017; 3.12 Parental Notification reviewed March 2017; 5.09 Search reviewed July 2019; 5.10 Client Contact reviewed July 2019. All policies were reviewed and signed by the CEO.	The agency's Comprehensive Safety and Emergency/Disaster Preparedness Policy 1.06 does not notate the length of time required for fire drill evacuation.
RATING	☐	☒	☐	☐	☐	The agency has an effective DCF license date of 12/15/20. The agency's last fire inspection was satisfactorily completed on 5/22/19. All the fire and mock drills were	**Exception** The evacuation time for two fire drills in December 2019 was 3 and 5 minutes in excess of the 2 minutes required.

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		
						completed according to standard requirements; however, the evacuation time for two fire drills in December 2019 was completed in 3 and 5 minutes in excess of the 2 minutes required. The mock drill forms also did not always indicate the time of the drill. The following is a list of inspections that were also successfully completed during the review period: Sprinkler System 10/16/19, Kitchen Hood 8/16/19, Group Care Health 9/27/19, Alarm System 10/14/19, Extinguishers 8/13/19, and Food 6/17/19. The agency's grounds were well groomed and the youth bedrooms were clean and neat with painted murals in each room. A bedroom drawer in Room 2 was noted to have some graffiti on the inside of the drawer. There were some hygiene products located in Room 1 and 2 in a empty drawer and a small sharp piece of plastic and a small earring in an empty drawer located in Room 4. These items were addressed with staff and the residential supervisor. It is the practice of staff to lock up all hygiene items and jewelry such as earrings. The bathrooms and shower areas are clean and functional.	

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 met standard requirements regarding agency vehicles. The agency has one vehicle that is equipped with safety equipment that includes a fire extinguisher, flashlight, glass breaker, seat belt cutter, and air bag deflator. Youth are engaged in meaningful, structured activities seven days a week. At least one hour of physical activity is provided daily. Church and other activities are offered for the youth such as Meditation on Sunday's. The daily schedule is also posted. The agency's detailed map and egress plans of the facility, general client rules, grievance forms, and hotline information are posted throughout the facility.	
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 policies in place to address this standard as follows: 3.02- Program Orientation, and 3.08- Grievance Process. These policies were last reviewed and signed by the CEO on March 2017.	No exception
RATING	☒	☐	☐	☐	☐	There were 4 youth charts reviewed. 2 open and 2 closed charts contained all required information regarding program	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						orientation. A youth handbook was provided to youth in all 4 charts at admission or within 24 hours. The orientation process was completed within 24 hours of admission. There is a grievance box located in the living area of the shelter. The orientation provided an opportunity for the youth to learn about the disciplinary action, grievance procedure, emergency/disaster procedures, contraband and rules, physical facility layout, daily activities, room assigned and suicide alert notification. Orientation included the signature of the youth and parent/guardian.	
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 3.03- Youth Room Assignments that addresses the requirement of this indicator. The policy was last reviewed and signed by the CEO in March 2017.	No exception
RATING	☒	☐	☐	☐	☐	There were 4 charts reviewed for 2 open charts and 2 closed charts. All the charts contained all required information indicating the youth room assignment. The charts were clear and information was easy to find. All files contained the youth's age, gender, history of violence, disabilities, physical size, suicide risk, criminal offenses, assault or aggressive	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						behavior, and gang involvement. Alerts are entered into the agency's alert system upon completion of the client intake and health screening and initial interactions and observations were also reviewed.	
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 very clear policy and procedures, 3.04- Log Books, that meets the requirement of the indicator. This policy was last reviewed and signed by the CEO in June 2018.	No exception
RATING	☒	☐	☐	☐	☐	The paper log books were reviewed for the review period. The agency returned to paper log books on July 1st, 2019. The agency's safety and security issues were documented and highlighted; however, the indicator requires a signature of the person making the entry. Most of the entries contained initials by staff and there is no staff key to reference while reviewing the log book from July 2019 to October 2019. Staff began signing or printing their names beginning November 2019 after an internal audit was conducted and a corrective action was implemented for this deficiency. Incidents with youth and staff involved were clearly written with date, time, and printed name or signature. All recording errors were appropriately corrected with clear indication of staff	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						making correction and date. The agency supervisor and all staff review the logbook for the previous two shifts. The supervisor's reviews are conducted weekly, dated, and signed. Supervision and resident counts are documented and consistently as well as visitation and home visits. It is noted that some staff are consistently leaving blank spaces throughout the log. It is best practice to always draw a line through blank spaces.	
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 clear policies and procedures for this indicator, 3.05-Behavior Management Strategies and 3.05A- Behavior Interventions, as well as the Family Resources Behavior Motivation System Implementation Handbook. These policies were last reviewed and signed by the CEO in March 2017.	No exception
RATING	☒	☐	☐	☐	☐	The program provides structured daily opportunities for residents to earn points. The agency has a very clear procedure on how this should be carried out and there are signs posted throughout the facility for the youth and staff to see. In addition, the behavior management procedure is included in the youth handbooks that they receive upon arriving at the facility. The residential handbook also describes the level system and the consequences of	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						good or poor behavior. Residents discuss levels achieved as a group each day. Staff, in discussion with the group, determines the level of performance off each item and designates a resident as being on one of the following levels: Orientation, Citizenship, Leadership, or Ownership. Rewards commensurate with the level of performance. The residential supervisor reviews the behavior system with the staff during staff meetings once a month. Four youth surveys indicate that the program rules and behavior system was explained to them during orientation. Three youth indicated that the care provided to them was good, 1 did not answer the question. There were 5 training files reviewed. All five had dates of completion for BMS training within 120 days of hire. Training files reviewed noted that staff are trained in the Florida Network approved crisis intervention model, Managing Aggressive Behaviors (MAB).	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) The agency has a policy and procedure 3.06 for Staffing and Youth Supervision. This policy was last reviewed and signed by the CEO in August 2019.	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☒	☐	☐	☐	☐	Upon reviewing staff schedules for this review period, it was observed that the agency does maintain 2 staff at all times with overlapping shifts. The agency meets all requirements for the 1 to 6 ratio during awake hours and 1 to 12 during the sleep period. Staff observe youth every 15 minutes while asleep and during illness. The staff schedule is posted in the living area and there is a roster which can be accessed when additional coverage is needed.	No exception
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) The agency has a policy and procedure 3.06 for Staffing and Youth Supervision. This policy was last reviewed and signed by the CEO in March 2017.	No exception
RATING	☒	☐	☐	☐	☐	There is written notice clearly posted and visible on the premises for the purpose of security. The system can store video for a minimum of 30 day and can record, date, time, location, and maintain resolution that enables face recognition. Back up capabilities consist of the system's ability to operate during a power outage with a new generator. All 14 cameras are visible and place in the interior and exterior general locations of the shelter where	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						youth and staff congregate and where visitors enter and exit. Supervisory review of video is conducted a minimum of once every 14 days and noted in the logbook and in a separate camera logbook maintained in the supervisor's office. The Vice President of Residential Services, Residential Supervisor, and two Supervisors from another location, who serve as a back-up, have authorized access to the Video Surveillance System. There were 3 random dates of overnight shifts reviewed with bed check logs and of those 3 days, bed checks under 15 minutes were found to be completed. However, the camera system's time is currently off by 5 minutes according to the times noted on the bed check logs matched to the time on the surveillance system. It is the policy of the agency to grant the request of video recordings within 24-72 hours for investigations and from program quality improvement visits.	

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)** 4.01- Healthcare and Admission Screening was reviewed by the CEO in March 2017.	No exception
RATING	☒	☐	☐	☐	☐	A review of four files, two open and two closed, reflects a preliminary physical health screening is performed for each youth at the time of admission. Non-health care staff performed all four screenings. Three screenings were reviewed by the nurse within five days. One screening states the youth was released prior to the nurse meeting with him. The preliminary health screenings include current medications, existing (acute and chronic) medical conditions, allergies, recent injuries or illness, presence of pain or other physical distress, observation for evidence of illness, injury, physical distress, difficulty moving, etc., and observation for the presence of scars, tattoos, or other skin markings. Zero of four youth show as currently taking medication. Zero of four youth show having current existing (acute and chronic)	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						medical conditions. Youth SP has a history of having a seizure at age six or seven. One youth has allergies. None of the youth files reviewed reported recent injuries or illnesses, presence of pain or other physical distress, or any evidence of illness, injury, pain, physical distress, or difficulty moving. Two of four youth had tattoo's or skin markings documented. None of the youth reviewed have diabetes, seizure disorder, cardiac disorder, asthma, tuberculosis, or hemophilia. None of the youth are pregnant or have head injuries occurring during the previous two weeks. No medical referrals or follow up medical appointments were needed. Due to no referrals being needed, it was not necessary for a parent to be involved with coordination and scheduling of follow-up medical appointments. The program does have a policy in place for referring youth, as well as a log sheet to document referrals in the youth's file.	
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)** 4.02B- Comprehensive Master Plan for Suicide Prevention and Response- Pinellas was reviewed by the Vice	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						President of Community Services in October 2019.	
RATING	☒	☐	☐	☐	☐	A review of four youth files, two open and two closed, show that each youth is screened for suicide risk, in accordance with the Florida Network's Policy and Procedure Manual, as part of initial intake and screening process. All four youth were screened, and all results were reviewed and signed by the supervisor and placed in the youth's case file. One of the four screenings indicated a suicide risk. The one youth was appropriate for sight-and-sound supervision based on the screening. The youth was placed on sight-and-sound supervision and remained on sight-and-sound until being assessed by a licensed professional the morning of the first business day following the screening. A Constant Sight and Sound Supervision Observation Log was completed for the time the youth was on sight and sound and placed in the youth's file. The log included the time, any comments, and the initials of the observer. Documentation was completed every 15 minutes. The supervisor signed each daily log form, including all three shifts, indicating that the log was reviewed.	No exception
4.03: Medication							

Quality Improvement Review

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 4.03						☒ **YES** ☐ **NO (explain)** 4.03- Medications and 4.03A- Medication Management and Distribution policies were reviewed by the CEO in March 2017. 4.03B Medication Disposal was reviewed by the CEO in May 2017.	No exception
RATING	☐	☒	☐	☐	☐	The program follows written procedures that address the safe and secure storage, access, inventory, disposal, and administration/distribution of medications. The reviewer found that all medications, except for Oral Topical Medications were kept in a Pyxis Med-Station 4000 Medication Cabinet. There is a locked box in a cabinet labeled for Oral Topical Medications. The Med-Station is not accessible to youth. The agency has a total of four Super Users for the Med-Station. The four Super Users are the nurse, supervisor, and two YDS'. The agency does not accept youth currently prescribed injectable medications, except for epi-pens. Oral medications are stored separately from epi-pen and topical medications. The agency has documentation that non-licensed staff have received training for the use of epi-pens by the nurse.	**Exception** There are no current discrepancies, however, it was stated medication discrepancies are cleared weekly, not after each shift. Topical medications appeared to be stored in a locked box in a cabinet, not in the Pyxis Med-Station. The facility does not currently have any of these medications. The nurse stated that it is an old box and they are kept in the top drawer of the Pyxis.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						There is a secure refrigerator for medications requiring refrigeration, however the agency has not had any medications that require refrigeration. The temperature of the refrigerator is appropriate for the storage of medications. A review of youth who are currently on medication reflect that a Medication Distribution Log is used for the distribution of medication by all staff daily. Shift-to-shift counts for controlled substances, verified by a witness, are conducted and documented in the Medication Log. An inventory with running balances is maintained for controlled substances. There are no current discrepancies, however, it was stated medication discrepancies are cleared weekly, not after each shift. Narcotics and controlled medications are stored in a locked box in the Med-Station. Only designated staff have access to secure medications. All sharps, including razors and scissors, are secured and inventoried daily. All Over-the-counter medications are brought in by the youth's guardian and are inventoried weekly. Monthly reviews of medication management practices are done. The	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						agency verifies medication and delivers medication per policy. The agency has one part-time nurse who is on duty from 6:00am-8:00am daily. The nurse delivers the medication when on duty.	
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)** 4.04- Medical and Mental Health Alert Process was reviewed by the CEO in March 2017.	No exception
RATING	☒	☐	☐	☐	☐	The program ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information is effectively communicated to all staff through their alert system. The program utilizes a color-coded alert system. Each alert is assigned a color. Red is for constant sight and sound, green is for mental health, blue is for substance abuse, purple is for sharps restriction, black is for medical issues, orange is for medications, and pink is for allergies and special diets. An assessment is completed on each youth and a color-coded sticker is placed on the side of the youth's file and on the programs alert board to inform staff of the alerts for each youth. The alerts are also logged in the logbook and it is	No exception

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						documented that each staff reviews the logbook when they come on staff. A review of two open and two closed files reflected that one youth was on sight and sound, one youth had a mental health alert, three youth had substance abuse alerts, one youth was on sharps restriction, two youth had medical alerts, and one youth had an allergy alert. All four files were properly marked with the correct color-coded alert. Each file included a key showing which color was assigned to each alert. The program alert board was properly marked for the two-current youth. The alerts were logged in the logbook on the day of admission. Staff are provided information and instructions as required in order to recognize and respond to the need for emergency care.	
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** 4.05 Episodic/Emergency Care was reviewed by the CEO in March 2017.	No exception
RATING	☐	☒	☐	☐	☐	The agency follows written procedure, including procedures for obtaining off-site emergency services, parental notification requirements, incident reporting to the CCC and Florida Network, development	**Exception** There was no verification receipt of medical clearance via discharge instructions with follow-up upon return to the facility present

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 implementation of a daily log, and verification of receipt of medical clearance, discharge instructions, and follow-up care upon youth's return to the shelter. A daily Episodic Logbook is kept for all incidents. The daily log includes the date, name of youth, a brief description of the incident, what treatment was rendered, any notifications, and staff initials. An incident report is also completed for each event and kept in an Incident Report Binder. A review of incidents for three closed youth reflects that all three incidents were logged on the daily log, and there was an incident report for each event. The youth's parent/guardian was notified in all three cases. Off-site emergency medical care was required for two of the three youth. CCC calls were made for both. There was a verification receipt of medical clearance via discharge instructions with follow-up present in one of the two files. All staff are trained on emergency medical procedures. All direct care staff are trained and certified in first aid and CPR procedures within three months of beginning work with youth. The program has a knife-for-life and wire cutters accessible to staff in a locked cabinet on	in the file of one youth who received off-site medical care. No aromatic spirits of ammonia in the first aid kit. Inspection/inventory of First Aid Kit completed on a monthly basis, rather than a weekly basis.

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 housing unit. The first aid kit is fully equipped, with the exception of aromatic spirits of ammonia, and located in the nursing station. An inspection of the first aid kit is done on a monthly basis, rather than weekly, to determine if any more supplies are needed.	