Florida Network for Youth and Family Services
Compliance Monitoring Report for

LSF NW – Currie House
4610 West Fairfield Drive
Pensacola, Florida 32506

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the LSF NW – Currie House for the FY 2019-2020 at its program office located at 4610 West Fairfield Drive, Pensacola, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. LSF NW – Currie House is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 2019 through June 30, 2020.

The review was conducted by Ashley Davies, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from LSF NW – Currie House present for the entrance interview were: Beth Deck, Regional Director; Sherri Swanson, Clinical Director; and Sherry Kuss, Youth Care Specialist III. The last onsite QI visit was conducted March 14 - 15, 2019.

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

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

2019-2020 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 03-11-2020

Agency Name: LSF NW – Currie House	**Monitor Name: Ashley Davies, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 4610 W Fairfield Dr., Pensacola, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 11 - 12, 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.	☐	☐	☒	☐	☐	Interview: The program currently has two staff members certified as DJJ QI Peer reviewers. Both staff have participated as a peer reviewer this season.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of additional contracts for FY 2019- 2020 was provided by the provider. The list includes name, funding source, contract amount, and beginning date. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, substance abuse, mental health partners, and other treatment providers. All of the agreements reviewed had recent contract/agreement dates.	**No recommendation or Corrective Action.**
Limits of Coverage	☐	☐	☒	☐	☐	Documentation:	**No recommendation or Corrective Action.**

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a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						Provided by Market Global Reinsurance Company. The provider's General Liability insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate and $10,000 each for medical expenses. The providers Automobile insurance provides limits of coverage of $1,000,000 combined for each accident. Coverage for the above policies is in effect for the current FY 2019-2020, 6/1/2019 – 6/1/2020. Professional Liability and Abuse/Molestation insurance is also through Market Global Reinsurance Company for limits of coverage of $1,000,000 each/$3,000,000 aggregate effective 6/1/2019 – 6/1/2020. The certificate does list the	

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						Florida Network on the consolidate certificate of liability as a certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	**N/A –** During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal policies are in place signed by the VP of Finance and the CFO with a revision date of 4/12/2017. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for general ledger, cost accounting, payroll, petty cash, computer backup, and other relevant financial processes.	**No recommendation or Corrective Action.**
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current FY2019-2020, as of 7/1/2019 to 01/31/2020. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program. The Ledgers showed current	**No recommendation or Corrective Action.**

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						balances and differences for two separate accounts.	
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 and Documentation: No change in practice was reported for the agency since the last onsite program review in March 2019. Reviewed petty cash Policy and Procedure. The Petty Cash fund does not exceed the established minimum. Petty cash is stored in a secure locked location in the building. The agency produced past documentation of monthly petty cash reconciliations. Petty cash is reconciled on a consistent basis (monthly/quarterly) by designated staff and reviewed by the Supervisor. Disbursements and invoices are approved by the Program Supervisor as required.	**No recommendation or Corrective Action.**
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements and Bank Reconciliations for the past six months for one account with Bank of America. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month and are signed by two parties. Checks disbursed are signed by two parties.	**No recommendation or Corrective Action.**

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						Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files which are kept in secure file cabinets in the Program Administration office.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Provider submitted evidence of its payroll services. Services are monitored through ADP. Documentation was reviewed for all four quarters of 2019, of payroll taxes being deposited into an account every two weeks.	**No recommendation or Corrective Action.**

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a Budget Report including the current fiscal year to date information. The report tracks all budget categories by current period actual and current period contract separately. Variances if applicable are identified through the beginning of the FY 2019-2020 to present for the CINS/FINS program. The program budget is reviewed and approved by the agency's Pres/CEO, Board, and Regional Director B. Deck.	**No recommendation or Corrective Action.**
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit was conducted for the fiscal year beginning June 30, 2019 – 2018 by BDO USA, LLP. A copy was submitted directly to the Florida Network of Youth and Family Services for before November 2019.	**No recommendation or Corrective Action.**
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete	☐	☐	☒	☐	☐	Documentation: The agency provided multiple Policies and Procedures. No changes in Confidentiality and Security protocols. The policies have been applied consistently across the required areas	**No recommendation or Corrective Action.**

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documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**						that include Data Back Up Systems; Information Security; and Confidentiality. Policies are signed by the Regional Director with a revision date of 4/12/2017.	

CONCLUSION

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

SUMMARY OF RECOMMENDATIONS

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

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Lutheran Services Florida/Northwest – Currie House
Residential Program

March 11-12, 2020

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 71.43%
Percent of indicators rated Limited: 14.29%
Percent of indicators rated Failed: 14.29%

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	Limited
2.09 Special Populations	Satisfactory
2.10 Stop Now and Plan (SNAP)	Satisfactory

Percent of indicators rated Satisfactory: 90.00%
Percent of indicators rated Limited: 10.00%
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	Limited
3.07 Video Surveillance System	Satisfactory

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

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 82.76%
Percent of indicators rated Limited: 13.79%
Percent of indicators rated Failed: 3.45%

Rating Definitions

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

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

Reviewer

Members

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

Tara Frazier - Department of Juvenile Justice

Tiffany Martin – Florida Network of Youth and Family Services

Aleundro McCray – Boys Town of Central Florida, Inc.

Jennessa Hart - Anchorage Children’s Home

Quality Improvement Review

Lutheran Services Florida/Northwest – Currie House – March 11-12, 2020
Lead Reviewer: Ashley Davies

Methodology

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

Persons Interviewed

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

Documents Reviewed

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

The agency reported the last couple of months the shelter has been full which has been helping the program catch up in numbers.

The Central Credit Union comes to the program and teaches the youth banking skills. They also come once a month and have game night with the youth.

The program takes the youth to Teen Court to watch so they can have a better understanding of the system and how it works.

Standard 1: Management Accountability

Overview

Lutheran Services Florida NW Currie House is managed by a Regional Director who oversees a Quality Services Manager and a Clinical Director. At the time of the review there were five vacant Youth Care Specialist (YCS) positions. The Registered Nurse (RN) position was also vacant. There were also two vacant non-residential counseling positions. The program lost four YCS staff in the past three weeks prior to the review due to various reasons. The program is having a hard time filling these vacant positions. As a result, staff are having to work longer hours and extra days to ensure staff to youth ratios are maintained.

The program is using the Clearinghouse for background screening. All employees are in the Clearinghouse. The program is using the Predictive Index as their pre-employment suitability assessment. Any applicants applying for a direct care position are required to complete this assessment prior to hire.

At the time of the review the program did not have a data collection process that was documented and able to be reviewed. Due to the significant shortage of staff and long working hours of the current staff the different committees involved in this process have been unable to meet. In addition, most of the staff on these committees no longer work for the program and these positions have not yet been replaced. It was verbally reported various risk issues are discussed during staff meetings. However, there have been no meeting minutes for the last six months to confirm this. There was no documentation to show the program has a process in place to review and improve the accuracy of data entry and collection.

During the on-site review, the team had to make a report to the Central Communications Center (CCC) due to falsification of documents. During a review of the video surveillance system during two different overnight shifts it was observed the same YCS documented bed checks that were not actually completed.

All indicators in standard one were rated satisfactory with the exception of 1.04 Training Requirements which was rated a limited and 1.05 Analyzing and Reporting Information which was rated as failed. Exceptions were noted in 1.03 Incident Reporting. Indicator 1.04 was rated a limited due to staff not receiving several required trainings and not meeting minimum training hours. Indicator 1.05 was rated a failed due to the program not having a data process in place that was documented and able to be reviewed. The exceptions noted in 1.03 were due to one CCC report not reported within the required time frame and one report not entered into the program’s logbook. All other indicators in standard one were rated satisfactory with no exceptions.

Standard 2: Intervention and Case Management

Overview

Lutheran Services Florida NW Currie House provides residential and non-residential counseling and case management services over two counties, Escambia and Santa Rosa, across Circuit 1.

The Clinical Director, who is a Licensed Mental Health Counselor (LMHC), oversees all counseling services at Currie House and Hope House, a sister shelter operated by the agency in the same circuit. A Counselor III oversees the day-to-day activities for both residential and non-residential counseling services at Currie House and reports to the Clinical Director. The residential counseling program consists of two master's level counselors, in addition to the Counselor III who is also a master's level counselor. At the time of the review the two non-residential counselor positions were vacant. The Counselor III and another counselor were filling these positions until they can be filled.

This location does offer Stop Now and Plan (SNAP) services. The SNAP program is overseen by a Site Coordinator. Services are provided by five Facilitators and one Case Manager. All staff working in the SNAP program have a bachelor's or master's level degree.

The program has not had any Staff Secure, Domestic Minor Sex Trafficking, Probation Respite, or Family and Youth Respite Aftercare Services (FYRAC) since the last on-site review. The program also does not provide Intensive Case Management Services at this location. The shelter has provided Domestic Violence Respite services. The agency is currently maintaining paper files.

All indicators in standard two were rated satisfactory with the exception of 2.08 Sexual Orientation, Gender Identity/Expression which was rated a limited. There was an exception noted in 2.01 Screening and Intake. Indicator 2.08 was rated a limited due to no documentation that newly hired staff or volunteers have knowledge of Florida Network policy #5.08. The exception noted in 2.01 was due to the residential files not containing documentation the parent and youth received the Parent/Guardian Brochure, possible actions occurring through involvement with CINS/FINS services, and grievance procedures. All other indicators in standard two were rated satisfactory with no exceptions.

Standard 3: Shelter Care

Overview

Lutheran Services Florida NW Currie House residential program is led by a Quality Services Manager and a Youth Care Specialist (YCS) III. The shelter runs three shifts. The YCS III oversees each shift. Each shift is staffed with full-time, part-time, and temporary YCS. At the time of the review there were there five vacant YCS positions. The program has lost four YCS in the last three weeks. This has caused a challenge when staffing the three shifts. Staff are having to work longer hours and extra shifts to ensure staff to youth ratios are maintained.

The program has not done any major upgrades or remodeling to the facility or grounds since the last on-site review.

The residential youth shelter building includes a large day room, individual girls' and boys' sleeping rooms, individual bathrooms, kitchen, laundry, residential and counseling staff offices. The building also has a separate medication and camera room and the exterior of the office includes a large back yard with a small basketball court and recreation area. The shelter has six bedrooms and is licensed for twelve youth. At the time of the review the shelter had five CINS/FINS youth.

The shelter has a daily program schedule in place that is posted in the dayroom for youth and staff to view. The schedule allows youth quiet time and time to complete homework. The schedule includes structured activities seven days a week with minimal idle time.

The program has an effective behavior management system in place. The youth receive a detailed outline of how to be successful using the behavioral management system at intake. The youth earn incentives by earning positive points throughout the day. The youth are promoted to different levels depending on their behaviors.

All indicators in standard three were rated satisfactory with the exception of 3.06 Staffing and Supervision which was rated a limited. There were exceptions noted in 3.02 Program Orientation and 3.07 Video Surveillance System. Indicator 3.06 was rated a limited due to falsification of bed checks and instances of only one staff being on duty during the overnight shift. The exceptions noted in 3.02 were due to two Orientation Checklists not completely filled out by either the youth or the staff. The exception noted in 3.07 was due to supervisory reviews of the video surveillance system not consistently being conducted every fourteen days. All other indicators in standard three were rated satisfactory with no exceptions.

Standard 4: Mental Health/Health Services

Overview

The residential counseling services in the shelter are overseen by the Clinical Director who is a Licensed Mental Health Counselor (LMHC). Services are provided by the Counseling Supervisor and a team of master's level counselors.

All youth are screened for suicide at intake using the six approved questions on the CINS Intake Assessment form and the Suicide Risk Evaluation (SRE). If youth receive a positive screening they are placed on sight and sound supervision until seen and assessed by a mental health professional. The counselors who are completing the Suicide Risk Assessments are unlicensed counselors working under the supervision of a licensed professional. However, none of the counselors have received the training required to complete the Assessments, including twenty hours of training that includes administering at least five Suicide Risk Assessments in the presence of a licensed professional.

At the time of the review the RN position was vacant. The previous RN resigned October 8, 2019. A new RN was identified for the position; however, due to the hiring process taking so long, found another job while waiting. The agency has the position advertised again and the shelter was in the process of trying to hire another RN for the position. At the time of the review trained YCS were distributing medications and the YCS III was overseeing the process. All newly hired staff are trained on the medication distribution process and the Pyxis Med-Station 4000 Medication Cabinet. Refresher training is provided as needed. All medications in the facility are stored in the Pyxis Med-Station 4000 Medication Cabinet. YCS complete shift-to-shift inventories of all controlled medications and maintain perpetual inventories of all other medications.

All indicators in standard four were rated satisfactory with the exception of indicator 4.02 Suicide Prevention which was rated a limited. There were also exceptions noted in indicators 4.01 Healthcare Admission Screening and 4.03 Medications. Indicator 4.02 was rated a limited due to the counselors completing Assessments of Suicide Risk working under the supervision of a licensed mental health professional not having the required training to do so. Also, it was observed on video surveillance, a youth on sight and sound supervision was not within sight and sound of a staff during sleeping hours. The exception noted in 4.01 was due to the Healthcare Admission Screenings not being reviewed by Registered Nurse. The exceptions noted in 4.03 were due to staff using an incorrect method to verify medications, the program only has one Super User assigned to the Pyxis Med-Station, and the Epi-Pen training received by staff is not conducted by a Registered Nurse. All other indicators in standard four were rated satisfactory with no exceptions.

STANDARD 1: MANAGEMENT ACCOUNTABILITY

Quality Improvement Indicators	Rating: Explain – Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☒ YES ☐ NO (explain) The agency has a policy in place titled 1.01 Background Screening of Employees and Volunteers that addresses the requirements of this indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were nine staff hired since the last review. All nine staff had a background screening, with an eligible rating, completed prior to hire. Seven of the staff were applicable for a pre-employment suitability assessment. All seven had an assessment completed using the Predictive Index. Two of the staff documented this assessment was completed after the staff's date of hire and not before. All nine newly hired staff had documentation of E-verify obtained from the Department of Homeland Security.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						There were no staff due for a 5-year rescreen during this review period. The program submitted the Affidavit of Compliance with Level 2 Screenings Standards to the DJJ Background Screening Unit on January 7, 2020 by fax.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ YES ☐ NO (explain) The agency has a policy in place titled 1.02 Provision of an Abuse Free Environment that addresses the requirements of this indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The program maintains a code of conduct which prohibits the use of physical abuse, profanity, threats, or intimidation. The Florida Abuse Hotline is posted throughout the program and signage is used to reflect that all youth are accepted, regardless of sexual orientation, gender identity, or gender expression are posted in the from lobby and in the dayroom of the shelter. There is a process in the program's policy for documenting any child abuse hotline calls. The policy also addresses how management takes immediate action to address incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						There are grievance forms available to the youth to provide feedback and address complaints, once completed, the youth will place this form into the locked box in the common area. The shelter supervisor is the only person who possesses a key to this box. The program has had one grievance since the last annual compliance review. This grievance was resolved within seventy-two hours by management. All grievances are maintained for a minimum of one year on-site.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) The agency has a policy in place titled 1.03 Incident Reporting that addresses the requirements of this indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☐	☒	☐	☐	☐	The program had a total of eleven Central Communications Center (CCC) reports in the past six months. Ten of the eleven reports were completed on an incident reporting forms. Ten of the eleven were reported within the two-hour mandatory timeframe. CCC#201904341 was not reported in a timely manner and the program handled	The CCC #20200994 report from March 2, 2020 could not be located at the program. The CCC #201904341 report was not reported in the required two-hour time frame. The CCC #202001030 incident from March 4, 2020 was not entered into the program's electronic logbook.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						this incident internally with the staff member. A sample of six CCC reports were compared to the NoteActive electronic logbook. Five of the six CCC reports were documented in the logbook.	
1.04: Training Requirements **Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☒ YES ☐ NO (explain) The agency has a policy in place titled 1.04 Training Requirements that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☐	☒	☐	☐	☐	There were five training files reviewed for first year training requirements. Only one of the five staff have completed a year. This staff only documented 70.25 of the required 80 hours of training for the first year of employment. This staff was also missing four required trainings and completed two trainings required during the first 120 days, late. The remaining four newly hired staff were reviewed for training completed during the first 120 days of employment. Three of the staff were missing one required training and the fourth staff was missing two required trainings.	**Exceptions:** One training file reviewed for first year training requirements only documented 70.25 of the required 80 hours of training. This staff was also missing four required trainings and completed two other trainings required in the first 120 days late. Out of four training files reviewed for trainings required during the first 120 days, three were missing one required training and one was missing two required trainings. Out of three training files reviewed for annual training requirements, one only

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 were three staff training files reviewed for annual training requirements. Two of the staff documented the required 40 hours of training for 2019. The third staff documented 36.5 of the required 40 hours for 2019. One of the three staff had an expired CPI certification. Another staff was missing two DJJ Skill-Pro trainings and had an expired CPR and First Aid certification. Each staff has an individual training file, which includes an employee training hours tracking form, and related documentation, such as certificates, sign-in sheets, and/or agendas for trainings attended.	documented 36.5 out of the required 40 hours. One of the three staff had an expired CPI certification. Another one of the three staff was missing two DJJ Skill-Pro trainings and had an expired CPR and First Aid certification.
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) The agency has a policy in place titled 1.05 Analyzing and Reporting Information that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☐	☒	☐	☐	☐	The program reported due to the staff shortage many of the requirements of this indicator were unable to be met for the last six months.	There was no documentation of a quarterly case record review report.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						There was documentation case records were individually reviewed by a supervisor; however, there was no documentation of quarterly case record review report. It was reported that incidents, accidents, and grievances were discussed at staff meetings sometimes; however, there were no minutes from these meetings to confirm this practice.	There was minimal documentation that incidents, accidents, and grievances are reviewed at least quarterly. There was no documentation of an annual review of customer satisfaction data or outcome data. There was no documentation to show strengths and weaknesses are identified, improvements are implements or modified and staff are informed and involved throughout the process. There was no documentation to show the program has a process in place to review and improve the accuracy of data entry and collection.
1.06: Client Transportation **Policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						☒ YES ☐ NO (explain) The agency has a policy in place titled 1.06 Client Transportation that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has implemented a transportation policy which includes approved drivers by administrative personnel and prohibits transporting a client without maintaining a minimum of at least one other passenger in the vehicle.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The third party in the vehicle may be an approved volunteer, intern, agency staff, or other youth, however, policy does include exceptions in the event that a third party is not present in the vehicle. If a single driver is approved to drive a single youth, the program supervisor or designee must document the approval in the NoteActive electronic logbook. The approved drivers must have a valid Florida driver's license and covered under company insurance policy. The program has two vehicles and both maintained vehicle logs which included the name/initials of the driver, date and time, mileage, number of passengers, purpose of travel, and location. Mileage logs reviewed were filled out in their entirety. All single client transports were reviewed for the last six months and all documented supervisor approval in the electronic logbook prior to the transport taking place.	
1.07: Outreach Services **The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) The agency has a policy in place titled 1.07 Outreach and Interagency	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		
						Agreements that addresses the requirements of this indicator. This policy was last reviewed on October 2, 2019 by the Regional Director.	
RATING	☒	☐	☐	☐	☐	The agency has a representative from the program attend numerous different community meetings monthly including: Drug Endangered Children and Communities, Northwest Florida Prevention Coalition, United Way, Circuit 1 Human Trafficking Task Force, and Opening Doors. There were agendas and meeting minutes from each one of these meetings attended by a staff member. The agency also has a representative from the program attend the Circuit 1 Department of Juvenile Justice Circuit Advisory Board Meetings for Escambia and Santa Rose counties. There were meeting minutes and agendas from each one of these meetings for the months for April 2019, June 2019, August 2019, September 2019, October 2019, November 2019, and January 2020. The program maintains written agreements with community partners which include services provided and a referral process. Written agreements the program has on file include: Big Brothers Big Sisters of Northwest Florida, Opening Doors, HIVevolution, Lakeview Center – Victim Services/Rape Crisis Center, Lakeview Center – Baptist Health Care,	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		
						Pensacola Police Department, Boy and Girls Club of the Emerald Coast, Avalon Center of Lakeview, A Safe Port Counseling Center, Escambia County Sheriff's Office, Santa Rosa Kids House, Gulf Coast Kids House, CDAC Behavioral Healthcare, Inc., School Board of Escambia County, Santa Rosa County School Board, Childrens Home Society, and Catholic Charities of Northwest Florida. All agreements reviewed were current and up-to-date. The program has documentation of attending at least twenty events in the community over the last six months to promote the program and the different services provided at the program. These events include: local school functions, Human Trafficking Summit, Transition Fairs, and local Sheriff's Department events. At each one of these events attended the program will set a table with a display of program services, brochures, and various items for attendees to take such as pencils, pens, bracelets, cards, magnets, and balloons.	

STANDARD 2: INTERVENTION AND CASE MANAGEMENT

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Two – Intervention and Case Management							
2.01: Screening and Intake							
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.01 Screening and Intake that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☐	☒	☐	☐	☐	There were ten files reviewed, five residential (two open and three closed) and five non-residential (two open and three closed). All ten files had an eligibility screening within seven calendar days of the referral. All ten files documented the youth and parent received available service options and rights and responsibilities, in writing. All five non-residential files had documentation the parent and youth received the Parent/Guardian Brochure, possible actions occurring through involvement with CINS/FINS services, and grievance procedures.	The five residential files did not contain any documentation the parent and youth received the Parent/Guardian Brochure, possible actions occurring through involvement with CINS/FINS services, and grievance procedures.
2.02: Needs Assessment							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.02 Needs Assessment that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were ten files reviewed, five residential (three open and two closed) and five non-residential (two open and three closed). All five non-residential files documented the Needs Assessment was completed within two to three face-to-face contacts. All five residential files documented the Needs Assessment was initiated within seventy-two hours of admission. All ten Needs Assessments were conducted by a bachelor's or master's level staff member. All ten Needs Assessments were signed by a supervisor upon completion. Three of the ten Needs Assessments identified the youth as an elevated risk of suicide and the youth were referred for an Assessment of Suicide Risk.	No exceptions
2.03 Case/Service Plan							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.03 Case/Service Plan that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were ten files reviewed, five residential (three open and two closed) and five non-residential (two open and three closed). All ten files documented the Case/Service Plan was developed within seven working days of the Needs Assessment. All Case/Service Plans were individualized and included prioritized needs and goals identified by the Needs Assessment. All Case/Service Plans included the service type, frequency, and location, persons responsible, target date(s) for completion, actual completion date(s), signature of youth, signature of parent/guardian, signature of counselor, signature of supervisor, and the date the plan was initiated. Four of the five non-residential files documented the Case/Service Plans were	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		
						reviewed for progress/revised by the counselor and parent (if available) every thirty days for the first three months and every six months thereafter. In the remaining file the youth and parent never engaged in services so there was not a need to review the Case/Service Plan. None of the Case/Service Plans were reviewed in the five residential files because the none of the youth were in the shelter longer than thirty days.	
2.04: Case Management and Service Delivery							
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.04 Case Management and Service Delivery that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were ten files reviewed, five residential (three open and two closed) and five non-residential (two open and three closed). All ten files documented a counselor was assigned to the youth at intake. Nine out of ten files documented referrals for services were made when applicable, documented coordination of Service Plan implementation, monitored the youth and	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						family's progress, and provided support to families. In the remaining file the family did not engage in services so none of the above elements are applicable. There was no monitoring of out of home placement and no referrals to the case staffing committee in any files reviewed. There was one residential file reviewed in which the youth was accompanied to court by the counselor. Two applicable youth had their court orders monitored by the counselor to ensure they were meeting the requirements while in the program. All closed files demonstrated case termination notes with only two of them having a thirty day follow up. All other files were either open or have not met the threshold for the thirty day follow up requirement. No files were in need of a sixty day follow up at the time of the review.	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.05 Counseling Services that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☒	☐	☐	☐	☐	There were ten files reviewed, five residential (three open and two closed) and five non-residential (two open and three closed). Nine out of ten files reviewed documented case coordination between the presenting problem and the Needs Assessment, Initial Case/Service Plan, and case management and follow ups. Nine out of ten files documented case notes were maintained for all counseling services provided and documented youth's progress. There was clear evidence that there is an ongoing internal process that ensures clinical reviews of case records and staff performance. Nine out of ten files documented youth and families received counseling services in accordance with their Case/Service Plan. One of the ten files reviewed there was a Needs Assessment, Case/Service Plan and several documented attempts to reach the family. The family however, never engaged in services. Group logs were reviewed from January 1, 2020 – February 29, 2020. Group	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		
						counseling sessions consisted of a clear leader or facilitator, relevant topic, date and time of group, list of participants, an opportunity for youth to participate, and the length of groups was at minimum thirty minutes. There was clear evidence groups were provided at least five days each week.	
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.06 Adjudication/Petition Process that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☐	☐	☒	☐	☐	There were no files reviewed for this indicator as a result of there being no Case Staffing's during the review period.	No exceptions
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.07 Youth Records that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were ten files reviewed, five residential (three open and two closed) and five non-residential (two open and three closed). All records were marked "confidential".	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						All records are maintained in a locked file room and locked in a file cabinet that is marked “confidential”. The file room door is also marked “confidential”. When in transport, all records are locked in an opaque container marked “confidential”. All records are maintained by number in the file cabinets. All clients are assigned a number at intake and they maintain that number each time they come to receive services.	
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.08 Sexual Orientation, Gender Identity, Gender Expression that addresses the requirements of this indicator. This policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☐	☒	☐	☐	☐	The program has not had any youth who fall under the requirements of this indicator since the last on-site review. There was one sign placed in the shelter dayroom and one sign placed in the front lobby of the shelter indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression.	**Exception:** There was no documentation that newly hired staff or volunteers have knowledge of Florida Network policy #5.08. Additionally, there was no evidence of the LGBTQ training completed.
2.09: Special Populations							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.09 Special Populations that addresses the requirements of this indicator. The policy was last reviewed on October 2, 2019.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has not had any Staff Secure, Domestic Minor Sex Trafficking, Probation Respite, or Family and Youth Respite Aftercare Services (FYRAC) since the last on-site review. The program also does not provide Intensive Case Management Services at this location. There were three Domestic Violence (DV) files reviewed. All three youth had a pending DV charge and were referred by the DJJ Juvenile Probation Officer (JPO) due to not meeting criteria for secure detention. All three files documented data was entered into NetMIS within three days of entry and discharge and JJIS within twenty-four hours. Two of the three youth were in the program longer than twenty-one days and there was documentation the youth were transferred to CINS/FINS. All three Case Plans reflected goals focusing on aggression, family coping	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		
						skills, and other interventions designed to reduce reoccurrence of violence in the home. All other services provided to the three youth were consistent with all other general CINS/FINS program requirements.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☒ YES ☐ NO (explain) The agency has a policy in place titled 2.10 Stop Now and Plan (SNAP) that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were eight SNAP files reviewed, four open four closed. All eight youth were screened to determine eligibility and identify presenting using the NetMIS screening form and the SNAP Brief Intake screening form. All eight youth had a consent signed by the parent/guardian prior to receiving services. All eight youth had a Needs Assessment initiated at intake.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						All eight youth had a Pre-Child Behavior Checklist (CBCL) completed at intake. Two of the eight files had the Pre-Teacher Report Form (TRF) completed in the file. The remaining six files contained documentation the TRF was sent to the teacher to be completed; however, the teacher did not return the completed form. Each of the six files contained follow-up attempts in the form of an email to obtain the completed form from the teacher. All eight files contained a TOPSE assessment completed at intake. All eight files contained a PAT assessment completed at intake. Three of the four closed files contained a Post-CBCL completed at discharge. In the remaining file the family stopped attending the sessions so the CBCL was sent to the parent to complete; however, the parent never returned it. One of the four closed files documented a Post-TRF was completed. Two of the remaining files documented the form was sent to the teacher to complete; however, the teacher did not return the form. The last file did not contain documentation the form was sent to the teacher. However, this youth changed schools and the new	

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		
						school the youth was attending was an alternative school and the school refused to give the counselor any information about the youth's teacher so the form could be completed. Three of the four closed files documented a PAT assessment was completed at discharge. In the remaining file the family stopped attending the sessions so the PAT assessment could not be completed. All four closed files documented the SNAP Discharge Report Summary was completed. The last completed cycle of SNAP in Schools was reviewed. There were two classrooms reviewed for this cycle. Each classroom documented weekly attendance sheets, with the youth's name and signatures of the teacher and facilitator, for all thirteen sessions. Each classroom documented pre and post evaluations were completed for the youth. Each classroom documented pre and post evaluations were completed for the teacher.	

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		
						Each classroom documented one Fidelity Adherence Checklist was completed for the 13-week cycle. The program has seven SNAP facilitators. Each facilitator had documentation of their SNAP Certification Certificate.	

STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Three – Shelter Care							
3.01 Shelter Environment **The shelter's environment is safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development.**							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						☒ YES ☐ NO (explain) The agency has a policy in place titled 3.01 Shelter Environment that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	A tour of the facility revealed furnishings were in good repair. The program was free of insect infestation. The grounds were landscaped and maintained. Bathrooms were clean and functional. There was no graffiti observed. Lighting was adequate. Exterior areas were free of debris and grounds were free of hazards. All doors were secure. Agency vehicles were equipped with major safety equipment. Key control was in place. Egress maps were posted in the facility. All required postings were observed. The DCF Child Care License was displayed. There was no contraband found. Chemicals were inventoried weekly. The washer and dryer were operational and clean. Youth have a safe place to keep	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		
						belongings. The annual fire inspection was satisfactory. There was at least one fire drill per month. There was one mock emergency drill per shift per quarter. All annual fire safety equipment inspections were valid and up to date. The agency had a current Satisfactory Residential Group Care inspection report. There was a current Satisfactory Food Service inspection report. All food was properly stored. Refrigerators and freezers were clean and maintained at required temperatures. Youth were engaged in meaningful and structured activities seven days a week and idle time was minimal. Youth were provided at least one hour of physical activity daily. Youth were able to participate in faith-based activities on Sunday's. Youth were provided opportunities to do homework and read. There was a daily schedule posted on the board in the living area of 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 a policy in place titled 3.02 Program Orientation that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☐	☒	☐	☐	☐	There were five files reviewed, three open and two closed. All five files had an orientation checklist located inside the file. The checklist were completed on the day of admission. The checklist covered all required items. Four of the five checklists were signed by the youth and all five were signed by the staff. One of the checklists was signed by the staff but each item was not initialed by the staff.	One orientation checklist was not signed by the youth. Another checklist was signed by the staff but each item on the checklist was not initialed by the staff.
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) The agency has a policy in place titled 3.03 Room Assignment that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The shelter Intake Assessment form collects all the initial classification information of the youth including a review of the youth's history, status and exposure to trauma, as well as the youth's age, gender, history of violence, disabilities, physical size/strength, any identified gang affiliation, suicide risk, gender identification, and sexually aggressive behavior. With this information, the staff assigns the youth to a room and enters any alerts that are required. All five files reviewed had the shelter Intake	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		
						Assessment form completed and the youth were appropriately assigned to a room.	
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) The agency has a policy in place titled 3.04 Log Books that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The program uses the NoteActive electronic logbook. The logbook was reviewed for the past three months. Any safety and security issues were documented and highlighted. All entries were brief. All entries included the date and time, name of the youth and staff involved, a brief statement, and the same and signature of the person making the entry. All errors were struck through with a single line. There were supervisory reviews of the logbook. All direct care staff review the logbook at the beginning of their shift for the previous two shifts. The program director reviews the logbook every week and makes a note with recommendations. The logbook documented supervision counts and any visitation or home visits.	No exceptions
3.05: Behavior Management Strategies							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The agency has a policy in place titled 3.05 Behavior Management Strategies that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The youth receive a detailed outline of how to be successful using the behavioral management system. The youth earn incentives by earning positive points throughout the day. Interventions are in place. An interview with a direct care staff revealed staff have knowledge of the system. The staff was able to explain how the youth earn positive points and negative points. The youth are promoted to different levels depending on their behaviors. The supervisor was also knowledgeable about the BMS and how to monitor staff's use of it. This system also has a grievance procedure that three different phases put in place to ensure the youth has some autonomy. All staff are trained on the behavior management system during new hire training.	No exceptions
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) The agency has a policy in place titled 3.06 Staffing and Youth Supervision that addresses the requirements of the	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	
RATING	☐	☒	☐	☐	☐	The program maintains a 1:6 staff to youth ratio during the awake hours and a 1:12 ratio during sleeping hours per Florida Administrative Code. A review of staff schedules for the last three months cross-referenced with the log book revealed these staffing ratios are consistently maintained. The program has a blue binder in the Youth Case Specialist's (YCS) office which contains the staff schedule and the overtime rotation roster with home telephone numbers of staff who are available for additional coverage if needed. The program has six bedrooms. Bedrooms one and two are across the hall from bedrooms three and four. Just down the hall are bedrooms five and six. All bedrooms sleep two youth, with the exception of bedroom six, which can sleep three if necessary. There were three random nights reviewed on the video surveillance system to ensure bed checks were being completed as documented. One of the three nights	During two of the three video surveillance reviews, one night, one of the staff left, leaving a staff alone on the shift. On the second night, there was no second staff member. During the second night, the single staff left the youth unsupervised and went to the kitchen for approximately ten minutes. On March 11, 2020, staff falsified three of her five ten-minute checks in a forty-minute period. The CCC was notified and accepted the call, #202001145. The third night had one falsification, from the same staff member on the first night, out of four, in a thirty-minute period. The CCC was notified of the additional falsification and added to #202001145.

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		
						reviewed checks were completed as documented.	
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) The agency has a policy in place titled 3.07 Video Surveillance System that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☐	☒	☐	☐	☐	The program has written notice posted on the premises for the purposes of video security. Cameras are visible and posted throughout the program covering the client hall, administration entry and lobby, parking lot, kitchen, Youth Care Specialist office, medical office, dining room, shelter entrance and shelter doors. The video does not cover the bathroom or bedrooms. The video surveillance system can store footage for thirty days, including the date, time, and location. During a power outage, cameras are maintained with a back-up battery. The Regional Director, Shelter Supervisor, and Senior Administrative Assistant are the only individuals with access to the video surveillance system. The program does have a process in place for third party review of video recordings after a request from program	A review of the video surveillance logbook revealed that supervisory reviews are not being conducted a minimum of once every fourteen days per policy. The logbook revealed reviews are being conducted, possibly monthly, but there were no dates of the reviews, only the month.

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		
						quality improvement visits and/or when an investigation is pursued.	

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Four – Mental Health /Health Services							
4.01: Healthcare Admission Screening							
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled 4.01 Healthcare Screening Admission that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☐	☒	☐	☐	☐	The FNYFS CINS/FINS Intake Form is utilized in completing the health screening process for new youth. The form assesses for both health and mental health needs, including chronic and acute conditions. Hospitalizations, medications, allergies, and dietary restrictions are captured on the form. Five youth files were reviewed for this indicator, three open and two closed files. All five youth files had documentation showing the Health Screening was completed at the time of intake. Three of five files indicated the youth was on medication at the time of intake. Two of these files had the name of the medication listed on the Health Screening Form.	The shelter does not currently have a nurse so none of the health screenings were reviewed by a nurse as 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		
						One of five files indicated existing medical conditions. These conditions were well documented and described under what conditions they were likely to occur. The conditions did not require follow-up or referral. One of five files indicated the youth had an allergy. One of five files indicated a youth had scars, tattoos, or other skin markings; these observations were clearly documented. All five files reviewed had clear and complete documentation on the Health Screening Form. All sections were addressed and the screening signed by the person completing it. All screenings included a peer review and clinical supervisor review. The youth's medical needs are clearly documented in the logbook and a variety of other places, making the information easily accessible to the YCS. Shelter files include a form which identifies allergies; a Pass-Down Log documents all youth with medications, including the time they are due, and allergies. Staff are required to sign the Pass-Down Log upon coming onto shift.	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						YCS and Shelter Manager work cooperatively to ensure youth receive proper medical care and referrals. When a nurse is on staff, they take the lead in assessing youth's medical needs.	
4.02 Suicide Prevention **There is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.**							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled 4.02 Suicide Prevention that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☐	☒	☐	☐	☐	The agency has a thorough policy regarding Suicide Prevention. The policy includes when screenings and/or assessments will be conducted and by whom, levels of supervision, involvement of licensed clinical staff, appropriate documentation, and the referral process as it relates to suicide prevention. Three files were reviewed for this indicator, all three of which were closed. All three files indicate a suicide risk screening was conducted during the initial intake and screening process. All of the screenings were signed by the supervisor and documentation is present in the case file.	The current practice of the program does not align with the FNYFS Operations Manual. The counselors identified as those responsible for completing the Suicide Risk Assessments are unlicensed counselors and have not completed the required training. The current practice consists of an unlicensed counselor completing the Suicide Risk Assessment and then contacting a licensed professional to confer with. The youth on Sight-and-Sound supervision sleep in their bedroom. It was verified through camera review that staff were not positioned within Sight-and-Sound supervision of a youth who was on Sight-and-Sound precautions. The staff were

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						All three files had Suicide Risk Assessments completed. Two of the three files had assessments that were completed within twenty-four hours of the initial screening. All three files contained "Sight and Sound Logs" and observations were documented at 30-minute intervals or less. The staff utilize the electronic log to supplement the paper observation forms for bedtime checks. The log documented all three youth's initiation of sight-and-sound supervision. The level of supervision determined was clearly documented and explained. All forms were signed off on by a licensed staff. All three youth had completed a safety plan.	positioned in an office and did not have a clear, unobstructed view of the youth in the bedroom.
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled 4.03 Medication that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☐	☒	☐	☐	☐	The program does not currently have a Registered Nurse (RN). The former RN resigned on October 8, 2019. The agency has attempted to hire an RN. A new RN was hired; however, due to the hiring process taking so long, found another job while waiting. The RN at Hope House, a sister shelter, has been helping out at this shelter occasionally. The agency has posted in the RN position again and is in the process of trying to find another RN. The agency has procedures in place which ensure the proper storage and delivery of medications. All medications are stored in a Pyxis Med-Station Cabinet, which is inaccessible to youth. Oral medications are stored separately from injectable epi-pen and topical medications. There is a refrigerator with appropriate locks on it in the same location as the Med-Station. Staff indicated this refrigerator's only purpose is to house medications requiring refrigeration and is not used for any other purpose; the temperature met requirements. Narcotics and controlled medications are stored in the Med-Station. Shift-to-shift counts are verified for each controlled medication. Staff were able to demonstrate their process for counting controlled medications, including signing into the Med-Station and verifying both	Staff report their current method of verifying medications include matching the description provided on the bottle of the medication to the physical medication and an internet search. The pharmacy is contacted in instances when staff are unable to verify medications using these methods. Staff provided examples as to when they have needed to contact the pharmacy. This method is not consistent with the four approved methods outlined within the FNYFS Operations Manual. The facility currently has one of two required Superusers for the Pyxis Med-Station. At the time of the review, the facility does not have a nurse on staff and an additional Superuser has not been identified. Staff do not have Epi Pen training by a Registered Nurse (RN) as required within the Operations Manual, which states non-licensed staff must have documentation that they received training in the use of Epi-Pens provided by a Registered Nurse. The Epi-Pen training the staff have received was not completed by a RN.

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		
						controlled medications that were onsite at the time of the review. Staff conducted the physical count and documented on the medication form the verification. Staff were able to verbalize the process for reporting a discrepancy, including contacting the Shelter Manager. Perpetual inventories are maintained with running balances for each controlled medication. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances. This reviewer was able to review the Medication Distribution Logs for three youth, two of which are current residents. One log had dates which did not indicate the medication had been provided. After a review of NoteActive, it was apparent the youth had refused to receive their medication. All sharps are located in a drawer of a locked filing cabinet. This filing cabinet is located in an office which is locked when staff aren't present. Staff presented a sign-in and out sheet which documents each time a youth is provided with a sharp for use. The practice of using this form appears to be consistent. Sharps are consistently inventoried on 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		
						All Over-the-Counter medications are inventoried weekly. A binder is kept which maintains a section for each Over-the-Counter medication, including weekly inventories. A medication distribution log is used for the distribution of medication by non-licensed and licensed staff. An interview with a YCS and Shelter Manager indicate that discrepancies are cleared following each shift.	
4.04: Medical/Mental Health Alert Process							
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled 4.04 Medical/Mental Health Alert Process that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five youth files reviewed, three open and two closed. Four of five youth had a medical or mental health condition or food allergy noted. All files required an alert as required by the agency's policy and procedure. Upon entering shelter, youth are screened for medical and mental health needs. YCS's are required to notify a counselor if a youth has an identified risk. YCS's are required to notify a counselor if a youth has an identified risk of suicide.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Of the files reviewed all five were appropriately placed on the program's alert system. The program utilizes a color-coded system which allows staff to quickly identify clients with alerts. Alerts are used to identify youth on Sight-and-Sound, High Risk, youth on medication, and clients admitted to the shelter for a Domestic Violence Respite. The staff also have access to a variety of documentation including the screening, Plan of Care, and Pass Down Log which include special alerts or conditions that may pertain to the youth. YCS are provided instruction on how to appropriately recognize and respond to the need for emergency care upon hire. YCS shadow senior staff, attend meetings and trainings, practice skills, and receive Crisis Prevention and Intervention (CPI) training.	
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled 4.05 Episodic/Emergency Care that addresses the requirements of the indicator. The policy was last reviewed on October 2, 2019 by the Regional Director.	No exceptions

Quality Improvement Review

Lutheran Services Florida/Northwest – Currie House – March 11-12, 2020
Lead Reviewer: Ashley Davies

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☒	☐	☐	☐	☐	There were no instances of Episodic/Emergency Care to review. The agency keeps a folder of episodic drills. There were episodic drills were reviewed from each shift within the past six months. Each drill outlines the scenario taken place, site, date, beginning and ending time for drill, time of contact for appropriate people, time and page for logbook entry, staff involved and critique. All staff are provided training in CPR and First Aid. There was one staff whose CPR and First Aid was expired during this review. This deficiency was captured in indicator 1.04 Training Requirements. Knife-for-life and wire cutters are located in the medication office. The facility has four First Aid kits- one in each vehicle (for a total of two), one in the kitchen, and one in the YCS office. The First Aid kits are checked and replenished as needed.	No exceptions