Florida Network for Youth and Family Services
Compliance Monitoring Report for

LSF NW – Hope House
18377 Clinton Boulevard
Crestview, 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 – Hope House for the FY 2019-2020 at its program office located at 18377 Clinton Boulevard, Crestview, 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 – Hope 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 – Hope House present for the entrance interview were: Beth Deck, Regional Director; Sherri Swanson, Clinical Director; and Lee Bandy, Youth Care Specialist III. The last onsite QI visit was conducted September 14 – 15, 2018.

In general, the Reviewer found that LSF NW – Hope House is in compliance with specific contract requirements. **LSF NW – Hope 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 10-02-2019

Agency Name: LSF NW – Hope House	**Monitor Name: Ashley Davies, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 18377 Clinton Blvd, Crestview, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): October 2-3, 2019**

Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
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. Neither staff member has participated as peer reviewer this season but are scheduled to participate on reviews later in the season.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: 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 list contained two current contracts, Lakeview Center and Child Care Food Program. 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	**No recommendation or Corrective Action.**

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						reviewed had recent contract/agreement dates.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: 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.	**No recommendation or Corrective Action.**

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						The certificate does list the 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 8/31/2019. 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 September 2018. 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 (July 2019- August 2019). 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. Reviewed bank statements for March thru August 2019. Bank reconciliations are conducted each month for the activities and bank statements for the	**No recommendation or Corrective Action.**

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						preceding month and are signed by two parties. Checks disbursed are signed by two parties. 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 the first two quarters of 2019, 1/2019 – 6/2019, 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, 2018 – 2017 by BDO USA, LLP. A copy was submitted directly to the Florida Network of Youth and Family Services for before November 2018.	**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 – Hope 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/NW-Hope House
Residential Program

October 2 - 3, 2019

Compliance Monitoring Services Provided by

Quality Improvement Review

LSF/NW-Hope House – October 2-3, 2019
Lead Reviewer: Ashley Davies

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 100.00%

Percent of indicators rated Limited: 0.00%

Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Reviewer

Members

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

Tara Frazier, Regional Monitor, Department of Juvenile Justice

Sarah Showers, Shelter Program Manager, Capital City Youth Services

Caitlyn Dorriety, Family Counselor, Anchorage Children's Home

Jessica Fansler, Contract Management Specialist, Florida Network of Youth & Family Services

Quality Improvement Review

LSF/NW-Hope House – October 2-3, 2019
Lead Reviewer: Ashley Davies

Methodology

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

Persons Interviewed

☐ Chief Executive Officer
☐ Chief Financial Officer
☐ Program Coordinator
☐ Direct – Part time
☐ Volunteer
☒ Clinical Director
☒ Counselor Non-Licensed
☐ Advocate
☐ Nurse – Full time

☒ Executive Director
☒ Program Director
☒ Direct – Care Full time
☐ Direct – Care On-Call
☐ Intern
☒ Counselor Licensed
☒ Case Manager
☒ Human Resources
☐ Nurse – Part time

☐ Chief Operating Officer
☒ Program Manager
1 # Case Managers
1 # Program Supervisors
NA # Food Service Personnel
0# 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
4 # Health Records
7 # MH/SA Records
3 # Personnel /Volunteer Records
7 # Training Records
5 # Youth Records (Closed)
5 # Youth Records (Open)
NA # Other: _____

Surveys

3 # Youth
3 # Direct Care Staff
0 # Other: **NA**

Observations During Review

☐ Intake
☒ Program Activities
☐ Recreation
☐ Searches
☒ Security Video Tapes
☒ Social Skill Modeling by Staff
☐ Medication Administration
☒ Census Board

☒ Posting of Abuse Hotline
☒ Tool Inventory and Storage
☒ Toxic Item Inventory and Storage
☐ Discharge
☐ Treatment Team Meetings
☐ Youth Movement and Counts
☒ Staff Interactions with Youth

☒ Staff Supervision of Youth
☒ Facility and Grounds
☒ First Aid Kit(s)
☐ Group
☐ Meals
☒ Signage that all youth welcome

Comments

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

Strengths and Innovative Approaches

The shelter's community food program continues to grow. They are able to provide food and other daily needs for about 500 households each month. They just enrolled in the Good 360 Program with Wal-Mart which is a donation program that they will use for the community.

The shelter had their 11th annual hurricane drill. The HOPE House teams, Red (Preparation), Green (Evacuation), and Blue (Recovery) did an amazing job. The shelter youth also participate in the weeklong chain of events and learned the importance of being ready for a disaster. They focused a lot this year on the sheltering of youth from another CINS/FINS shelter. They had the opportunity last year to host youth and staff from Anchorage in Panama City and learned a lot from that experience.

The shelter has had many different celebrations with the youth including Thanksgiving Day Feast, Christmas and New Year's celebrations, Super Bowl party, 4th of July fireworks, Halloween/Harvest party, National Ice Cream Day, and a number of birthday celebrations.

The youth have learned to do comparison shopping, baking, cooking, gardening, organization, and many other things. Comparison shopping covers a range of goods from groceries to clothing to setting up a new apartment.

The youth have visited a fire station and museums. The youth have taken cards and gifts to two nursing homes and visited with the patients there. The youth made and distributed homeless care packages. The youth also sent appreciation cards to members of the military and Golden Star families.

The shelter has had several speakers this year talking to the youth about a variety of subjects including local firefighters, careers such as plumbing, welding, computer tech, auto repair, and weekly Bible study. The youth also toured a fire station.

The youth have learned to make putty, stress balls, crochet, painting, and a variety of craft activities. They have done some yard work, cleaning the vans, creative writing, and made strawberry jam.

The shelter has had two youth with very limited English, and the counseling intern has been that invaluable resource who translates and ensures understanding, not only of the language, but also of the culture.

Standard 1: Management Accountability

Overview

Lutheran Services Florida NW Hope 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 three vacant youth care specialist (YCS) positions and three vacant YCS temp positions. The Registered Nurse (RN) position was also vacant. The Administrative Assistant position has been restored back to the budget as a full-time position and a YCS was in the process of transitioning back into this position full-time.

The shelter recently had two older vans donated to the program from Okaloosa County. One of the vans has still has the cage inside so this van will be used for maintenance and running errands. The other van will be used to transport youth.

All indicators in standard one were rated satisfactory with exceptions noted in indicators 1.04 Training Requirements and 1.05 Analyzing and Reporting Information. The exceptions noted in 1.04 were in training files reviewed for first year employees that revealed some required trainings completed outside the 120-day requirement. The exceptions noted in 1.05 were due to improvements that are implemented and monitored through the data collection process not being consistently documented in the meeting minutes each month. A deficiency was noted in indicator 1.03 Incident Reporting due to an incident being reported outside the two-hour time frame; however, this deficiency did not result in an exception. All other indicators standard one were rated satisfactory with no deficiencies.

Standard 2: Intervention and Case Management

Overview

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

The clinical director, who is a Licensed Mental Health Counselor (LMHC), oversees both programs. The residential counseling program consists of one master's level counselor. The non-residential counseling program also consists of one master's level counselor. The non-residential program also offers Intensive Case Management (ICM) services. ICM services are provided by an ICM coordinator. The ICM coordinator is a master's level staff.

This location does not offer Stop Now and Plan (SNAP) services. SNAP services for this circuit are provided at a sister shelter operated by the agency in the same circuit. The clinical director oversees ICM services. The program has provided domestic violence, probation respite, and ICM services this review period. At the time of the review the program had not provided any staff secure, domestic minor sex trafficking, or Family and Youth Respite Aftercare (FYRAC) services since the last on-site review.
The agency is currently maintaining paper files.

All indicators in standard two were rated satisfactory with the only exception noted in indicator 2.03 Case/Service Plan. The exception in 2.03 was due to none of the residential files reviewed showing completion dates on the Case Plans and three residential files did not have parent signatures on the Case Plan and did not have any documentation of attempts/discussion of Case Plan with the parent to cover the missing parent signature. Indicator 2.10 Stop Now and Plan was rated as “not applicable” as those services are not offered at this location. All other indicators in standard two were rated satisfactory with no deficiencies.

Standard 3: Shelter Care

Overview

Lutheran Services Florida NW Hope House residential program is lead by a quality services manager and a youth care specialist (YCS) III. The shelter runs three shifts. The YCS III oversees each shift. The first shift has two YCS I staff and two vacant YCS I positions. The second shift has three YCS I staff and one vacant YCS I and YCS II positions. The third shift has a YCS I and YCS II staff and has two vacant YCS I positions.

The camera system was recently upgraded and provides a much clearer resolution. New cabinets and a new sink were installed in the laundry room.

The youth shelter is a residential home that has been converted into a shelter. There are three bedrooms upstairs, one-bedroom sleeps four youth and the other two bedrooms sleep two youth each. The one bedroom that sleeps four youth is primarily used for the boys’ room and the other two bedrooms are primarily used for the girls.

There are eight beds licensed for CINS/FINS services. At the time of the review there were five CINS/FINS youth in the shelter.

All indicators in standard three were rated satisfactory with exceptions noted in indicators 3.01 Shelter Environment and 3.04 Logbooks. Exceptions noted in 3.01 were due to chemicals being inventoried on a monthly basis instead of weekly. Exceptions noted in 3.04 were due to the program director not documenting weekly reviews of the

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

Standard 4: Mental Health/Health Services

Overview

The residential counseling services in the shelter are overseen by the clinical director who is a Licensed Mental Health Counselor (LMHC). Services are provided by one master's level counselor.

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 qualified mental health professional. All staff receive training on suicide prevention.

Health services are overseen by a part-time registered nurse (RN). At the time of the review the RN position was vacant. The previous RN resigned August 31, 2019. A new RN was hired but resigned during the first twenty-one hours of training. 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 for 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 only exception noted in indicator 4.03 Medication. The exception noted in 4.03 was due to the shelter not currently having a RN. All other indicators in standard four were rated satisfactory with no deficiencies.

STANDARD 1: MANAGEMENT ACCOUNTABILITY

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☒ YES ☐ NO (explain) A policy titled Background Screening is in place and was reviewed on October 3, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were two newly hired staff who were reviewed for a background screening completed prior to hire. Both documented a background screening was completed prior to hire with an eligible rating. Both staff were applicable for a pre-employment suitability assessment and both had one completed using the Predictive Index. Both staff had documentation of E-Verify obtained from the Department of Homeland Security. There was one staff eligible for a 5-year rescreening and the rescreening was completed as required. The Affidavit of Annual Compliance was completed and submitted on January 10, 2019.	No exceptions
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) A policy is in place titled Provision of an Abuse Free Environment and was	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						reviewed on October 3, 2019 by the Regional Director.	
RATING	☒	☐	☐	☐	☐	All staff have signed a code of conduct. There is signage throughout the facility reflecting all youth are accepted. There are postings of the Abuse Hotline number in the shelter. The program has a process in place for documenting abuse hotline calls. Management takes immediate action to address incidents of physical, psychological abuse, verbal intimidation, use of profanity, or excessive use of force. There is an accessible grievance process in place. There is a locked grievance box in the shelter. Direct care staff do not handle grievances. Youth have access to blank grievance forms. There has been one grievance in the last six months filed 9/28/19. Staff was in the process of addressing that grievance at the time of the review.	No exceptions
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) There is a policy in place titled Incident Reporting that was last reviewed October 3, 2019 by the Regional Director.	No exceptions
RATING	☐	☒	☐	☐	☐	The program notified the Department's CCC no later than two hours after reportable incidents in nine out of ten incidents in the last six months. One incident was reported outside the two-hour time frame. Any follow up tasks required	Deficiencies noted did not result in any exceptions.

Quality Improvement Indicators	Rating: Satisfactory	Explain: 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)
						by the CCC were completed and the reports were successfully closed out. Incidents are documented in program logs. Incidents are documented on incident reporting forms. All incident reports were reviewed and signed by the program supervisor.	
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) There is a policy in place titled Training Requirements that was reviewed October 3, 2019 by the Regional Director.	No exceptions
RATING	☐	☒	☐	☐	☐	An individual training file was maintained for each staff that includes an annual employee training hour tracking form and related documentation. There were two staff training files reviewed for training completed in the first year of employment. One staff had well over the required 80 hours of training for the first year with three months left to receive additional trainings. There were two trainings completed after the 120-day requirement, Suicide Prevention and Child Abuse. Both trainings were completed in Skill Pro; however, were completed outside the 120-day requirement. This staff still had time to receive all additional trainings required after the first 120 days. The second staff has documented 81.25 training hours for the first year of employment. There were	There were two staff training files reviewed for training completed in the first year of employment. One staff had two trainings that were completed after the 120-day requirement. The other staff also had the same two trainings completed after the 120-day requirement, as well as, three additional trainings required during the first year that were not completed.

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		
						two trainings completed after the 120-day requirement, Suicide Prevention and Child Abuse. Both trainings were completed in Skill Pro; however, were completed outside the 120-day requirement. There was also one other training, CINS/FINS Core, required in the first 120 days that was not documented as being completed. This staff also had three additional trainings that were required in the first year that were not completed. There were five staff training files reviewed for annual training requirements. The 2019 training cycle was reviewed so all five staff still had three months left in the cycle to receive additional trainings. All five staff were on track to receive all required trainings and had already received more than the required 40 hours.	
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) There is a policy in place titled Analyzing and Reporting Information that was last reviewed October 3, 2019 by the Regional Director.	No exceptions
RATING	☐	☒	☐	☐	☐	The agency has six different committees to review and report on all required data monthly. The six committees are: Safety, Risk Management, Consumer Satisfaction, Program Improvement,	Improvements that are implemented and monitored through the data collection process were not consistently documented in the meeting minutes each 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		
						Outcome Measurements, and Case Review. The agency completes monthly reviews of case records. There are also monthly reviews of incidents, accidents, and grievances, if applicable. Customer satisfaction data is reviewed monthly. NetMIS data is reviewed monthly. Findings from these monthly reviews are discussed during the monthly team meetings that include all program staff. Strengths and weaknesses are identified; however, improvements that are implemented and monitored through these meetings were not consistently documented in the meeting minutes each month. The agency has identified a process to review and improve accuracy of data entry and collection. The Clinical Director will review information in JJIS monthly to ensure accuracy of data entry and collection. At the time of the review this process had not started; however, was described in the policy.	
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) A policy titled Client Transportation is in place and was reviewed on October 3, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	Staff approved for transporting youth have valid Florida Driver's License and are covered under the agency's auto	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		
						insurance. Transportation records from the last six months were reviewed. The logs record the purpose of travel, destination, date/time out/in, number of passengers, and mileage. The agency documents supervisor approval for single youth transport in the electronic logbook and in the comments section of the transportation logbook. For the records reviewed all single youth transports received supervisor's approval before transporting youth.	
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) A policy titled Outreach Services is in place and was reviewed on October 3, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	Local DJJ Board and Council Meetings are attended and minutes are collected. Documentation in Netmis was provided for the time period of March 1, 2019 – October 2, 2019 showing that outreach has been taking place throughout the community through various events, meetings, and activities. The agency has a multi-dimensional food assistance program for the families in the community which also provides the opportunity to educate the community about the services the agency can provide. The agency has	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		
						food distribution records that track the number of families they make contact with and provide assistance too. The agency provided six current Memorandums of Understanding (MOU).	

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) There is a policy in place titled Screening and Intake that was last reviewed on October 3, 2019 by the regional director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five residential (three closed and two open) and five non-residential (three open and two closed) files reviewed. All ten of the files were screened for eligibility within seven days of the referral. All ten files also showed that the youth and guardian had been made aware of their rights and responsibilities, available service options, possible actions occurring through involvement with CINS/FINS, and grievance procedures.	No exceptions
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) There is a policy in place titled Needs Assessment that was last reviewed on October 3, 2019 by the regional director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five residential (three closed and two open) and five non-residential (three open and two closed) files	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: 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)
						reviewed. In the five residential files reviewed all had the Needs Assessments completed within the first seventy-two hours of the youth's admission. The Needs Assessment was completed within the required three face-to-face sessions in all ten reviewed files. All ten assessments were conducted by at least a master's level counselor and all had signatures from the supervisor once completed. None of the reviewed files had an elevated risk of suicide.	
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) There is a policy in place titled Case/Service Plan that was last reviewed on October 3, 2019 by the regional director.	No exceptions
RATING	☐	☒	☐	☐	☐	There were five residential (three closed and two open) and five non-residential (three open and two closed) files reviewed. All ten files reviewed had Case Plans completed within seven days of the Needs Assessment. All ten files demonstrated individualized needs and goals on the Case Plan. All ten Case Plans also clearly indicated service type, frequency, location, target dates, and persons responsible. None of the closed residential files had completion dates on the Case Plan. All ten Case Plans had the youth's signature and counselor's	Of the five residential files reviewed none of the files showed completion dates on the Case Plans. Three residential files did not have parent signatures on the Case Plan and did not have any documentation of attempts/discussion of Case Plan with the parent to cover the missing parent signature.

Quality Improvement Indicators	Rating	Explain				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)
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						signature clearly documented and dated. All five residential files and three of the non-residential files had the supervisor signature located on the Case Plan. Two of the non-residential files had missing supervisor signatures on the Case Plan but thorough case notes showed that the files and the Case Plans had been reviewed by the supervisor. Four residential files did not have parent signatures on the Case Plan. Of the four files with missing parent signatures, three of the files also did not have documentation of attempts/discussion of Case Plan with the parent to cover the missing parent signature. One non-residential case did not have a parent signature on the case plan but did have sufficient documentation of attempts. None of the residential files were eligible for case review either because the case was closed before the thirty-day mark or the file is not yet due for a case review. Of the eligible non-residential files all have thirty-day Case Plan reviews and updates.	
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) There is a policy in place titled Case Management and Service Delivery that was last reviewed on October 3, 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 residential (three closed and two open) and five non-residential (three open and two closed) files reviewed. All ten files reviewed had an assigned counselor who provided satisfactory case management and service delivery. None of the ten files reviewed showed a need for a referral but did show that there is a documentation process for referrals. For each reviewed file the Case Plans were implemented, and counselors/case managers monitored case progress and provided support to the families. Out-of-home placements and case staffing's were not applicable for the five residential files and four non-residential files reviewed but was applicable and satisfactory for one non-residential file. None of the reviewed files had a need for a counselor/case manager to monitor or accompany any youth to court hearings but a policy is in place. All ten files demonstrated successful thirty- and sixty-day follow-ups and termination documentation.	No exceptions
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) There is a policy in place titled Counseling Services that was last reviewed on October 3, 2019 by the regional director.	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
RATING	☒	☐	☐	☐	☐	There were five residential (three closed and two open) and five non-residential (three open and two closed) files reviewed. Of the ten files reviewed all reflected the coordination of the Needs Assessment and Case Plan with the youth's presenting problem. None of the five residential files were applicable or due for Case Plan reviews. Four of the five non-residential files were eligible for Case Plan reviews and all four of those files had satisfactory Case Plan reviews and updates documented. All files displayed satisfactory case notes, and provided individual, family, and group counseling services in accordance to the individual Case Plan. Group counseling was noted at least five days a week for the residential files, lasting at least thirty minutes with a clearly identified facilitator and topic. All five residential files reviewed showed group participation.	No exceptions
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) There is a policy in place titled Adjudication/Petition Process that was last reviewed on October 3, 2019 by the regional director.	No exceptions
RATING	☐	☐	☐	☒	☐	Though a policy is in place there have been no adjudication/petition cases in over six months.	No exceptions
2.07: Youth Records							

Quality Improvement Review

Quality Improvement Indicators	Rating: Satisfactory	Explain: 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)
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) There is a policy in place titled Youth Records that was last reviewed on October 3, 2019 by the regional director.	No exceptions
RATING	☒	☐	☐	☐	☐	All ten files reviewed were marked confidential and maintained in a neat and orderly manner. All residential files were stored on-site in locked file cabinets marked confidential. All non-residential files were maintained off-site by the non-residential counselor in a locked office. All files are transported in a black, locked, opaque case marked confidential.	No exceptions
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) There is policy in place titled Sexual Orientation, Gender Identity, and Gender Expression that was last reviewed October 3, 2019 by the regional director.	No exceptions
RATING	☒	☐	☐	☐	☐	All staff are trained on all policy and procedures during orientation training, which includes a review of this policy. Youth participating in services with this shelter have all identified as cisgender, they have not had any situations working with gender expansive youth in the last year. There are two signs in the shelter indicating it is a “safe place” or “safe zone” for LGBTQ+ youth.	No exceptions

Quality Improvement Review

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes. Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☒ YES ☐ NO (explain) There is a policy in place titled Special Populations that was last reviewed October 3, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The agency did not have any examples of Staff Secure, Domestic Minor Sex Trafficking, FYRAC, or Probation Respite to review for the past year. There were three domestic violence (DV) files reviewed. All three had a pending DV charge. Data entry was entered into NetMIS in the time frames. None of the youth stayed longer than twenty-one days. Case plans focused on anger management and family coping skills. All other services provided were consistent with all other general CINS/FINS program requirements. There were four Intensive Case Management files reviewed. All four youth were court ordered to the program. All four files documented well over the six required direct and collateral contacts each month. All four files documented a Child Behavior Checklist was completed within fourteen days of intake. All had evidence of a youth self-report assessment completed at intake and at least every 90 days. All case plans demonstrated a strength-based, trauma-informed focus. All four files contained a plethora of documentation of engaging 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		
						family, advocating on behalf of the family, helping access support in the community, teaching problem solving skills, and modeling productive behavior.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☐ YES ☐ NO (explain) Not applicable	
RATING	☐	☐	☐	☐	☒	Not applicable	This indicator was rated as not applicable as the provider does not offer SNAP services at this location. All SNAP services are provided at a sister shelter operated by the agency in the same circuit.

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) A policy is in place titled Shelter Environment that was last reviewed on October 3, 2019 by the regional director.	No exceptions
RATING	☐	☒	☐	☐	☐	The program is well maintained, free of debris, hazards, and contraband both inside and outside, as well as free of insect infestation. All doors were secure, including personal and program vehicles on the premises. The only graffiti observed was on the closet door in bedroom number one. The only garbage can in the program is in the kitchen, but the cover was propped up next to the can, not on the can. The dumpsters outside were covered. The program has two vehicles, and both were equipped with the major safety equipment. In and out access is limited to staff members with key control compliance. All appropriate forms are posted inside the program. The agency has a current DCF Child Care License valid through September 2020. Each youth has their own individual bed with	Inventory on chemicals has a monthly perpetual count, but is not inventoried weekly, as per policy and procedure.

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		
						clean and sufficient linens, blanket, and pillows. An operational washer and dryer are available at the program. Most of the youth's property is sent home with the parents, however, there is a locked safe on property for youth's personal belongings. The program had their annual fire inspection conducted with the local fire marshal this year. The agency has a current satisfactory food service and satisfactory residential group care inspection report from the Department of Health this year. The program's fire extinguisher and alarm system were inspected this year and are up to date. The program conducted mandatory fire drills monthly and at least one mock drill per shift quarterly. All food is stored appropriately. The Maytag refrigerator was running at 52 degrees Fahrenheit, which is above average temperature. All chemicals on-site have a monthly perpetual count, but are not inventoried weekly, as per policy and procedure. Each chemical had a MSDS maintained for that item in a binder in the Youth Care Specialist's office. The program encourages youth to engage in meaningful, structured activities, including one hour of physical activity daily, homework, and reading. The daily schedule is posted in the program and in the youth's handbook. Youth may	

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		
						participate in faith-based activities, if they choose.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) A policy is in place titled Program Orientation that was last reviewed on October 3, 2019 by the regional director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five youth files reviewed. All five youth received a comprehensive orientation on the date of admission. At orientation, the youth receives a handbook which includes the following, disciplinary action, the grievance procedure, emergency procedures, contraband rules, a tour of the program, room assignment, signature of youth and parent, daily activities, and the number of the abuse hotline. None of the five youth were admitted with a suicide hit and needed to be placed on the suicide prevention alert notification.	No exceptions
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) A policy is in place titled Youth Room Assignment that was last reviewed on October 3, 2019 by the regional director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five youth files reviewed. All five youth were assigned a room based upon an initial classification. This	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: 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)
						classification includes, a review of the youth's history, status, and exposure to trauma, age, gender, history of violence, any disabilities, physical size, gang affiliation, suicide risk, sexually aggressive or reactive behavior, and gender identification. All five files had initial interactions and observations of the youth and had documentation of collateral contacts approved by the parents.	
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) A policy is in place titled Logbook Requirements that was last reviewed on October 3, 2019 by the regional director.	No exceptions
RATING	☐	☒	☐	☐	☐	The program uses NoteActive, an electronic logbook. All entries were brief and legible, and included the date and time of the incident/activity/event, names of youth/staff, brief statement, and signature of the staff making the entry. Any safety and security issues which could impact the youth and/or program were highlighted. All direct care and supervisory staff review the logbook at the beginning of each shift for the previous two shifts. Documentation of this review is in the logbook with the date and the signature of the staff at the time of the entry. All supervision and resident counts, as well as visitation, or home visits are documented in the logbook.	The program director has not conducted any weekly reviews of the 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		
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) A policy is in place titled Behavior Management Strategies that was last reviewed on October 3, 2019 by the regional director.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has a detailed written description of the behavior management motivation system (BMMS) in the youth's handbook, which is explained during orientation. The program uses appropriate interventions to teach youth new behaviors and help them understand natural consequences for their actions, as well as a wide variety of positive incentives and rewards to encourage participation to complete the program. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior. Consequences for a violation of program rules are applied logically and consistently. BMMS provides constructive discipline that encourages youth to meet behavior expectations. It provides for positive reinforcement and recognition, minimizing separation of youth from the general population. Disciplinary measures never deny the youth their basic rights. Overall, BMMS, promotes order, safety, security, respect, fairness, and protection of resident rights. All staff are trained in the theory and	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						practice of administering BMMS rewards and consequences. Supervisors have received training to monitor the use of behavior interventions by their staff to include the use of point based and level-based interventions. There is a protocol in the policy and procedures for providing feedback and evaluation of staff regarding their use of positive and negative consequences.	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) A policy titled Staffing and Youth Supervision is in place and was reviewed on October 3, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The agency maintains a minimum staffing ratio of one staff to six youth during awake hours and community activities. The staff ratio is one staff to twelve youth during sleeping periods. There were a minimum of two staff present during overnight shifts. This was observed via staff schedules, the electronic logbook documentation, and while reviewing the video surveillance system. The staff schedule is maintained in the “Pass Down” folder located in the YCS Office, where staff can easily access the schedule. There is a roster, listing staff and their contact information in case additional staff coverage is necessary. This information is also located in 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		
						"Pass Down" folder. Staff conduct ten-minute checks on youth while they are in their rooms. These checks are recorded in the electronic logbook and were confirmed while reviewing the video surveillance system.	
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) A policy titled Video Surveillance is in place and was reviewed on October 3, 2019 by the Regional Director.	No exceptions
RATING	☒	☐	☐	☐	☐	The surveillance system was updated since the last review (approximately three weeks ago). There are interior and exterior cameras taking surveillance footage twenty-four hours a day seven days a week. All cameras are visible. There are no cameras located in any of the bathrooms or bedrooms. The surveillance system retains footage for thirty days and has a backup battery system to ensure that the surveillance system continues to operate when there is a power outage. The surveillance system records date, time and location, while maintaining a resolution that allows for facial recognition. There is a list of the personnel that have access to the surveillance footage. They are able to access the surveillance system remotely. The surveillance camera logbook was reviewed and indicated that the supervisor	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		
						is conducting fourteen-day reviews of the surveillance system. There is a process for a third party to receive video recordings if/when requested.	

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

Quality Improvement Indicators	Rating: Satisfactory	Rating – Explain: Deficiency Identified	Rating – Explain: No Eligible Items For Review	Rating – Explain: No Practice	Rating – Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard Four – Mental Health /Health Services							
4.01: Healthcare Admission Screening							
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled Healthcare Screening Admission that was last reviewed October 3, 2019 by the regional director.	No exceptions
RATING	☒	☐	☐	☐	☐	At intake into the facility the staff assess medical needs by completing the CINS/FINS Intake Assessment form which includes a physical health screening and a visual inspection of the youth. The shelter nurse reviews all intakes within five business days. If there is a medical, dental, or mental health condition that exists, the youth care staff will contact the counselor. The counselor will contact the parent/guardian. There were five youth files reviewed, three opened and two closed. All five files documented the CINS/FINS Intake form was completed on the day of admission. There was one youth on medication for allergies and one youth with a recent injury. These conditions were documented in the file and also entered into the shelters alert system. The shelter has procedures in place for follow-up care if it is needed. None of the	No exceptions

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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		
						files reviewed required any type of follow up care or medical referral.	
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 Suicide Prevention that was last reviewed October 3, 2019 by the regional director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were six files reviewed (two open and four closed). In all six files the suicide screening happened during intake using the CINS Intake Assessment form and the Suicide Risk Evaluation (SRE). All screenings were reviewed and signed by a supervisor. All youth were placed on the appropriate level of supervision based on the screening results. Two of the youth were placed on sight and sound supervision. These two youth were seen and assessed by a qualified mental health professional within twenty-four hours and placed on normal supervision levels. Both youth had documentation of thirty-minute observations maintained the entire time on suicide precautions. All observations logs were signed by the supervisor and clinical director.	No exceptions
4.03: Medication							
Provider has a written policy and procedure that meets the requirement						☒ **YES** ☐ **NO (explain)**	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
for Indicator 4.03						The agency has a policy in place titled Medications that was last reviewed October 3, 2019 by the regional director.	
RATING	☐	☒	☐	☐	☐	The agency has a list of staff who are trained to supervise the administration of medications. The registered nurse (RN) is listed as one of the Super Users of the Pyxis Med-Station, as well as, the residential services manager. The RN distributes any needed medications when onsite. Trained youth care specialists (YCS) with access to the Pyxis Med-Station distribute medications when the RN is not onsite. Trained YCS complete an inventory every shift of controlled medications. This inventory is documented on the youth's Medication Distribution Log (MDL). A perpetual inventory is maintained on each medication as it is given and documented on the MDL. Over the counter (OTC) and prescription medications are stored in the Pyxis Med-Station which is stored in a locked room accessible only to authorized staff. Oral medications are stored separately from topical medications. The shelter has a medication refrigerator that is locked, and the temperature is set to 46 degrees. The RN trains all staff on the use of the Pyxis Med-Station, Epi Pens and the medication administration process at hire. Training documents were located in the medication room. Medications are verified at admission by contacting the pharmacy.	At the time of the review the shelter did not currently have a nurse. The previous nurse resigned August 31, 2019. A new nurse was hired but resigned during the first twenty-one hours of training. The agency has the position advertised again and the shelter was in the process of trying to hire another nurse for the position.

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						Reports reviewed show that there were no open discrepancies in the Pyxis Med-Station. Staff are aware that discrepancies should be cleared at the end of each shift. A monthly review of Pyxis reports is conducted by the RN. The shelter currently does not accept prescribed injectable medications. There is locked file cabinet in the kitchen where sharps are stored. All sharps are inventoried weekly.	
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 Medical/Mental Health Alert Process that was last reviewed October 3, 2019 by the regional director.	No exceptions
RATING	☒	☐	☐	☐	☐	There were four files reviewed (three open and one closed). The shelter utilizes a color-coded system for medical and mental health alerts. All files contained color-coded alert dots that corresponded with identified alerts. Alerts were also appropriately documented on the dry erase board (upstairs and downstairs in the shelter) and in NoteActive. Any dietary alerts are documented on a form located in the kitchen. Staff were provided sufficient information to recognize and respond to the need for emergency care.	No exceptions
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement						☒ **YES** ☐ **NO (explain)**	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
for Indicator 4.05						The agency has a policy in place titled Episodic/Emergency Care that was last reviewed October 3, 2019 by the regional director.	
RATING	☒	☐	☐	☐	☐	The program has a practice in place for off-site emergency medical situations. They have not had any off-site medical situations in the last six months. All staff have current training in CPR/First Aid. There are first aid kits located in the kitchen, YCS Office upstairs and downstairs, and the vehicles. The contents of all first aid kits are checked monthly by the nurse. The shelter has two sets of knife-for-life and wire cutters. One set in located in a box, in the closet of the nurse's office. The second set is located in a box, in a drawer in the upstairs YCS office. A seatbelt cutter, window punch, and air bag deflater are located in each vehicle.	No exceptions

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