# Florida Network for Youth and Family Services
# Compliance Monitoring Report for

**March 5, 2020**

**Safe Children's Coalition**
1106 South Briggs Avenue, Sarasota, FL 34237

**Compliance Monitoring Services Provided by**

## EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) with Florida Network of Youth and Family Services (FNYFS) monitoring visit for the Safe Children's Coalition (SCC) for the FY 2019-2020 at its program office located at 1106 South Briggs Avenue, Sarasota, 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. Safe Children's Coalition 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 Nitara LaTouche, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from SCC present for the entrance interview were: Brena Slater, President/CEO; Jennifer Powers, Director of Contracts; Shad Renick, Director of Residential Programs; Charles Harris Jr., Program Coordinator; Stacey Schaeffer, Senior Director of Prevention and Diversion Services; Jennifer Warwick, Clinical Supervisor; and Jill Steiner, Senior Director of Out of Home Care. The last onsite QI visit was conducted on February 6, 2019.

In general, the Reviewer found that Safe Children's Coalition is in compliance with specific contract requirements. **Safe Children's Coalition received an overall compliance rating of 100% for achieving full compliance with 11 out of 11 applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit; however, there was (1) recommendation that 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 03-05-2019-2020

| | |
|---|---|
| **Agency Name: Safe Children's Coalition** | **Monitor Name: Nitara LaTouche, Lead Reviewer** |
| **Contract Type : CINS/FINS** | **Region/Office: 1106 South Briggs Ave., Sarasota FL** |
| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): March 4-5, 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**<br>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. | ☐ | ☐ | ☒ | ☐ | ☐ | **I:** The agency has 3 certified peer reviewers: Shad Renick, Kenneth Kochenderfer and Charles Harris that are certified to participate in on-site quality visits for the agency. The agency was able to participate in (1) QI review for this QI season prior to the statewide quarantine due to COVID-19. | **No recommendation or corrective action.** |
| **Additional Contracts**<br>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** | ☐ | ☐ | ☒ | ☐ | ☐ | **D:** In addition to the current contract with the Florida Network, the agency has 3 other contracted funders. The contract with Florida Network was recently renewed 7/1/19 until 6/30/24. The additional funders are: SCC/DCF (7/1/19 – 6/30/20), Sarasota County Government (10/1/19 – 9/30/20), and MSC Foundation (12/1/19 - 11/30/20). | **No recommendation or corrective action.** |
| **Limits of Coverage**<br>a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as | ☐ | ☐ | ☒ | ☐ | ☐ | **D:** The agency maintains general liability coverage through the Alliance of NonProfits for Insurance Risk Retention for limits of $1,000,000 each and general aggregate of $3,000,000 | **No additional corrective action needed.** |

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| Major Programmatic Requirements | Unacceptable | Conditionally Unacceptable | Fully Met | Exceeded | Not Applicable | | |
| 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** | | | | | | and $20,000 for any one person with medical expenses. This policy is effective 7/1/2019-7/1/2020.<br><br>Alliance of NonProfits for Insurance Risk Retention provides the additional coverage:<br>Automobile liability coverage is effective 12/2/2019-7/1/2020 and has a combined single limit per accident of $1,000,000.<br>Umbrella liability coverage is effective 7/1/2019-7/1/2020 with $6,000,000 for each occurrence or aggregate.<br>Professional liability coverage is effective 7/1/2019-7/1/2020 with $1,000,000 limits per occurrence or $3,000,000 per aggregate.<br><br>Workers Compensation is provided through Zenith Insurance Company, effective 1/1/20-1/1/21, with a policy limit of $500,000 each accident, each employee, or aggregate policy limit.<br><br>A copy was provided after the onsite review that clearly indicated that the Florida Network was listed on the | |

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| | | | | | | | |
| | Explain Rating | | | | | | |
| **Major Programmatic Requirements** | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:**<br>**(Attach Supportive Documentation)** |
| | | | | | | Insurance Certificate as certificate holder for the workers compensation policy.<br><br>Florida Network is listed as the Certificate Holder on all policies. | |
| **External/Outside Contract Compliance**<br>a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE** | ☐ | ☐ | ☐ | ☐ | ☒ | **I,D:** No external CAP has been cited but it was observed that a recommendation was made in the independent audit. See Fiscal practice item (h). | **Not Applicable.** |
| **Fiscal Practice**<br>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** | ☐ | ☐ | ☒ | ☐ | ☐ | **D:** The agency provided the following fiscal policy and procedures that states all accounting policies are in accordance with GAAP and the accounting requirements of funding sources. The policies provided are as follows:<br>Accounting Procedures, Data Breach Notification, Budgets, Chart of Accounts Structure, Internal Accounting Control, Independent Audit, General Ledger Entries, Public Access to Corporate Records and Meetings, Records Retention, Lobbying, and Petty Cash Funds. The agency has recently changed it's name to Safe Children's Coalition and | **No recommendation or corrective action.** |

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| Major Programmatic Requirements | Unacceptable | Conditionally Unacceptable | Fully Met | Exceeded | Not Applicable | | |
| | | | | | | the policies and procedures provided were observed to have Sarasota YMCA on all of the policies currently being used by the agency, which the agency explained would be updated during the next revision. | |
| 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** | ☐ | ☐ | ☒ | ☐ | ☐ | **D:** The agency's general ledger was provided for the current FY for 7/1/2019 – 1/31/2020. The general ledger provides details to demonstrate that all activity is tracked and funds are managed separately for FNYFS contract. | **No recommendation or corrective action.** |
| c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | **I,O:** The agency has a policy, CM -130 Petty Cash Funds, and maintains a petty cash system that is secured in a locked box and managed by the Director of Residential Services. The finances are disbursed, and reconciliations are verified by the designee in the finance department before reimbursement is made. The petty cash ledger system maintains a balance of $450 and was balanced that day using a reconciliation worksheet and observed to have a cash balance of $153.57 and the remaining difference $296.43 was | **No recommendation or corrective action.** |

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| | | | | | | documented in receipts and logged on the reconciliation worksheet. | |
| 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** | ☐ | ☐ | ☒ | ☐ | ☐ | **O,D:** Once the wire transfers are received from the FNYFS, the funds are transferred to an operating account at Northern Trust Bank, where daily transactions take place for the entire agency, including CINS FINS programming payroll and non-payroll expenses. Bank reconciliation statements were provided as evidence of bank reconciliation for disbursements for vendors from July 2019 – Dec 2019. The agency reports financial statements are reconciled monthly and there is supporting documentation observed on file. Individual vendor files are maintained and vendors are listed in the general ledger. The reconciliations are maintained at the Northgate location in the account payables office. | **No recommendation or corrective action.** |
| 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** | ☐ | ☐ | ☐ | ☐ | ☒ | **I,D:** There were no new items purchased since the last onsite visit.<br><br>The inventory list was provided for review. The agency maintains an inventory list that includes the location, | **Not Applicable** |

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| | | | | | | asset tag, description, serial number (when applicable), date equipment/item acquired, and value of all items purchased with FNYFS funds. | |
| 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** | ☐ | ☐ | ☒ | ☐ | ☐ | **D:** Agency submits payroll taxes and deposits as evidenced by 941 Employers Quarterly Federal Tax Returns for the 3rd and 4th quarter for January 2020 for sufficient evidence of payroll taxes paid. A zero balance was observed for both quarters being reported. | **No recommendation or corrective action.** |
| g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | **D:** The 'Statement of Revenues and Expenditures' was provided for July 2019-Jan 2020 and includes revenue and expenses for current and YTD budget including variances. The documents provided reflect a net deficit for the current FY. The variances within the budget are monitored and approved on an ongoing basis by management. | **No recommendation or corrective action.** |
| h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to | ☐ | ☐ | ☒ | ☐ | ☐ | **D:** The agency provided an independent financial auditor's report for June 30, 2019 and 2018 was completed by certified public accounting firm, Kerkering Barberio and Co. and dated December 20, | **No recommendation or corrective action.** |

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| 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** | | | | | | 2019 which reported a finding concerning the previous subcontractor for case management services not performing up to standard in their oversight capacity of cases and case managers.<br>As a result, the subcontractor was terminated for non-performance and a plan has been put into place to have a new subcontractor provide case management services and a corrective action plan was implemented that the agency's quality management team will pull a 10% sample on a monthly basis with new subcontractor to ensure compliance with timeframes for case management services in Manatee County.<br><br>As a result, 'a management letter is not required due to no findings that needed to be reported in a management letter as required per Florida Statutes section 215.97(9)(f) and 215. 97(10)(d)'. | |

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|---|---|---|---|---|---|---|---|
| i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personnel information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | **D:** The agency has policies in place to meet requirements as follows: number IT-220, File and Data Security Procedure, FM-265, Records Retention, and FM-290, Data Breach Notification, FM 225, Internal Accounting Control. The policies cover the standard operating procedures for maintaining confidentiality and ensuring security of employee and client data. | **No recommendation or corrective action.** |

## CONCLUSION

Safe Children's Coalition (SCC) has met the requirements for the CINS/FINS contract as a result of full compliance with 11 out of 11 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the thirteen indicators were not applicable because the provider: 1) 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, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited 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.

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 Safe Children's Coalition - Sarasota, FL
CINS FINS Program

March 4-5, 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 | Satisfactory |
| 1.06 Client Transportation | Satisfactory |
| 1.07 Outreach Services | Satisfactory |

**Percent of indicators rated Satisfactory: 85.71%**
**Percent of indicators rated Limited: 16.67%**
**Percent of indicators rated Failed: 0.00%**

**Standard 2: Intervention and Case Management**

| | |
|---|---|
| 2.01 Screening and Intake | Satisfactory |
| 2.02 Needs Assessment | Satisfactory |
| 2.03 Case/Service Plan | Satisfactory |
| 2.04 Case Management & Service Delivery | Satisfactory |
| 2.05 Counseling Services | Satisfactory |
| 2.06 Adjudication/Petition Process | Satisfactory |
| 2.07 Youth Records | Satisfactory |
| 2.08 Sexual Orientation, Gender Identity/ Expression | Satisfactory |
| 2.09 Special Populations | Satisfactory |
| 2.10 Stop Now and Plan (SNAP) | Not Applicable |

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

**Standard 3: Shelter Care & Special Populations**

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

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

**Standard 4: Mental Health /Health Services**

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

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

**Overall Rating Summary**
**Percent of indicators rated Satisfactory: 96.43%**
**Percent of indicators rated Limited: 3.57%**
**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

Nitara LaTouche - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services

Kara Brown - Department of Juvenile Justice

Diane Lindsay – Tampa Housing Authority

Jocie Fletcher - Hillsborough County Department of Children's Services

Julia Coley – Family Resources

# Quality Improvement Review

Safe Children's Coalition – March 4-5, 2020
Lead Reviewer: Nitara LaTouche

## Methodology

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

### Persons Interviewed

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

### Documents Reviewed

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

### Surveys

- **7** # Youth
- 6 # Direct Care Staff
- **0** # Other: _____

### Observations During Review

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

### Comments

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

## Strengths and Innovative Approaches

Rating Narrative

The agency has experienced several staff changes and turnover since May 2019.

In May 2019, the shelter was transitioned to Jill Steiner, Senior Director of Out of Home Care, and the Family Management Services (FMS) was transitioned to Stacey Schaeffer, Senior Director of Prevention and Diversion Services.

The program hired a new Clinical Supervisor of FMS, Jennifer Warwick, and the non-residential program changed its name to Youth Prevention Services.

In August 2019, the shelter implemented a new positive approach behavior management system that encourages youth to achieve points through following program rules and demonstrating core behavior values that allows youth to receive additional privileges based on the level attained.

The program did not receive the Basic Center Grant contract in September 2019 and as a result, there were some changes in staff positions. The program lost 2 positions; Residential Manager and the Adventure Based Counselor position. Ken Kochenderfer transitioned from his Case Manger position to the YPS program. The case manager position was filled by former Residential Manger, Aaron Bellamy, in September 2019.

The CINS FINS Program fully transitioned to the Safe Children's Coalition on October 1, 2019.

The program has experienced some challenges in an increase in youth with elevated mental health needs and has opened a new group home on the campus to look at providing services to youth needing this high end level of mental health care that may not be suitable for youth served in the CINS FINS program.

The agency is also exploring opportunities to obtain a newer and larger facility within the next three years.

## Standard 1: Management Accountability

### Overview

Narrative

The corporate headquarters office is located at 1500 Independence Blvd., Suite #210, Sarasota, Florida. Safe Children's Coalition is a non-profit community-based care provider that focuses on education, prevention, diversion, and child welfare services. Safe Children's Coalition is contracted with the Florida Network of Youth and Family Services to provide direct services to Children in Need and Families in Need (CINS/FINS). The CINS FINS Program transitioned to the Safe Children's Coalition on October 1, 2019. The President and Chief Executive Officer (CEO) is Brena Slater.

Beginning in May 2019, CINS FINS Programs experienced several leadership and staff changes. The Vice President of Youth and Family Services position was dissolved, and the former VP position, Sonia Santiago, was transitioned to Clinical Director of Family Management Services (FMS). The shelter was transitioned to Jill Steiner, Senior Director of Out of Home Care, and the FMS position transitioned to Stacey Schaeffer, Senior Director of Prevention and Diversion Services. In June 2019, Sonia Santiago, resigned from her Clinical Director position and left the program in July 2019.

The agency's human resource department manages the processing of all employee and personnel files including the required contractual state and local background screenings. The agency does use the Clearinghouse (CLH) for background screenings for new hires and 5-year re-screenings. The agency has developed and implemented the 'Candidate Evaluation Form' tool to assess new hires for suitability prior to hiring using behavioral interview. The annual affidavit of compliance was signed on January 9, 2020 and submitted to the Department of Juvenile Justice Background Screening Unit to affirm compliance with Chapter 984 and 985 and Section 435.04, of the Florida Statutes.

The shelter and YPS collects and tracks data separately for their respective programs. The data is reviewed collectively in meetings where they discuss any areas impacting the CINS FINS program as a whole and addresses any identified areas with the staff in their individual team meetings.

All indicators in standard one were satisfactory with the exceptions in the following indicators: 1.01 – Background Screening; 1.04 –Training Requirements; 1.05 – Analyzing and Reporting Information. 1.04 – Training Requirements resulted in a 'limited' rating. All other indicators in standard one were rated satisfactory with no deficiencies.

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## Standard 2: Intervention and Case Management

**Overview**
Rating Narrative

Stacey Schaeffer, Senior Director, was the interim director until a new Clinical Supervisor, Jennifer Warwick, was hired in August 2019. A former shelter employee was hired, Tamara Cush, to the Program Coordinator position for Youth Prevention Services in September 2019. During the past 6 months, the program reports there has been staff changes due to position changes and turnover of staff choosing to resign or being terminated for poor work performance. In January, one counselor acquired additional schools with the intention to focus primarily on case staffing and adjudication petitions.

Safe Children's Coalition Youth Prevention Services Program is housed at 1084 South Briggs Avenue, Sarasota, Florida. The agency serves youth in the 12th Judicial Circuit that includes Sarasota, Manatee, and Desoto counties. The Youth Prevention Services (YPS) program is currently staffed by the Senior Director of Prevention and Diversion Services, the Clinical Supervisor, the Program Coordinator, 6 Counselor positions (5 full time and 1 part-time). At the time of the review, there was 1 vacancy for a full-time counselor position. All positions have a master's or bachelor's level degree. The counselors are responsible for providing services to youth (ages 10-17 years old) that are at risk of issues at home or in school. Services may be provided in school-based sessions or at home. The program uses paper files for youth records and maintains the files in a locked cabinet in the YPS office.

The CINS FINS program provides services to special populations defined as domestic violence respite, domestic minor sex trafficking, probation respite, and staff secure populations. The program does not currently provide Intensive Case Management Services, Stop Now and Plan (SNAP) Services and does not participate in the Family/Youth Respite Aftercare Services (FYRAC) within their Non-Residential Services Program.

All indicators in standard two were rated satisfactory with exceptions noted for 2.08 – Sexual Orientation, Gender Expression and indicator 2.10 Stop Now and Plan is 'not applicable'.

## Standard 3: Shelter Care

**Overview**
Rating Narrative

Safe Children's Coalition residential shelter is housed at 1106 South Briggs Avenue, Sarasota, Florida. The shelter is open 24 hours a day 7 days a week and provides temporary residential housing and services to youth between the ages of 10-17 years old who are at risk of runaway, homelessness or experiencing conflict within their family. The Program Director was recently promoted to Director of Residential Programs, which now oversees both the CINS FINS shelter and the other group home on campus. The CINS FINS shelter is staffed by the Senior Director of Out of Home Care, the Director of Residential Programs, the Program Coordinator, a Case Manager, a Residential Counselor, and 18 Behavior Coaches (including 7 full time and 11 PRN positions). There are currently 2 vacancies at this time that are in the process of recruitment to be filled.

The program schedule is provided to each youth at orientation, in the youth handbook, as well as being posted in the shelter for youth and staff to view at any given time. The shelter uses a 5-level behavior management system designed to encourage and reward key core values in behavior including: honesty, caring for others, respect for yourself and others, and responsibility. At the time of admission into the program, youth are assigned a 'point card' and begin automatically on level '0' with the opportunities to earn more privileges with each higher level achieved. Youth are able to reference an example of behaviors that may result in gaining/losing points and/or levels in their youth handbook.

The shelter is accredited by the Council on Accreditation (COA) through June 2021. The shelter has a childcare license posted from the Department of Children and Family effective from October 24, 2019.

All indicators in standard three were rated satisfactory with exceptions noted in indicators 3.01 Shelter Environment and 3.06 – Staff and Supervision.

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## Standard 4: Mental Health/Health Services

**Overview**
Rating Narrative

The shelter has a dedicated Residential Counselor, that is a Licensed Mental Health Counselor, Case Manager, and Program Coordinator.

All youth are screened at intake for eligibility for services and possible concerns regarding mental health or substance abuse, as well as their physical, medical and dental needs at admission. Each youth is screened using the six approved questions on the CINS Intake Assessment Form. If the youth answers yes to any question, they will be placed on constant sight and sound observation and the licensed Residential Counselor will be contacted to conduct a face to face assessment. An alert board system identifies any youth with special needs, allergies, or higher risks or concerns.

All staff are required to complete training on suicide prevention and are CPR and First Aid certified. There are currently two contracted part time nurses (RN) that works in the morning and in the afternoon. The agency uses the Pyxis Med-Station 4000 to store all medication onsite. Staff receive training on the use of epi-pens from a registered nurse.

Staff are trained on completing the necessary intake paperwork to screen youth at intake. The health screenings are later reviewed by the RN and if any medical issues are identified the RN will notify management immediately.

The agency uses the Pyxis Med-Station 4000 to store all medication onsite. The RN is primarily responsible for distributing medications whenever they are onsite. The program currently has four super users of the Pyxis Med Station 4000. Injectable and topical medications are stored separately from oral medication. The program has a refrigerator for medication that requires cool storage.

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

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# STANDARD 1: MANAGEMENT ACCOUNTABILITY

| Quality Improvement Indicators | Rating | | | | | Review Based Upon<br>Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(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)<br>The agency has a Policy 1.01 was last reviewed and approved by the Shelter Director and CEO on 8/19. This policy meets all requirements of this indicator. | |
| **RATING** | ☐ | ☒ | ☐ | ☐ | ☐ | The agency has evidence of the completion of the Annual Affidavit of Compliance for Good Moral Character was notarized on January 9, 2020 prior to the January 31st deadline and was submitted via email on 1/14/20.<br><br>1 out of 10 new hire files reviewed contained the suitability assessment was completed prior to date of hire.<br><br>14 out of 15 staff completed the initial screenings prior to new hire position or transition into the CINS FINS program. The only file that lacked the DJJ screening was for the CEO who only had evidence of the completed DCF screening on file. The agency was informed and it was explained that this screening is needed for all staff providing management and | **Exceptions:**<br>1 out of 15 files reviewed was missing the DJJ background screening. The agency was made aware of the 1 missing DJJ screen for the CEO and the agency submitted the necessary screening paperwork that same day.<br><br>9 out of 10 new hire staff did not contain evidence that the completed pre-employment suitability assessment is in the file. The suitability screen was implemented in December 2019. |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | oversight to the program to ensure all necessary access to DJJ services and confidential information of youth records and all aspects of service provision. The agency explained that during the transition of CINS FINS changing agencies they were not aware it was missed and they were not aware it needed for that position level and would look at having it completed and submitted to the BSU.<br><br>The HR department maintains an internal tracking system to ensure that all contractual requirements for background screenings for all employees is managed due to the Clearinghouse system tracking by last 'retained fingerprints date' that can vary depending on the requesting agency. | |
| **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)<br>The provider's policy and procedure for Provision of an Abuse Free Environment, #1.02, which was last reviewed and approved on August 2019 by the Shelter Director. The policy fully meets the requirements for this indicator. | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | The program documented in their policy that physical or emotional abuse is prohibited by staff. The SOGIE and Florida Abuse Hotline signage was clearly visible throughout the shelter, including the living room and kitchen areas. The | No exceptions to be reported. |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | agency utilizes incident reports to document any calls to the Abuse Hotline and the CCC. The locked grievance box was observed in the living room area where the youth normally congregate. The grievances (13) were reviewed by the Shelter Director and resolutions were normally documented within 48 hours, less than the 72-hour requirement. Most of the grievances were specific to youth issues. There were (6) grievances that were specific to the staff which documented resolutions. The majority of those appears to be in regard to staff communication with the youth and dropping down a level.<br><br>In reviewing the youth surveys, the youth documented that they feel safe at the shelter and the staff has been respectful to them. Most are aware of the abuse hotline and some reported that they did not know where the signage was posted but indicated they know the hotline is available to them. No one reported denial to call the abuse hotline. No youth documented denial of food, clothing, or medical care. Some youth were aware of the grievance process and documented that the system was fair. No other concerns were documented.<br><br>The staff surveys reflected knowledge of the Abuse Hotline and CCC protocol and | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | verified training has been completed. No staff has reported seeing any abuse by other staff towards any of the youth in the shelter. No other concerns were documented. | |
| **1.03: Incident Reporting** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.03** | | | | | | ☒ YES ☐ NO (explain)<br>The provider's policy and procedure for Incident Reporting, #1.03, which was last reviewed and approved on August 2019 by the Shelter Director. The policy fully meets the requirements for this indicator. | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | Incident reports completed between August 2019 – February 2020 were reviewed. All reportable incident reports were called in to the CCC within the first (2) hours.<br>Documentation in their incident reporting binder reflect emails and communication with the CCC to provide updates and inform of corrective actions and/or resolutions.<br>All reports are neatly kept in the incident reporting binder and signed by the Shelter Director. | No exceptions to report. |
| 1.04: Training Requirements<br>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)<br>The provider's policy and procedure for Training Requirements, #1.04, which was last reviewed and approved on August | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | 2019 by the Shelter Director. The policy fully meets the requirements for this indicator. | |
| **RATING** | ☐ | ☒ | ☐ | ☐ | ☐ | A total of (8) 4 training files were reviewed, (4) from the non-residential program and (4) from the residential program.<br>Out of the (8) files, (4) files (one residential and three non-residential) were reviewed to capture completion of the required 120-day training hours.<br>Four files (three residential and one non-residential file) were reviewed to identify their training hours. For the 120 days training review, two out of the four files reflected completion of all hours within the timeframe. All staff have exceeded the required (80) annual required hours.<br>The agency has stated that the Skillpro Universal Precaution training was having technical issues and staff was unable to produce proof of completion for the Universal Precaution Training**.** There was no documentation provided for this specific training course issue at the time of the review. The staff member has completed a total of 96 hours since hire date of 9**/**30/19.<br>3 files were reviewed for the suicide risk training for non-licensed mental health staff all 3 files were in compliance. | **Exceptions:**<br>1 new hire training file (DOH 9/30/19) was missing universal precaution training that is required to be completed within the first 120 days of hire**.**<br>1 YPS annual training file (anniversary date 3/29/18 - 3/29/19) was reviewed and there was missing documentation for 2 trainings: Suicide Prevention 2 and Child Abuse Reporting, which is required annually. Another training was outside of the timeframe, but this was due to being late in a previous year and not completing the training on the correct cycle of the hire date anniversary.<br>1 residential file had all training completed but 2 DJJ Skillpro trainings (Human Trafficking and Sexual Harassment) were late outside of the timeframe by approximately 15 days. They were also missing 20 hours of the annual required training.<br>1 residential staff member had a late training for managing aggressive behavior and was missing one training. They did not have a completed certificate on file for the Fire Safety training for annual training 2018-19 in Skillpro due to technical issues, as reported by the agency. An email was |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | One non-residential training file was reviewed to reflect completion of 1st year (80 hours) requirements, anniversary training date of 1/21/19 - 1/21/20. The staff has exceeded the total required hours and completed (112.75) hours. All required trainings were completed by the staff member.<br><br>The program advised that training is calculated annually from date of hire. For the (4) annual training files reviewed, 1 out of 4 files reflected completion of all requirements.<br><br>3 residential staff files hours were reviewed for the minimum 40-hour requirement. Staff hours obtained were 42 hours, 20 hours, and 52 hours. 1 YPS file had 77.5 hours total for the year (but only 24 hours are required annually for YPS). 3 out of 4 files met the requirement for annual hours needed.<br><br>1 YPS annual training file (anniversary date 3/29/18 - 3/29/19) was reviewed and a total of (77.5) training hours were completed. 8 of the applicable trainings were on-time as required. It was observed that one training was completed outside of the agency's policy by date of hire anniversary date (Human Trafficking 101) on 8/23/19 which is 5 months outside of | reviewed dated 1/23/20 reflecting communication with DJJ's Skillpro team who reported some courses may not upload and provided instructions to address the issue. |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | the date of hire, however, it appears this was due to the training being previously completed late on 8/24/18.<br><br>Residential Behavior Coach (PRN) training file was reviewed to reflect completion of annual trainings. The Behavior Coach anniversary date from 10/2/18 - 10/2/19 was reviewed. The Behavior Coach completed (20) out of the (40) annual hours.<br><br>The agency discussed the technical issues with certain training in DJJ SkillPro and proof to DJJ SkillPro Team communication was provided via email regarding suicide prevention missing in the system and fire safety training freezing prior to completion. The response advised the online course needed to be updated and had to be removed but it could take a few months and the agency would need to complete an instructor led suicide prevention if the timeframe was an issue and provided directions to check system requirements are set up correctly to allow the fire safety course to load properly. | |
| **1.05: Analyzing and Reporting Information**<br><br>**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.** | | | | | | | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.05** | | | | | | ☐ YES ☒ NO (explain)<br>The agency has policy 1.05 – Analyzing and Reporting Information that was last revised on 8/19 and is approved by the CEO. | Policy does not mention findings are regularly reviewed and shared with stakeholders. |
| **RATING** | ☐ | ☒ | ☐ | ☐ | ☐ | The program has a robust and thoughtfully considered quality improvement plan in place. The provider discussed how they analyze data through determining the root cause to analyze where the deficiency or cause of a deficiency may be and communicates across both the shelter and the YPS program to collaborate as a team and identify the needed resolution.<br><br>The provider utilizes both internal and NetMIS reports from data collection to analyze data for strengths and weaknesses and addresses them with staff in various ways including communication in team meeting minutes, trainings during team meetings, one to one supervision, and staff specific corrective action plans. The program reports they have a process in place where every file is reviewed at intake and again at discharge by the Program Coordinator. The logbook is reviewed daily by supervising staff and agenda is created based on a review of all program operations and data available through reports. | **Exception:**<br>Agency did not have evidence that case record reviews are completed on a quarterly basis as required. The last report completed was Dec 2019, however, it was observed that the agency appeared to have several staff changes, staff turnover and were transitioning to the current agency since May 2019. |

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| Quality Improvement Indicators | Rating | | | | | Review Based Upon<br>Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | Several months of management reports were provided and reviewed from August 2019- January 2020. Staff Meeting Minutes were provided for the following months: February 20, October 2019, September 2019, and August 2019. The meeting minutes include communication on staff related matters and expectations of staff, programmatic responsibilities, program operations and statistics, training reminders for staff to remain in compliance, and the topic or title of any trainings that may be held during the team meeting.<br>SCC Board Meeting Minutes are provided to communicate information to stakeholders on a regular basis were provided. The board minutes reflected that discusses program operations and the financial health of the programs, monitoring and compliance of outreach for each program and upcoming monitoring and the results of previous monitoring visits, program/agency highlights, programmatic updates, and a CEO report that involves communication on everything from legislative changes to current status of development and fund raiser opportunities.<br><br>The agency completes an internal report called 'Community Success Factors' that looks at quarterly data for outcomes for youth to determine the impact their service | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | delivery is making on the community. The outcomes involves outcome measures analyzing data for safe exits of youth, former youth still living with family or suitable living situations 30 days after discharge, needs assessments being completed within 72 hours of intake, at risk youth engaging and participating in family counseling services, satisfaction with service provision, number of youth served that are at risk of homelessness, truancy or foster care between ages 10-17. The report also prompts the agency to ensure that the program information shared with the community is accurate in the 211 system.<br><br>The shelter provided a quarterly case record review report for December 2019, where they achieved 98% for overall compliance. The shelter obtained 100% on all reviewed items except they achieved 66% for 'timeframes for goal achievement missed youth signature'. YCS reports completing individual supervision for their program and addressing concerns individually as needed.<br><br>The agency exceeds the quarterly requirement for review of accidents, incidents, and grievances by completing this review on a monthly basis during monthly team meetings. The Director of | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon<br>Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | Residential Services advised they discuss customer satisfaction data and outcome data on a monthly basis during team meetings as well, which exceeds the annual review requirement. They have an end of the year team meeting that looks at this data across the months to compare data and will analyze the data for achievements from the year and opportunities to improve in any areas that are needed going into the new fiscal year. | |
| **1.06: Client Transportation**<br><br>**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)<br>The policy number is 1.06 and is the Client Transportation policy/ procedure. It was last reviewed and approved on 8.1.19 by Brena Slater, CEO and Shad Renick, shelter Director. The policy and procedures follow the Florida Network of Youth and Family Services quality improvement standards. | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | Per the agency's policy and procedures, staff who provide transportation to youth while at the shelter must pass a driver's license background check prior to employment and have a valid Florida driver's license that is in good standing with the state of Florida. Staff is trained and must pass a physical driver's test administered by administrative personnel prior to transporting a client. All staff who | No exceptions. |

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| Quality Improvement Indicators | Rating | | | | | Review Based Upon<br>Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | have completed their driver training and are in good standing are covered under the Safe Children Coalition's (SCC) insurance policy. The SCC's procedure states that if feasible, a third party will be present in the vehicle while transporting a client. If a third party cannot be obtained for transport, the clients' history, evaluation and recent behavior is considered. The work performance and history of the driver must indicate that no inappropriate behavior is likely to occur. When a driver is transporting a single client in a vehicle, there is evidence that the program coordinator or shelter director is aware prior to the transport and consent has been given and documented. Six instances of Single transport driver were observed to be approved and documented in the log book. Each night, the managers discuss the next day's transport schedule and what staff will transport, as indicated on the school transportation schedule form.<br><br>If a single transport is needed after that time, the program director or shelter manager can approve the transport. The white board located in the staff office indicates what youth cannot have a single transport.<br><br>Approved agency drivers are documented as having a valid Florida driver's license | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | located in their personnel file and via email sent from Human resources indicating that they have been approved to transport and are under the agency's insurance policy. Shelter staff that are transportation eligible are also listed in the transportation log.<br><br>The transportation logs were reviewed and the initials of driver, date and time of transport, mileage, number of passengers and purpose of travel and location were all documented in the transportation logs. | |
| **1.07: Outreach Services**<br><br>**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)<br>The provider's policy and procedure for Outreach Services, #1.07, which was last reviewed and approved on August 2019 by the Shelter Director. The policy fully meets the requirements. | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | The Shelter Director regularly attends the DJJ Board and Council meetings which are held quarterly. Agendas and attendance were reviewed to reflect his participation. In addition, he participated in other community-based meetings including School Health Advisory Committee on 2/5/2020 and Tobacco Free Partnership of Sarasota County (9/11/2019). | No exceptions to report. |

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| Quality Improvement Indicators | Rating | | | | | Review Based Upon<br>Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | Monthly reports for the agency showed active outreach to the community. Some of the outreach activities include providing tours of the facility to community members, attending other community meetings which provided an opportunity to share about agency services, and emailing partners the agency pamphlet. A total of (10) events and (6) meetings were reviewed. The agency currently has a total of (17) community partners. Community partner agreements were reviewed and reflect a clear referral process and responsibilities for each agency involved. | |

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# STANDARD 2: INTERVENTION AND CASE MANAGEMENT

| Quality Improvement Indicators | Rating | | | | | Review Based Upon<br>Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(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)<br>The agency has a Policy 2.01 – Screening and Intake was last reviewed and approved by the Shelter Director and CEO on 8/19. This policy meets all requirements of this indicator. | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | A total of 7 files were reviewed for this indicator. 3 of the files were residential files, 1 opened and 2 closed. The remaining 4 files were non-residential. 2 opened and 2 closed. All 3 Residential and 4 Non-Residential Files contained screenings that were completed within 7 days of the referral.<br><br>7 of 7 files contained a signed document stating that the youth and parent/guardians had received in writing all available service options, rights and responsibilities, parent/guardian brochure, grievance procedure and possible actions occurring through involvement with CINS/FINS services. | No exceptions. |

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| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | Writer also reviewed youth surveys which indicated that youth are aware of the process for filing a grievance. | |
| **2.02: Needs Assessment** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.02** | | | | | | ☒ **YES** ☐ NO (explain)<br>Policy 2.02 – Needs Assessment was last reviewed and approved by the Shelter Director and CEO on 8/19. This policy meets all requirements of this indicator | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | A total of 7 files were reviewed for this indicator. 3 of the files were residential files, 1 opened and 2 closed. 4 of the files were non-residential, 2 opened and 2 closed.<br><br>3 out of 3 residential files included a Needs Assessment that was initiated within 72 hours of admission.<br><br>4 out of 4 non-residential files contained needs assessments that were completed either at intake or within 2-3 face to face sessions.<br><br>7 out of 7 needs assessments were completed by a bachelor's or master's level staff and included a supervisor signature. 5 of 7 files reviewed identified an elevated risk of suicide as a result of the Needs Assessment and all 5 files had an Assessment of Suicide Risk completed | No exceptions |

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| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | under the supervision of a licensed mental health professional. | |
| **2.03 Case/Service Plan** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.03** | | | | | | ☒ YES ☐ NO (explain)<br>Policy 2.03 – Case/Service Plan was last reviewed and approved by the Shelter Director and CEO on 8/19. This policy meets all requirements of this indicator | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | A total of 7 files were reviewed for this indicator. 3 of the files were residential files, 1 opened and 2 closed. 4 of the files were non-residential, 2 opened and 2 closed.<br><br>3 out of 3 residential Files had service plans completed within 7 working days of the Needs Assessment being completed.<br><br>1 of 4 of the non-residential files had the service plan completed within 7 working days of the Needs Assessment, an observation about the other 3 non-residential files is below.<br><br>7 out of 7 of the service plans included individualized and prioritized needs and goals identified by the Needs Assessment. | No exceptions |

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| Quality Improvement Indicators | Rating | | | | | Review Based Upon<br>Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | 7 out of 7 files included service plans that document the service type, frequency and location, person(s) responsible, target dates for completion, actual completion dates and all applicable signatures. It was observed that 1 of the residential files was missing target dates for completion on the initial service plan goals, this writer interviewed the Case Manager who stated this was due to not being able to meet with the client, which was reflected in the progress notes.<br><br>4 of 7 files required a 30-day review of the service plan goals which was completed on time.<br><br>It was observed in 3 of the 4 non-residential files reviewed, the service plan was developed prior to the need's assessment being completed. Per the policy of the FL Network and the Agency, the service plan should be developed within 7 working days following the completion of the needs assessment. In one of the files, a service plan update was made after the needs assessment being completed, it was documented that this update was done with the client present, but there is no documentation that this update was reviewed with the parent. | |
| **2.04: Case Management and Service Delivery** | | | | | | | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | 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 2.04** | | | | | | ☒ **YES** ☐ NO (explain)<br>Policy 2.04 – Case Management and Service Delivery was last reviewed and approved by the Shelter Director and CEO on 8/19. This policy meets all requirements of this indicator | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | A total of 7 files were reviewed for this indicator. 3 of the files were residential files, 1 opened and 2 closed. 4 of the files were non-residential, 2 opened and 2 closed.<br><br>7 of 7 files were assigned a Counselor/Case Manager who established referrals based on the youth/family's needs. All files reviewed monitored the youth/families progress in services, provided support, and provided referrals when needed.<br><br>4 of 4 closed files contained Case Termination notes. A binder containing documentation of 30-day and 60-day follow-up calls was reviewed. 2 of the 4 files have been due for 30 and 60 day calls since closure, both of which were completed on time as evidenced by the completed follow-up call forms in the binders. | No exceptions. |
| **2.05: Counseling Services** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.05** | | | | | | ☒ **YES** ☐ NO (explain) | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | Policy 2.05 – Counseling Services was last reviewed and approved by the Shelter Director and CEO on 8/19. This policy meets all requirements of this indicator | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | A total of 7 files and one residential group binder was reviewed for this indicator. 3 of the files were residential files, 1 opened and 2 closed. 4 of the files were non-residential, 2 opened and 2 closed. One binder containing documentation of residential groups was reviewed. Youth surveys were also reviewed, and no concerns identified.<br><br>7 of 7 files reflect case coordination between the presenting problem and the needs assessment, case service plan and case service plan reviews.<br><br>7 of 7 files contain case notes for all counseling services provided and document the youth's progress in services, services are provided in accordance with counseling services policy.<br><br>7 of 7 files contain documentation of regular clinical reviews and staff performance.<br><br>3 out of 3 shelter files contain documentation that group counseling is provided at least 5 days/week. Groups are | No exceptions |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | one hour in length. A binder was reviewed which contained documentation of groups that included the date and time the group, the topic, the facilitator, and a list of the participants. Each youth had an opportunity to participate.<br><br>Writer also reviewed 7 youth surveys which indicated that the youth are assigned a counselor who is working with them towards reaching their goals while in shelter. | |
| **2.06: Adjudication/Petition Process** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.06** | | | | | | ☒ **YES** ☐ NO (explain)<br>Policy 2.06 – Adjudication/Petition Process was last reviewed and approved by the Shelter Director and CEO on 8/19. This policy meets all requirements of this indicator | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | A total of 3 open case staffing files and a case staffing binder were reviewed for this indicator.<br><br>3 of 3 files contained documentation that the client was referred to case staffing by a school representative. Upon receipt of this referral, a Safe Children's Coalition staff member then initiated a case staffing meeting by sending a certified letter to the family no less than five working days prior to the staffing. | No exceptions. |

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| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | A binder of emails was reviewed and the clinical supervisor was interviewed to obtain documentation that the case staffing committee is notified of the meeting no less than 5 working days prior to the meeting. This binder also shows documentation that there is an established case staffing committee, regular communication with committee members and a regular schedule of bi-monthly meetings.<br><br>3 of 3 files showed documentation that a local school district representative and the clinical director of the Safe Childrens Coalition is present at all staffing meetings.<br><br>3 of 3 files showed that youth and family were provided with a new or revised plan for services as a result of the case staffing committee's recommendations and that a copy of the case staffing recommendations was provided to the parent/guardian either at the meeting, or within seven days following the meeting.<br><br>2 of 3 files reviewed required a CINS Petition as a result of the case staffing committee recommendation, and it was documented that the petition was submitted to the circuit court, and the case manager/counselor working with the | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | family completed a review summary prior to the court hearing. | |
| **2.07: Youth Records** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.07** | | | | | | ☒ **YES** ☐ NO (explain)<br>Policy 2.07 – Youth Records was last reviewed and approved by the Shelter Director and CEO on 8/19. This policy meets all requirements of this indicator | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | It was observed via tour of the shelter and non-residential counseling office and files reviewed that the agency maintains all records in accordance to the policy.<br><br>All records reviewed were marked confidential. All records were observed to be kept in a secure room with locking file cabinets labeled confidential.<br><br>All records that are transported are placed in opaque containers marked confidential. It was observed that the container the Clinical Supervisor was using to transport records between the two sites was not marked confidential, but upon pointing it out, the container was then appropriately marked.<br><br>All records were observed to be maintained in a neat and orderly manner. | No exceptions. |
| **2.08: Sexual Orientation, Gender Identity, Gender Expression** | | | | | | | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(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 2.08** | | | | | | ☐ YES ☒ NO (explain)<br>The agency has policy 2.08 – Sexual Orientation, Gender Identity, and Gender Expression that was last revised and reviewed 8/19 by the CEO. | Policy does not include that all staff, service providers, and volunteers have knowledge of Florida Network policy #5.08 and the terms therein. |
| **RATING** | ☐ | ☒ | ☐ | ☐ | ☐ | The agency has signage posted in the front entrance and the common areas indicating that all youth are welcome.<br><br>4 applicable files were reviewed for this indicator. 3 non-residential and 1 residential. Youth surveys were also reviewed.<br><br>For the 1 residential file, it was observed through documentation in the file and from interview with the Shelter Supervisor that the client was addressed according to their preferred name and gender pronouns by staff and youth's preferred name was displayed on the census board while they were in shelter. Throughout the file, youth's preferred name was documented. Youth had to be placed in a single room due to violent threats towards parents, but per supervisor, had the youth expressed a room preference based on their gender, this would have been discussed and accommodated if possible. Youth did not request any specific hygiene products during their stay, per supervisor. | **Exception:**<br>Two non-residential file did not clearly indicate the youth's gender identity preference. One youth lacked evidence this was discussed during the course of the counselor's work with the youth. The other youth identified their gender as male on the needs assessment and was entered as trans-male in NETMIS, but in some parts of the needs assessment, the client was referred to as "he" and other parts "she." It is not clear what gender this client wished to be addressed as via the documentation reviewed. |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | For the 3 non-residential files. It was observed in 1 of 3 files that youth was addressed according to their preferred name and gender pronouns both in the documentation inside the file, and on the label on the outside of the file. No specific referrals were necessary<br><br>For 2 non-residential files, 1 included the youth's preference in NetMIS. The writer could not find any documentation in the other non-residential file reviewed about the youth identifying as another gender, but in NETMIS their gender is not entered.<br><br>7 youth surveys were reviewed at 5 out of 7 indicated that the shelter is a safe place for all clients regardless of sexual orientation and gender identify. A staff meeting was conducted on 1/29/19 which included a S.O.G.I.E training. | |
| **2.09: Special Populations** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.09** | | | | | | ☒ YES ☐ NO (explain)<br>Policy 2.09 – Special Populations was last reviewed and approved by the Shelter Director and CEO on 8/19. This policy meets all requirements of this indicator. | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | There were no applicable files to review for DMST or Probation Respite during the period under review. | No exceptions. |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | There were 3 appliable files for domestic violence. All files reviewed contained evidence of that the youth was admitted for DV respite placement with a pending DV charge or were screened by detention. 2 youth files were discharged from placement within 21 days and 1 youth was transferred to the CINS FINS program prior to exceeding 21 days.<br><br>Each youth file documented case plan goals that focused on aggression management or positive coping skills. All files reviewed reflected that all other service provision is consistent with all CINS FNS program requirements.<br><br>The agency does not provide ICMS or FYRAC services.<br><br>The agency made several attempts to pull the data entry lag report, however, the report could only pull a group data entry lag report so there was no way to verify if the time frames were met for the individual reviewed for this indicator. The Program Coordinator notified the Florida Network and email correspondence was provided indicating that currently a more detailed report regarding the lag was not available and they are working on repairing the lag report. | |
| **2.10: STOP NOW AND PLAN (SNAP)** | | | | | | | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.10** | | | | | | ☐ YES ☐ NO (explain)<br>**Indicate policy number, authorized signee, date(s) of last review/revision/approval, and exceptions in notes.** | This agency's policy states that they do not currently provide SNAP services. |
| **RATING** | ☐ | ☐ | ☐ | ☐ | ☒ | | This agency does not currently provide SNAP services. |

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# STANDARD 3: SHELTER CARE

| Quality Improvement Indicators | Rating | | | | | Review Based Upon<br>Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| **Standard Three – Shelter Care** | | | | | | | |
| **3.01 Shelter Environment**<br>**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)<br>The provider's policy and procedure for Shelter Environment, #3.01, was last reviewed in 8/2019 and was approved by the CEO and Shelter Director. | Policy does not address fire or emergency drills, chemicals, key control, or that the dumpster/trash cans should be covered. |
| **RATING** | ☐ | ☒ | ☐ | ☐ | ☐ | A facility tour was conducted to review the shelter environment. The furnishings throughout the facility were mostly in good repair. The kitchen chairs were worn; however, the provider indicated they are working to get them replaced. Lighting throughout the facility is adequate for the tasks performed. The facility is free of insect infestation and there is no graffiti throughout the facility. A detailed map and egress plans of the facility were posted in every room. General rules, grievance forms, abuse hotline information, and the DJJ Incident Reporting number were posted throughout the facility. The bathrooms and shower areas were clean and functional. The washers and dryers were operational and the area was clean. Each youth has their own individual bed | **Exceptions:**<br>There was no MSDS for Fabric Softener or Oven Cleaner.<br>Inventory count stated there were four Comet Cleansers and five were counted, inventory stated there were six Genuine Joe Wipes and seven Clorox Wipes were counted, along with one more empty package in the trash, inventory stated there was six Lysol sprays and five were counted, and the inventory stated there were 1 each of RID Lice Away Shampoo and RID Lice Away Gel and zero were counted. |

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| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | with a clean covered mattress, pillow, sufficient linens, and a blanket. Each youth has a safe locker on the dorm to store their belongings. All interior areas were free from hazardous objects and did not contain contraband. The grounds are landscaped and well maintained. They are free of hazards and debris.<br><br>All facility doors were secure. Outside doors are secured and access is limited to staff members with keys. Supervisory staff have their own set of keys that they take home with them. All other staff will ring a doorbell when they arrive at the facility. Staff will let them in and then they sign out keys and document it in the logbook. The logbook was reviewed to verify this practice. The keys are kept in a cabinet in the staff office. When keys are signed out the staff will take the set of keys they logged out and place their personal keys in the cabinet. The three van keys are also kept in the cabinet. A random sample of staff vehicles in the parking lot were all locked, and all three facility vehicles were locked. Three vehicles were observed to verify they contained all required items. All three vehicles contained two first aid kits, a fire extinguisher, flashlight, glass breaker, seat belt cutter, and air bag deflater. | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon<br>Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | The agency has a current DCF Child Care License displayed at the facility. The license was effective as of October 24, 2019.<br><br>All chemicals used in the facility are stored securely in locked cabinets in the laundry room, kitchen, staff office, and boy's bathroom. The facility has a Material Safety Data Sheets logbook to store Material Safety Data Sheets for the chemicals they utilize. Material Safety Data Sheets & Inventory Logs do not mirror the product the facility is using. For example, the inventory calls for Genuine Joe Wipes and the MSDS is for Genuine Joe Wipes, but the facility is using Clorox Wipes. The facility completes a weekly chemical count log to inventory their chemicals. A count of chemicals was conducted to verify the current chemical inventory. The inventory was correct for twelve of seventeen chemicals. Two chemicals that were not on the inventory were observed; however, they were added to the inventory sheet during the period of the review. It is not listed on the chemical inventory sheet when staff use or move chemicals, making it difficult to keep a proper count.<br><br>An annual facility fire inspection was conducted on February 25, 2020. All annual fire safety equipment inspections | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon<br>Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | are valid and up to date. The extinguishers were inspected on February 12, 2020, the sprinklers were inspected on June 7, 2019, the alarm system was inspected on February 21, 2020, and the kitchen overhead hood was inspected on January 8, 2020.<br><br>Six months of fire drills and emergency drills were reviewed. The facility completed a fire drill on each shift monthly. None of the drills were completed in two minutes or less. All of the drills were completed in between three and six minutes. The facility indicated that they calculate from the time the alarm goes off until everyone is back inside, not the time from when the drill starts until everyone has cleared the building. The facility also conducted an emergency drill every month on each shift.<br><br>The facility has a current Satisfactory Residential Group Care inspection report from the Department of Health on October 1, 2019. They have a current Satisfactory Food Service inspection report from the Department of Health on January 28, 2020. The food menu is posted and all menus are signed by a licensed dietitian on January 21, 2020. All cold food is properly stored, marked, and labeled, and the pantry area is clean and food is properly stored. The refrigerators and | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | freezers are clean and well maintained and all appliances are operable and clean. The refrigerators and freezers were maintained at the required temperatures. The big refrigerator was forty degrees and the little refrigerator was thirty-five degrees. The big freezer was negative eight degrees and the little freezer was negative fifteen degrees.<br><br>Youth are engaged in meaningful, structured activities seven days a week during awake hours. Schedules are posted in the kitchen and common area. Youth are provided with at least one hour of physical activity daily. Daily programming includes opportunities for youth to complete homework. The youth have access to reading materials and are given time to read. Youth are able to participate in faith-based activities on Sunday's if they would like. | |
| **3.02: Program Orientation** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.02** | | | | | | ☒ YES ☐ NO (explain)<br>The provider's policy and procedure for Program Orientation, #3.02, was last reviewed in 8/2019 and was approved by the CEO and Shelter Director. | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | Three files, two open and one closed, were reviewed to verify the youth orientation process at the facility. All three files contained documentation verifying | No exceptions. |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | that each youth received a comprehensive orientation and were provided with a copy of the handbook within twenty-four hours of admission. All three orientations were held on the day of admission. Documentation in each file verified the orientation included all required information including, but not limited to: disciplinary action, the grievance procedure, emergency/disaster procedures, contraband rules, layout of the facility, room assignment, suicide prevention/alert notification, daily activity, and the abuse hotline contact information. Each orientation form listed the required items and the youth initialed next to each item to validate they received the information. A review of seven youth interviews indicated each youth received an orientation that reviewed the rules and behavior system. Four interviewed youth stated they were not told what to do in case of a fire. The signature of the youth with the parent/guardian was obtained for all three youth indicating they received an orientation. | |
| **3.03: Youth Room Assignment** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.03** | | | | | | ☒ YES ☐ NO (explain)<br>The provider's policy and procedure for Youth Room Assignment, #3.03, was last reviewed in 8/2019 and was approved by the CEO and Shelter Director. | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | Three youth files, two open and one closed, were reviewed to verify the facility's room assignment process. Documentation in all three files indicates an initial classification is completed including a review of the youth's history, status and exposure to trauma, age, gender, history of violence, disabilities, physical size, gang affiliation, suicide risk, sexually aggressive or reactive behavior, and gender identification. Alerts are identified during the classification/screening and are placed on the alert board in the staff office. Alerts are also placed on the side of open files. A review of two opened files indicated the appropriate alerts were identified. According to the documentation, staff review documentation and document initial interactions and observations.<br><br>It was observed that there is no way to see if a youth had an alert in place if the file is closed out and communicated with the program to consider when archiving files. | |
| **3.04: Log Books** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.04** | | | | | | ☒ YES ☐ NO (explain)<br>The provider's policy and procedure for Log Books, #3.04, was last reviewed in | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | 8/2019 and was approved by the CEO and Shelter Director. | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | A review of the electronic logbooks indicates any safety and security issues that could impact the youth or program are highlighted. There is a color-coded system in place for highlighting entries. For example, all entries placing a youth on sight and sound are highlighted in green. All entries are brief and legible, as the logbooks are completed electronically. All recording errors are struck through with a single line with the staff's initials and date. No white out is used, as the logbook is electronic. All entries include the date and time, names of youth and staff involved, a brief statement with pertinent information, and the name and signature of the person making the entry.<br><br>A review of the electronic logbooks since December 3, 2019 indicates all supervisory staff and direct care staff review the logbook for the previous two shifts. All entries indicate that the logbook was reviewed for the previous two shifts or since their last shift worked. The review of logbooks indicates the shelter director reviews the facility logbook every time he is in the facility. The dates reviewed are reflected by the signature, date, and time in the entry. There was one example of the shelter director making an entry with recommendations or follow-up based on | No exceptions. |

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| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | his review of the logbook. The shelter director indicated that he typically writes any recommendations or follow-up needed on the white board in the staff office for all staff to see.<br><br>A review of the logbooks indicated supervision and residential counts are documented, as well as visitation and home visits. | |
| **3.05: Behavior Management Strategies** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.05** | | | | | | ☒ YES ☐ NO (explain)<br>The policy number is 3.05- Behavior management strategies. The procedure name is Log books. The policy and procedure was last reviewed and approved on 8.1.19, by Brena Slater, CEO, and Shad Renick, Shelter Director. | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | The Sarasota Youth Shelter's Handbook policy states that it uses a behavioral management system to define rewards, privileges, and consequences as part of the extended family model. Consequences for violation of program rules are directly related to the seriousness of the behavior. Staff members are strongly encouraged to reward positive behaviors through praise and the points system. The level system is explained to each resident at intake and written in the Youth Shelter Resident Handbook. There are five levels used at | No exceptions. |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon<br>Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | SCC, 0 to Masters level. Each level has certain responsibilities and privileges associated with it. When the youth comes into the shelter, they are automatically placed on level 0, but can immediately begin earning points. In order to reach a higher level, the youth needs to earn points each day. Points can be earned by doing things that are listed on their point cards. The youth can earn extra points by volunteering to do extra chores, or activities that help the shelter or staff. At the end of the day, the points are added up to determine what level the youth will earn for the following day. House meetings are held every Monday and Thursday will all youth to discuss their progress and what skills/ behaviors they would like to work on. They are given level up assignments to help them to work on the various skills they have chosen. The youth are given their point sheets nightly so that they are aware of what their level is. They sign the point sheets to ensure that they are aware of the level they have earned. Four client files were reviewed to see written documentation of signed point sheets and daily log notes. Documentation included all signed point sheets by youth and staff notes indicating behavior observations of youth. The behavior management system promotes order, safety, security, respect , fairness and protection of resident rights as | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon<br>Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | explained in The SCC resident handbook and on the daily point sheet indicators. Disciplinary methods are fair, and do not deny the youth meals, snacks, clothing, sleep, physical or mental health services, education or visitation. These are outlined in the SCC youth resident handbook under Shelter guidelines. Staff are trained in the theory and practice of administering the behavior management system's ( BMS) rewards and consequences at orientation, during staff meetings, and during shadow shifts. Supervisors provide feedback to staff on their use of the BMS during evaluations, shadow shifts and as needed. The SCC does not use room restriction, confinement, or any other form of unsupervised disciplinary sanctions at any time. The use of physical interventions are never used to gain behavioral compliance. The staff is trained to use the Managing Aggressive Behaviors ( MAB) intervention to de-escalate youth and to keep the youth and staff safe. If in the event that physical intervention is unavoidable then staff are expected to utilize the minimal amount of force necessary to prevent harm to anyone. Law enforcement is contacted during the escalation of behavior, if needed, to prevent the need for hands on interventions. | |
| **3.06: Staffing and Youth Supervision** | | | | | | | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | 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 3.06** | | | | | | ☒ YES ☐ NO (explain)<br>The provider's policy and procedure for Staffing and Youth Supervision, #3.06, was last reviewed in 8/2019 and was approved by the CEO and Shelter Director. | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | The facility maintains their minimum staffing ratio of one to six youth during awake hours and community activities and one to twelve youth during sleeping periods as required by Florida Administrative Code and contract. A review of shelter census' and staff schedules for a random sample of thirteen days over the last six months, two per month and one this month, verified that the facility has maintained their staffing ratio. The facility is required to have a minimum of two staff present on overnight work shifts. A review of video surveillance from seven random one-hour overnight periods in the last forty-five days validates that the facility has a minimum of two staff present on overnight shifts.<br><br>The program staff schedule is posted in the staff office where it is visible to all staff. If a staff member is unable to work their assigned shift, they are responsible for finding coverage. There is a staff list with all staff member's phone numbers | **Exception:**<br>One of the two staff members on one overnight shifts appeared to be sleeping for one of the hours periods looked at. Bed checks were conducted by the other staff member. |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | available for staff to utilize to find coverage. There is a weekly on-call rotation for supervisors. If a staff is unable to find coverage, they will contact the on-call supervisor who is then responsible for finding coverage. If the on-call supervisor is unable to find coverage they will be responsible to come in and cover the shift.<br><br>A random sample of video surveillance from seven one-hour time periods was observed to verify staff are observing the youth at least every fifteen minutes while they are in their sleeping room. There is a boy's dorm, a girl's dorm, and two single rooms. The facility's practice is to observe the youth in their sleeping rooms every ten minutes. The video surveillance verified the facility is following this practice and ten-minute checks are being conducted. A review of the logbook for the dates and times observed verify staff are documenting the checks in real time. | |
| **3.07: Video Surveillance System** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.07** | | | | | | ☒ YES ☐ NO (explain)<br>The provider's policy and procedure for Video Surveillance, #3.07, was last reviewed in 8/2019 and was approved by the CEO and Shelter Director. | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | The facility has a written notice that video surveillance in in use, posted on the front door of the facility for the purpose of security. The facility has cameras on the interior and exterior where youth and staff congregate and where visitors enter and exit. There are sixteen cameras at the facility, eight indoors and eight outdoors. The indoor cameras are in the education room, medication station area, living room, laundry room, kitchen, front lobby, front hallway, and conference room. The outdoor cameras are on the kitchen door, front porch, shed, and deck, and in the driveway, back yard, and two in the courtyard. All cameras are visible, and no cameras are placed in the bathrooms or sleeping quarters.<br><br>The facility's video surveillance system is able to capture and obtain video that can be stored for forty-five days. The system records date time and location and maintains a resolution that enables facial recognition. The cameras have back-up capability that allows them to operate during a power outage. According to the shelter director, only supervisory staff has access to the video surveillance system and the shelter director has off-site capabilities.<br><br>A review of the surveillance camera review logs for the past six months | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | indicate that a supervisory review of video is conducted and logged at least every fourteen days. The date of the review, camera number and date reviewed, staff involved, issue noted, action taken, signature of the supervisor conducting the review, and the director's signature are noted on the log. The log does not include the activities observed or what time periods were looked at. An interview with the shelter director indicates that they look at a variety of activities including groups, mealtimes, and overnight checks. He stated they will look to ensure the staff are following the rules and the schedule is being followed. All recordings are made available for third party review after a request from quality program improvement visits or when an investigation is pursued after an allegation of an incident. | |

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# STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(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)**<br>The policy number is 4.01 Healthcare Screening Admission.<br>The last review and approval date is 8.1.19. The policy and procedures were approved by Brena Slater, CEO and Shad Renick, Shelter Director. The policy and procedures follow the Florida Network Youth and Family Services quality improvement standards. | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | 3 open and 3 closed files were reviewed, All files contained documentation of medications if applicable, existing medical conditions if applicable allergies noted as applicable. Of the six files reviewed, all health screenings completed within procedural time frame. Clients were asked if they had recent injuries, other physical distress, observation for injury, illness, presence of scars and/ or other skin markings. Youth with chronic medical conditions are referred to community medical providers as appropriate. The program utilizes medical referral forms and they are documented on a daily log as applicable. The program has procedures | No exceptions. |



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| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | to include a thorough referral process and procedure for necessary follow- up services for youth admitted with chronic medical conditions. | |
| **4.02 Suicide Prevention**<br>**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)**<br>The policy number is 4.02 Suicide Prevention. The last review and approval date is 8.1.19. The policy and procedural manual was approved by Brena Slater, CEO and Shad Renick, Shelter Director. The policy and procedures follow the Florida Network of Youth and Family Services quality improvement standards. | No exceptions. |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | 3 open and 3 closed files were reviewed. All suicide risk screenings occurred during initial intake and licensed clinician reviewed and signed screening and assessments within policy/ procedure time frame. The youth that were placed on sight and sound supervision stayed on log until a licensed clinician assessed the youth within agency time frames. All six files reviewed indicated that each youth was placed on the appropriate level of supervision based on the results of the suicide risk assessment. Youth's behavior was documented within 30 min. Intervals as appropriate and per agency procedures. A review of the agency's electronic log book, Note Active, indicated | No exceptions. |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | that all 6 files screened and assessed for suicidal risk were documented in the log book and the assessment were completed by a licensed clinician within the agency's policy timeframes.<br>There appears to be a consistent understanding about the Suicide Response process and the medical alerts/mental alerts system appears to effectively communicate to the staff the required needs for the youth. | |
| | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.03** | | | | | | ☒ **YES** ☐ **NO (explain)**<br>The policy number 4.03 Medications The last review and approval date is 8.1.19. The policy was approved by Brena Slater, CEO and Shad Renick, Shelter Director. The policy and procedures follow the Florida Network of Youth and Family Services quality improvement standards. | No exceptions. |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | 3 open and 3 closed files were reviewed. All medications are stored in a Pyxis Med station 4000 medication cabinet that is locked and inaccessible to youth. The agency maintains a minimum of 2 Super Users, and currently has 4 active Super Users. The program does not currently accept youth that are prescribed injectable medications, except for Epi-Pens. Oral medications are stored separately from injectable epi- pens and topical medications in a locked box in the locked staff office. The agency has | No exceptions. |

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| Quality Improvement Indicators | Rating | | | | | Review Based Upon<br>Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | documentation that non licensed staff have received training in the use of epi-pens by a registered nurse. They currently have two contracted nurses that are scheduled for a morning shift and a night shift. When a nurse is present, he/ she acts as the primary administrator of medications to youth, Youth taking medications have a red dot next to their names on the program's census board, located in the staff office, indicating they are taking medication. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, and the agency follows the temperature requirements for refrigerated medications which is 2-8 degrees Celsius or 36-46 degrees Fahrenheit. The agency maintains a perpetual inventory with a running balance for controlled medications, and a weekly inventory for over the counter, sharps and syringes medications. A medication distribution log is used for the distribution of medication by non- licensed and licensed staff. The agency verifies medication using one of the four methods listed in the FNYFS Operations Manual. The program's delivery process of medications is consistent with the FNYFS medication management and distribution policy. Any medication discrepancies are cleared and documented after each shift. Six quality improvement youth surveys were reviewed | |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | and asked if youth were given feminine hygiene products when needed. Of the six, one was left blank, 3 answered yes and three answered no. However, it is likely this is due to the youth not needing these products based on gender or preference. | |
| **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)**<br>The policy number reviewed is 4.04, Medical/Mental Health Alert process.<br>The policy's last review and approval date was 8.1.19 The policy was approved by Brena Slater, CEO and Shad Renick, Shelter Director. The agency's policy and procedural manual for medical and mental health alert processes follow the FNYFS quality improvement standards. | **N**o exceptions**.** |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | 3 open and 3 closed files were reviewed for compliance with the program's alert process. All 6 files contained documentation on the admission form indicating what alert each youth required. The program uses a color coded/ dots alert system to inform staff of the youth's specific alert. Concerns include medical (blue dot), substance abuse( black dot), anger/ aggression (brown dot), suicide risk/ sight and sound (yellow dot), medications (red dot), sharps restriction (orange dot) runaway risk ( purple dot), allergies( green dot), and red check mark( mental health issues). There is a client | No exceptions. |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | board in the staff office which indicates all youth currently residing at the program and the corresponding dot/ check mark next to their names. The board is updated as needed to alert staff of each youth's specific alerts/ needs. Each youth has a shelter alert log with their name and admission date listed at the top of the form. The log has the alert listed, the reason for the alert, a referral column and resolution column that is updated as needed. Note Active is updated with alerts and highlighted with different colors to inform the staff of alerts/ needs. 6 quality improvement staff surveys were reviewed that asked the staff are aware of where to find medical and mental health alerts. All 6 responded that they were able to find this information on the Census board, medical alert log or during shift transitions. | |
| **4.05: Episodic/Emergency Care** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.05** | | | | | | ☒ **YES** ☐ **NO (explain)**<br>The policy number reviewed is 4.05, Episodic/ Emergency care.<br>The policy was last updated and reviewed on 8.1.19. The policy was approved by Brena Slater, CEO and Shad Renick, Shelter Director. The agency's policies and procedures for episodic and emergency care follows the FNYFS quality improvement plan. The policy provides the agency staff with specific | No exceptions. |

| Quality Improvement Indicators | Rating | | | | | Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
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| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | guidelines to ensure client safety by providing appropriate emergency dental and medical care. | |
| **RATING** | ☒ | ☐ | ☐ | ☐ | ☐ | All the direct care staff maintain current training in CPR/ first aid, and the use of the knife -for –life. All instances of first aid will be documented in the first aid log, and episodes of emergency care is documented on the episodic emergency care log. Parents/ guardians are required to transport youth to all medical appointments. If a youth needs emergency medical treatment, 911 is called or, for less severe issues, arrangements will be made with the parents to ensure the youth is taken to the emergency room. The agency has procedures and processes in place for submitting referrals and/or incident reports for medical and dental care, which ensures the proper protocols are followed when a youth needs emergency care. If a youth is in need of care, the parent/ guardian is notified, and it will be documented on the daily log. The agency completes an incident report on any youth that leaves the shelter for emergency care. Once the youth returns, the agency will keep all documented receipts, including medical clearance, discharge instructions and all recommended follow up in the youth's file. All staff are trained on emergency medical procedures. Mock emergency drills are held on a quarterly | No exceptions. |

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| Quality Improvement Indicators | Rating | | | | | Review Based Upon<br>Document Source: Interview/Surveys, Observation, and/or Type of Documentation<br>Summarize Findings Based on Completed Worksheets | Notes<br>Explain Exception, Failed, or Not Applicable Indicators:<br>(Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | | Explain | | | | | |
| | Satisfactory | Deficiency Identified | No Eligible Items For Review | No Practice | Not Applicable | | |
| | | | | | | basis. The knife- for -life and wire cutters are located in the behavior coaches' office. First aid kits are located in the kitchen, in all vehicles and in the behavior coaches' office. One file was reviewed and program practice was consistent with all requirements. Documentation showed evidence that youth required emergency care on 2.12.20 and an incident report was completed and CCC was notified. The mother was notified and there was verification of medical clearance and it documented in the log accordingly. | |

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