Florida Network for Youth and Family Services
Compliance Monitoring Report for

SMA Beach House
3875 Tiger Bay Road
Daytona Beach, FL 32124

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for SMA Beach House for the FY 2019-2020 at its program office located at 3875 Tiger Bay Road Daytona Beach, 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. SMA Beach House is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 2019 through June 30, 2020.

The review was conducted by Ashley Davies, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from SMA Beach House present for the entrance interview were: Andrew Williams, Senior Director; Pam Palmer, Director of Residential Adolescent Services; and Jessica Szymczyk, LMHC Clinical Director. The last onsite QI visit was conducted September 27 and 28, 2018.

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

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

2019-2020 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 11-13-2019

Agency Name: SMA Beach House	**Monitor Name: Ashley Davies, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 3875 Tiger Bay Road, Daytona Beach, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): November 13 - 14, 2019**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The program currently has at least two staff members certified as DJJ QI Peer reviewers. One of the staff members has participated as peer reviewer this season.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency provided a list of six additional contracts for FY2019- 2020. The list includes: the Name of Contract, Contract Period, and Contract Amount. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed had current contract/agreement dates with the exception of two.	**No recommendation or Corrective Action.**
Limits of Coverage	☐	☐	☒	☐	☐	Documentation:	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						General Liability through Philadelphia Indemnity Ins Co., for limits of coverage $1,000,000 each $3,000,000 aggregate, and $5,000 medical, effective 6/30/19-6/30/20. Workers Comp insurance through Accident Fund Insurance Company of America for limits of coverage $1,000,000 each accident, effective 4/1/2019 – 4/1/2020. Automobile insurance through Philadelphia Indemnity Ins Co. for combined limits of liability/property damage for $1,000,000 each and aggregate. Policy effective for 6/30/2019-6/30/2020. Professional Liability Claims insurance through Philadelphia Indemnity Ins Co., for limits of coverage $1,000,000 each/aggregate effective 6/30/2019-6/30/2020. Florida Network is listed on the Worker's Compensation certificate as certificate holder.	

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External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	**N/A –** During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in the Financial Services Policy and Procedures Manual. The manual is divided into eight sections with subsections in each one. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. All policies have a revision date of May 2019.	**No recommendation or Corrective Action.**
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current FY, through August 31, 2019. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program.	**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**	☐	☐	☒	☐	☐	Observation/Documentation: No change in practice was reported for the agency since the last onsite program review in September 2019. Reviewed petty cash Policy and Procedure was conducted. The Petty	**No recommendation or Corrective Action.**

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						Cash fund does not exceed the established minimum. Petty cash is stored in a secure locked location in the building. Petty cash is reconciled on a consistent basis (monthly/quarterly) by designated staff and reviewed by the Supervisor. Disbursements and invoices are approved by the Program Supervisor as required.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation and Observation: Reviewed Bank Statements and Bank Reconciliations for the past six months for one account held with Wells Fargo. Financial Statements are reported on a monthly basis and were found to be current. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month. Reconciliations signed by two individuals with signing authority. Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files.	**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.	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**

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In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**							
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency Provided documentation, through print-outs from the EFTPS website, that payroll taxes were paid each pay period for the last six months.	**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**	☐	☐	☒	☐	☐	Documentation: Agency provided a Budget to Actual statement, as of July 31, 2019, with budget comparison for the current FY. A review of these documents was conducted. Report shows program budget and variances with YTD Total Budget. Variances in budget are monitored on a regular basis and approved by management.	**No recommendation or Corrective Action.**
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2018 and 2017 was completed by James Moore, C.P.A. and Consultants. Their report was issued on November 6, 2018. A separate Management Letter requiring a Corrective Action Plan was not	**No recommendation or Corrective Action.**

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	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						issued by the auditor. A copy of the audit was submitted to the FNYFS.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Procedures relating to confidentiality and data backup are found in the Financial Services Policy and Procedure Manual. The policies were reviewed and appear to provide for sound internal control. The agency has an IT department that maintains strict control over the security of all computers and laptops. All documents are shredded after seven years.	**No recommendation or Corrective Action.**

CONCLUSION

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

SUMMARY OF RECOMMENDATIONS

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

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of SMA Beach House
Residential Program

November 13 - 14, 2019

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Reviewer

Members

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

Ken Phillips, Regional Monitor, Department of Juvenile Justice

Pamela Washington, Supervisor, Arnette House

Mary Simmons, Counselor/Case Manager, CDS Family & Behavioral Health Services

Corlissa Pope, Counselor, Youth Advocate Program

Quality Improvement Review

SMA Beach House – November 13 - 14, 2019
Lead Reviewer: Ashley Davies

Methodology

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

Persons Interviewed

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

Documents Reviewed

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

Surveys

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

Observations During Review

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

Comments

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

Strengths and Innovative Approaches

The program is going through major construction and renovations. The school that is currently located in the very back of the property away from the main buildings is being moved closer, so it is more centrally located. This will keep all programs and services provided to the youth in the main buildings on campus making them easier to access and reducing the need for staff to walk the youth to the back side of the campus for school.

The counseling building is also undergoing major renovations, to house all counselors and the entire clinical team in one building centrally located on campus.

The program now has multiple clinical staff covering weekends instead of just one. This makes access to counseling and clinical services on the weekends easier.

The Basic Center Grant has afforded the program the ability to hire an Outreach Specialist.

Standard 1: Management Accountability

Overview

SMA Beach House is managed by a Director of Adolescent Services who oversees a Manager of Operations. At the time of the review there was one full-time and one part-time Youth Specialist position. At the time of the review the program was undergoing major construction and renovation. The school was being moved up closer to the campus, so it is more centrally located. Currently the school is housed in portables in the very back of the campus away from the main buildings. The counseling and clinical team was temporarily housed in a building further back on campus while renovations were taking place in the counseling building.

All indicators in standard one were rated satisfactory with exceptions noted in 1.01 Background Screening and 1.04 Training Requirements. The exception noted in 1.01 was due to the program not submitting their Annual Affidavit of Compliance with Level 2 Screening Standards. The exceptions noted in 1.04 were due to some required trainings during the first 120 days of employment either not being completed or being completed late in the sample of files reviewed. There were deficiencies noted in indictors 1.03 and 1.07 Outreach Services. The deficiency noted in 1.03 was due to one Central Communications Center (CCC) report not being documented in the program logbook. Deficiencies noted in 1.07 were due to two Interagency Agreements that had expired. None of these deficiencies noted resulted in any exceptions.

Standard 2: Intervention and Case Management

Overview

SMA Beach House provides residential and non-residential counseling and case management services across two counties in circuit seven, Volusia and Flagler.

The residential and non-residential counseling programs are overseen by one Clinical Director who is a Licensed Mental Health Counselor (LMHC). The residential program has two master’s level counselors providing services. There is also a case manager position at the residential program that was vacant at the time of the review.

The non-residential program has three bachelor’s level counselors providing services. The non-residential counseling program is housed on-site with offices in the counseling building.

The program is currently staffing all youth once a week. The staffing includes school participants, case management, and counseling staff. The purpose of the staffing is to evaluate the youth's progress in all areas of the program.

The non-residential program also offers Family/Youth Respite Aftercare Services (FYRAC). Intensive Case Management (ICM) services and Stop Now and Plan (SNAP) services are not offered at this location.

The residential program has provided domestic violence respite services. At the time of the review the program had not provided any staff secure, probation respite, or domestic minor sex trafficking services. The agency is currently maintaining paper files.

All indicators in standard two, with the exception of indicator 2.10 Stop Now and Plan (SNAP), were rated satisfactory with no exceptions noted. Indicator 2.10 was rated not applicable as the agency does not provide SNAP services at this location. A deficiency was noted in indicator 2.03 Case/Service Plans due to one Case Plan reviewed not having a parent or guardian signature. This deficiency did not result in an exception.

Standard 3: Shelter Care

Overview

Family Resources Clearwater residential program is led by a Manager of Operations. The shelter runs three shifts. Each shift is led by an Operations Supervisor and staffed with Youth Specialists. There are currently ten full-time and part-time Youth Specialists.

The youth shelter consists of a large with a hallway of male and female bedrooms. Each bedroom has two beds and the youth share a community bathroom and shower area. The shelter has twenty beds and ten of those beds are designated for youth that meet the eligibility requirements for CINS/FINS services. At the time of the review there were eight CINS/FINS youth in the shelter.

All indicators in standard three were rated satisfactory with no exceptions or deficiencies noted.

Standard 4: Mental Health/Health Services

Overview

The residential counseling services in the shelter are provided by two master's level counselors and one case manager. At the time of the review the case manager position

was vacant. The two counselors and case manager are overseen by the Adolescent Clinical Director who is a Licensed Mental Health Counselor (LMHC).

All youth are screened for suicide at intake using the six approved questions on the CINS Intake Assessment form. If youth receive a positive screening they are placed on sight and sound supervision until seen and assessed by a qualified mental health professional. All staff receive training on suicide prevention.

Health services are overseen by two part-time Registered Nurses (RN). The RN's are responsible for both programs located on the campus. An RN is on-site Monday – Friday from approximately 6:30am until approximately 3:30pm. The RN will distribute all medications when on-site and trained Youth Specialists will distribute medications when the RN is not on-site.

The RN provides training for all newly hired staff on the medication distribution process and the Pyxis Med-Station 4000 Medication Cabinet. Refresher training is provided for as needed.

All medications in the facility are stored in the Pyxis Med-Station 4000 Medication Cabinet. The RN completes a weekly inventory of all medications on-site. Youth Specialists complete shift-to-shift inventories of all controlled medications and maintain perpetual inventories of all other medications.

All indicators in standard four were rated satisfactory with no exceptions. There were deficiencies noted in indicators 4.01 Healthcare Admission Screening and 4.02 Suicide Prevention. Deficiencies noted in 4.01 were due to two of the six healthcare screenings reviewed being reviewed by the RN late. Deficiencies noted in 4.02 were due to one suicide risk screening not being signed by a supervisor and one suicide risk assessment completed by an unlicensed counselor documenting a consultation with the LMHC; however, did not document the date and time the consultation took place. None of these deficiencies noted resulted in any exceptions.

STANDARD 1: MANAGEMENT ACCOUNTABILITY

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☒ YES ☐ NO (explain) The agency has a policy in place titled Employee Eligibility and Background Check. The policy was last reviewed November 5, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☐	☒	☐	☐	☐	The program utilizes the ApplicantStack system which is an applicant tracking system used to screen all new potential hires. A review of the employee roster found a total of six staff who have been hired since the last annual compliance review. All six personnel records found evidence each staff had a completed background screening prior to their hire date. All were determined eligible. Each of the six records also contained evidence of the E-Verify for all new employees, obtained by the Department of Homeland Security. In addition, all six records had evidence of the completed ApplicantStack screening questionnaire. A review of the employee roster found no staff who required a five-year re-screening for the scope of this annual compliance review.	At the time of the review the program had not submitted their Annual Affidavit of Compliance with Level 2 Screening Standards.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						There were no reported volunteers who required a background screening. The program did not submit their Annual Affidavit of Compliance with Level 2 Screening Standards by January 31, 2019.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ YES ☐ NO (explain) The agency has a policy in place titled Code of Ethical Conduct. The policy was last reviewed November 5, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	A review of the program's written policy and procedures, as well as the program manual, found evidence of a code of conduct which prohibits the use of physical abuse, profanity, threats, or intimidation. The policy indicates management takes immediate action to address incidents of physical and psychological abuse. An interview with the program director found there has been no incident during the scope of the annual compliance review where disciplinary action was needed and taken for staff engaging in this behavior. Observations made during the annual compliance review found postings of emergency numbers for the Florida Abuse Hotline and Central Communications Center, as well as signage to reflect all youth were	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						accepted regardless of sexual orientation, gender identity, or gender expression. Postings were seen in main hallways and youth living area hallways. An interview with the operations supervisor found youth have the opportunity to make abuse calls if they choose to. Any contacts are documented within the youth's record, or the master logbook. The program's grievance process is addressed within the program manual and the youth handbook. The grievance process was also observed posted in youth common areas. The process is divided into three phases which include the Informal, Supervisor, and Program Director Phase. Blank forms are available to youth on the wall of the living areas. Once a youth completes the grievance, he or she gives it to a staff member who will address the issue. If the grievance is not resolved initially, it can be sent to the supervisor and the program director, both of whom have seventy-two hours to respond to the grievance once received. All completed grievances are maintained in a binder for a minimum of a year. A review of the binder found there were two grievances for the scope of this annual compliance review. Both were completed and resolved within the required timeframe.	
1.03: Incident Reporting							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) The agency has a policy in place titled Occurrence Reporting. The policy was last reviewed November 5, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☐	☒	☐	☐	☐	A review of all reports to the Central Communication Center (CCC) within the scope of the annual compliance review found a total of ten reports. All ten incidents were reported within the two-hour required timeframe. A review of the incidents found the program completes any follow-up communication or special instructions as required by the CCC. A review of the program logbooks found all CCC incidents were documented as required with only one exception. In the event of a significant incident, the program completes incident reports using an Occurrence Report. These are completed by staff initially, then submitted to a supervisor for review. The supervisor completes a Supervisor Occurrence Response form. The documents are then scanned and forwarded to the program's Performance Improvement Department for review. Samples of these reports were reviewed to ensure consistency with the practice.	The deficiency noted did not result in any exceptions, however, 1 out of the 10 incidents reviewed was missing in the program logbook.
1.04: Training Requirements **Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions**							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☒ YES ☐ NO (explain) The agency has a policy in place titled Training Requirements. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☐	☒	☐	☐	☐	There were two training files reviewed for first year training requirements. The first staff documented one training required during the first 120 days of employment was completed late and another training required during the first 120 days was not competed at all. This staff had more than the required 80 hours of training during the first year and still had approximately three months left in their training cycle to receive all required trainings. The second staff documented three trainings required during the first 120 were not completed and one required training was completed late. This staff had more than the required 80 hours of training during the first year and still had approximately three months left in their training cycle to receive all required trainings. There were four training files reviewed for annual training requirements. Two of the staff documented over the required 40 training hours for the 2019 training cycle. The other two staff documented 30 and 31 hours so far for 2019. All four staff still had approximately one and a half months left in the 2019 training cycle to receive the	Out of the two training files reviewed for first year training requirements there were four trainings that were not completed and two trainings that were completed late.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						additional required trainings and required hours. All training documentation is maintained in one binder with a divider separating each staff. Each divider has a different staff members name. Each section has the training log for that applicable staff which documents all trainings completed and the total number of hours, as well as all certificates for each training completed.	
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) The agency has a policy in place titled Performance Improvement Plan. The policy was last reviewed November 5, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	The provider conducts monthly Performance Improvement Meetings with all area program directors to review areas such as process and outcome measures, utilization of resources, clinical record quality reviews, occurrence reports, grievances, and client and family surveys. In addition, monthly review of NetMIS data reporting was completed to ensure the consistency with submitting the information. Documentation of monthly Corporate Compliance Review Committee Meetings were reviewed, which addresses	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						program compliance and ensures corrective action is taken for any issues identified in this process. The program director facilitates monthly Staff Meetings with all facility staff to review and discuss programmatic items such as employee/client safety, occurrence reports, facility drills, trainings, campus activities, and communication, which includes open discussion for staff. A review of meetings agendas, minutes, and staff sign-in sheets were reviewed to confirm this practice. In addition, the program participates in Adolescent Advisory Committee Meetings on a quarterly basis, which consists of a membership comprised on community volunteers. The committee discusses items such as program activities and services delivered. Meeting minutes, as well as sign-in sheets were reviewed to confirm the practice.	
1.06: Client Transportation **Policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						☒ YES ☐ NO (explain) The agency has a policy in place titled Transportation of Clients. The policy was last reviewed November 5, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	The program's transportation policy addresses requirements of all staff	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						responsible for transporting youth are approved drivers with a valid driver's license. The purpose of this policy is to ensure clients who are to be transported by the program are done so in as safe a manner as possible. The policy indicates only program approved drivers may transport youth only in designated vehicles. The program currently has four vehicles used to transport youth to off-campus appointments or activities. A review of all staff driver licenses found agency approved drivers have a valid driver's license and are covered under the program's certificate of liability insurance. Transportation logs were found within the program vehicles. A review of these logs discovered documentation of the date of the transport, name of the driver, number of youth and staff involved in the transport, destination and purpose of the trip, the mileage in and out, and the time in and out. The logs reviewed contained no documentation of trips taken where only one staff and one youth were involved in a transport. In each transport, there was a third party documented as present. An interview with the program director and the operations supervisor revealed it is not the program's practice for staff to transport a single youth by a single staff. On November 14, 2019, the program director provided an updated policy which language reflected the following: At no	

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						time will a staff member transport a client alone. An approved third party such as a volunteer, intern, agency staff, or other youth must be present when a staff member is providing transportation. This may only be done in an emergency situation, and only when the program supervisor has authorized the transportation and documented this accordingly.	
1.07: Outreach Services **The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) The agency has a policy in place titled Interagency Agreements and Outreach. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☐	☒	☐	☐	☐	The program is a member of the National Safe Place Network. The program has conducted numerous outreach activities in the past six months. There is a tracking system used to track all outreach events. Flyers and other materials are handed out at each event. Staff participate in the local DJJ Circuit meetings. Sign-in sheets were provided from the meetings. All Interagency Agreements were reviewed and current with the exception of two that had expired. These agreements with	The deficiency noted did not result in any exceptions, however, it was observed that 2 interagency agreements had expired and were not current at the time of review.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						various service providers allow for a comprehensive referral process.	

STANDARD 2: INTERVENTION AND CASE MANAGEMENT

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Two – Intervention and Case Management							
2.01: Screening and Intake							
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☒ YES ☐ NO (explain) The agency has a policy in place titled Screening and Intake. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five residential (three open and two closed) and five non-residential (two open and three closed) files reviewed. All ten of the files were screened for eligibility within seven days of the referral. All ten files also showed that the youth and guardian received in writing their rights and responsibilities, available service options, parent/guardian brochure, possible actions occurring through involvement with CINS/FINS, and grievance procedures.	No exceptions
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) The agency has a policy in place titled Needs Assessment. The policy was last reviewed November 8, 2019 by the	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Director of Residential Adolescent Services.	
RATING	☒	☐	☐	☐	☐	There were five residential (three open and two closed) and five non-residential (two open and three closed) files reviewed. In the five residential files reviewed all had the Needs Assessments initiated within the first seventy-two hours of the youth's admission. The Needs Assessment was completed within the required three face-to-face sessions in all five non-residential files reviewed. All ten assessments were conducted by a bachelor's or master's level counselor and all had signatures from the supervisor once completed. None of the reviewed files had an elevated risk of suicide.	No exceptions
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) The agency has a policy in place titled Case/Service Plans. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☐	☒	☐	☐	☐	There were five residential (three open and two closed) and five non-residential (two open and three closed) files reviewed. All ten files reviewed had Case Plans completed within seven days of the Needs Assessment. All ten files demonstrated individualized needs and goals on the Case Plan. All ten Case	The deficiency noted did not result in any exceptions, however, One residential file did not have a parent signature.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Plans also clearly indicated service type, frequency, location, target dates, and persons responsible. All closed files had completion dates on the Case Plan. All ten Case Plans had the youth's signature and counselor's signature clearly documented and dated. All ten files had the supervisor signature located on the Case Plan. Nine of the ten files had the parent signature on the Case Plan. None of the residential files were applicable for a Case Plan review/revision either because the case was closed before the thirty-day mark or the file is not yet due for a case review. Of the eligible non-residential files all had the applicable thirty, sixty, and ninety-day Case Plan reviews and updates.	
2.04: Case Management and Service Delivery							
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) The agency has a policy in place titled Case Management and Service Delivery. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five residential (three open and two closed) and five non-residential (two open and three closed) files reviewed. Of the ten files reviewed, all files were assigned a counselor/case manager. All ten files establish referral needs and coordinated referrals to	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						services based upon the ongoing assessment of the youth's/family's problems and needs, coordinated service plan implementation, monitored youth's/family's progress in service, and provided support to families. None of the files were applicable for monitoring out-of-home placement. No files were applicable for referrals to case staffing committee or accompanying youth/guardian to court hearings and related appointments. All ten files provided case monitoring and reviews and five applicable files all provided case termination notes. Of the ten files reviewed, three files were applicable for a thirty-day follow-up and one file was applicable for a sixty-day follow-up. All were completed as required.	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) The agency has a policy in place titled Counseling Services. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five residential (three open and two closed) and five non-residential (two open and three closed) files reviewed. All ten files reviewed documented coordination between the youth's presenting problems and the Needs Assessment, case management	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						and follow ups, and case notes were maintained for all counseling services provided and documented youth's progress. All ten files documented coordination between the youth's presenting problems and the initial Service Plan and Service Plan review. All ten files include an on-going process that ensures clinical reviews of case records and staff performance, youth and families received. All ten files documented counseling services in accordance with the Service Plan, and documentation that the program provides individual and family counseling. All five applicable residential files provide documentation that all youth are given the opportunity to participate in group counseling sessions which consist of a facilitator or leader and a relevant topic that is educational, informational, or developmental and are at least thirty minutes in length.	
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) The agency has a policy in place titled Adjudication/Petition Process. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	There were three case staffing files reviewed, two closed and one open. In all the cases the person initiating the staffing was the school. Notification was made to	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						the family and the committee at least five working days prior to the staffing. The case staffing's included all required members. In all three cases the youth and family were provided a revised plan for services. A written report was provided to the parent within seven days of the staffing. The program has an established case staffing committee and has regular communication with the members, including a schedule for committee meetings.	
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) The agency has a policy in place titled Youth Records. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	All files were marked confidential. All files were kept in a secure room or locked in a file cabinet marked confidential. All files maintained in a neat and ordered manner. The program has a locked, opaque container that is used to transport files.	No exceptions
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) The agency has a policy in place titled Sexual Orientation, Gender Identity and Gender Expression. The policy was last	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						reviewed November 8, 2019 by the Director of Residential Adolescent Services.	
RATING	☒	☐	☐	☐	☐	During the review period, the program did not have any SOGIE youth on their roster for review. While completing the walk-through, it was identified that the agency is complying with required postings. There are signs posted in every section of the shelter where the youth reside and in visitor areas, including the lobby.	No exceptions
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☒ YES ☐ NO (explain) The agency has a policy in place titled Special Populations. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has not had any examples of Staff Secure youth, Domestic Minor Sex Trafficking, Probation Respite, or Family and Youth Respite Aftercare Services (FYRAC) youth in the last year. This site also does not provide Intensive Case Management Services. There were three Domestic Violence (DV) cases reviewed. All three youth had a pending DV charge and did not meet criteria for secure detention. Data was entered into JJIS within twenty-four hours of admission and seventy-two hours of release. None of the youth stayed in the	No Exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						program longer than twenty-one days. All three case plans reflected goals focusing on anger management and family coping skills. All other services provide were consistent with all other general CINS/FINS program requirements.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☐ YES ☒ NO (explain) Not Applicable	The agency does not provide SNAP services at this location.
RATING	☐	☐	☐	☐	☒	Not Applicable	The agency does not provide SNAP services at this location.

STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Three – Shelter Care							
3.01 Shelter Environment **The shelter's environment is safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development.**							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						☒ YES ☐ NO (explain) The agency has a policy in place titled Shelter Environment. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	The shelter is clean and well kept. The furniture, walls, bathrooms, and showers are clean, functional, and free of any graffiti. Each youth has their own bed with clean blanket, pillow, and mattress. The grounds are undergoing construction; however, there was no debris or hazardous materials left out. All agency and staff vehicles were secured. First aid kits and fire extinguishers were observed in the agency vehicles. Detailed egress maps and general postings were observed throughout the shelter. A current DCF Child Care License was on display. All chemicals were securely stored and inventoried weekly. The washer and dryer were operational and lint collectors were clean. An annual fire inspection and an	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						annual fire safety equipment inspection were completed with satisfactory results. At least one fire drill is documented each month. There was a mock emergency drill on each shift for each quarter. The shelter had a current satisfactory Residential Group Home Inspection and a current satisfactory Food Service Inspection. Food menus were posted and signed by a Licensed Dietician. All food was properly stored, marked, and labeled. Refrigerators and freezers were clean and maintained at required temperatures. Youth are engaged in meaningful, structured activities seven days a week and idle time minimal. There is at least one hour per day provided for physical activity. Youth are provided the opportunity to participate in faith-based activities if they want. The daily schedule allows youth time for homework and reading. The schedule is posted so it is accessible to both youth and staff.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) The agency has a policy in place titled Program Orientation. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☒	☐	☐	☐	☐	There were six files reviewed, three open and three closed. All six files documented the youth received an orientation and were provided a handbook upon admission to the shelter. There was documentation disciplinary actions, grievance procedures, emergency procedures, and contraband rules were explained to the youth. The youth were given a tour of the facility and were assigned a room. All applicable suicide prevention alerts were entered. The daily activity schedule was reviewed, and the Abuse Hotline number was provided. Orientation paperwork was signed by the youth and parent/guardian.	No exceptions
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) The agency has a policy in place titled Youth Room Assignment. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	There were six files reviewed, three open and three closed. All six files documented the CINS Intake Screening form was completed at intake. A review of the youth's history, status, exposure to trauma, age, gender, history of violence, size, disabilities, suicide risk, gang affiliation, and maturity level was documented and considered when making	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						the youth's room assignment. Collateral contacts and initial observations of the youth were also reviewed. Any applicable alerts were documented and entered in the shelters alert system. Each youth was appropriately assigned to a bedroom.	
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) The agency has a policy in place titled Logbook Requirements. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	Logbooks were reviewed from April 2019 through November 2019. All entries were brief and legibly written. Any safety and security issues were highlighted. Entries included: date and time of activity, names of youth and staff involved, a brief statement, and signature of person making the entry. Any recording errors were struck through with a single line, initialed, and dated. Supervisors documented a review of the logbook for the previous two shifts. Direct care staff coming on duty sign in and document a review of the logbook for the previous two shifts. The program director documented a review of the logbook weekly, documenting a chronological note with dates reviewed and any recommendations. Supervision and	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						resident counts were documented in the logbook. Visitation and home visits were also documented.	
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The agency has a policy in place titled Behavior Management Strategies. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	The Behavioral Management System is named the VIP (Very Important Person) Program which is based on the AYD logic model and is designed to provide a reward system for adaptive behaviors based on behavior modification and communication techniques. These methods are incorporated in family therapy and in educational groups in order to prepare the youth and family for discharge from the program. The program consists of three levels: Orientation, VIP, and Super VIP. The system uses a variety of rewards and positive incentives. Behavioral interventions and consequences are applied immediately and appropriately. All staff are trained on the system upon hire and supervisors are trained to monitor the use of the system by their staff. The system promotes order, fairness, and safety for the youth.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						Disciplinary actions do not deny the youth of any of their basic rights.	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) The agency has a policy in place titled Staffing and Youth Supervision. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	Staff schedules were reviewed for the last six months. Minimum staffing ratios were maintained with at least one staff to six youth during the awake hours and one staff to twelve youth during the sleeping hours. The overnight shift consistently maintained at least two staff on duty. The staff schedule is clearly posted on the door to the nurse's station for all staff to see. Bed check logs were reviewed and confirmed youth are observed at least every fifteen minutes while they are in their sleeping rooms. A review of four random nights on the video surveillance system also confirmed youth are observed at least every fifteen minutes while in their rooms.	No exceptions
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain)	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The agency has a policy in place titled Video Surveillance System. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	
RATING	☒	☐	☐	☐	☐	The shelter has a video surveillance system that is operational twenty-four hours a day, seven days a week. There were written notices posted around the grounds of the shelter stating that recording was in progress. Cameras were located in the interior and exterior areas of the shelter where youth and staff congregate and where visitors enter and exit. All cameras were visible. There were no cameras in sleeping rooms or bathrooms. The system can retain video and photographic images for up to thirty days. The system captures date, time, and location and maintains resolution for facial recognition. The cameras can operate during a power outage. There was a list of four staff who have access to the video surveillance system. A supervisory review of video is conducted at least every fourteen days and documented in the logbook. The review includes a random sample of overnight shifts. The shelter has a process in place for third party review of video recordings.	No exceptions

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Four – Mental Health /Health Services							
4.01: Healthcare Admission Screening							
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled Healthcare Admission Screening. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☐	☒	☐	☐	☐	There were six youth files reviewed, four open and two closed. All six files documented a healthcare screening was completed on the day of admission. Three of the youth were on medications and names of the medications were documented. One youth was documented as having asthma and used an inhaler as needed. Three of the youth had different allergies documented. None of the youth had any recent injuries, illnesses, or pain. Two of the youth were documented as having scars or tattoos. There are procedures in place to involve the parent in any follow-up medical care needed for any chronic conditions. Four of the six health screenings were reviewed by the Registered Nurse (RN) within five business days. One heath screening was reviewed seven business days later and	The deficiency noted did not result in any exceptions.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						the last one was reviewed approximately one month later.	
4.02 Suicide Prevention **There is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.**							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled Suicide Prevention. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☐	☒	☐	☐	☐	There were three different instances of youth being placed on suicide precautions reviewed. All three instances documented a suicide risk screening was competed at intake resulting in the youth being placed on suicide precautions. Two of the three instances documented the screening was reviewed by a supervisor. One screening had no supervisor signature. In one of the three instances the youth was baker acted. The youth remained on one-to-one supervision until law enforcement arrived to transport the youth. The youth was placed on constant sight and sound supervision upon returning to the program from the baker act facility. A suicide risk assessment was completed by a Licensed Mental Health Counselor (LMHC) within twenty-four hours and the youth was placed on normal supervision. The other two youth were placed on constant sight	The deficiency noted did not result in any exceptions.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						and sound supervision after the intake screening until seen and assessed by a qualified mental health professional. Both youth were assessed within one hour of being placed on suicide precautions. One youth was assessed by the LMHC and placed on normal supervision and the other youth was assessed by a registered mental health intern working under the supervision of the LMHC. The risk assessment completed by the registered intern documented a consultation with the LMHC; however, did not document a date or time. The youth was removed from suicide precautions upon completion of the suicide risk assessment and the LMHC signed the assessment two days later. It was unable to be determined if the consultation with the LMHC occurred prior to the youth being removed from suicide precautions. All three youth documented thirty minute observations were maintained while on constant sight and sound supervision.	
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled Medications. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☒	☐	☐	☐	☐	All medications are stored in the Pyxis Med-Station 4000 Medication Cabinet. The program provided a list of fourteen staff who are authorized to use the Pyxis Med-Station with six of those staff documented as Super Users. The agency does not accept injectable medications; however, does have an epi-pen on site. All staff have been trained on the use of the epi-pen by the Registered Nurse (RN). Oral medications are stored in a separate drawer in the Pyxis Med-Station then the topical medications. There is a refrigerator in the medication room that is used solely for the purpose of storing any medications requiring refrigeration. There were no medications requiring refrigeration at the time of the review; however, there is documentation the temperature of the refrigerator is checked daily. There were no controlled medications at the time of the on-site review; however, documentation reviewed confirmed staff inventory all controlled medications at each shift change with two staff present, one staff from the shift leaving and one staff from the on-coming shift. A perpetual inventory with running balances is maintained on each youth's individual Medication Distribution Record (MDR). Only staff who have completed training provided by the RN have User Permissions for the Pyxis Med-Station. The only sharps the program has are two	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						pill cutters and three pairs of scissors. There was documentation these items were counted weekly. All over-the-counter medications are inventoried weekly by the RN. The RN reviews reports in the Knowledge Portal at least monthly. All medication is verified at admission either by the RN or by staff calling the pharmacy. An RN is on-site Monday thru Friday from approximately 6:30am until 3:30pm. During those times the RN will distribute any medication. Trained staff will distribute medication when the RN is not on-site. Medication discrepancies are cleared out after each shift. There were no open discrepancies at the time of the review. The delivery process of medication is consistent with the FNYFS Medication Management and Distribution Policy.	
4.04: Medical/Mental Health Alert Process							
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled Medical and Mental Health Alert Process. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	A review of six youth files was conducted. All applicable alerts were documented in the youth's file. All files also had a sticker on the front of the file checked "yes" for alerts if applicable. If the youth had any allergies, then they were also documented on the front of the file. Any allergies and	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						medications were documented on the Emergency Information Form in the front of each file as well. There was sufficient information and instructions regarding the youth's medical conditions, allergies and information to allow them to recognize and respond to the need for emergency care and treatment, inside the youth's file. All alerts were also appropriately documented on the large dry erase board in the Youth Specialists' office. Alerts were documented on the board using applicable color-coded dots.	
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled Episodic/Emergency Care. The policy was last reviewed November 8, 2019 by the Director of Residential Adolescent Services.	No exceptions
RATING	☒	☐	☐	☐	☐	The shelter has four first aid kits located throughout the facility. There was documentation these first aid kits were checked monthly by the Registered Nurse (RN) for expired items and replenished as needed. The agency also maintains first aid kits in each of the three vehicles which are checked monthly as well. A knife for life and a pair of wire cutters are maintained on a shadow board in the medication room. There were three instances of off-site emergency medical	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						care reviewed. All three instances were documented on an incident report and reported to the Central Communications Center (CCC). All three incidents documented the parent was notified and discharge instructions were filed. None of the youth had any type of follow-up medical care. A daily log is maintained which documented all five events. All staff are trained on emergency medical procedures.	