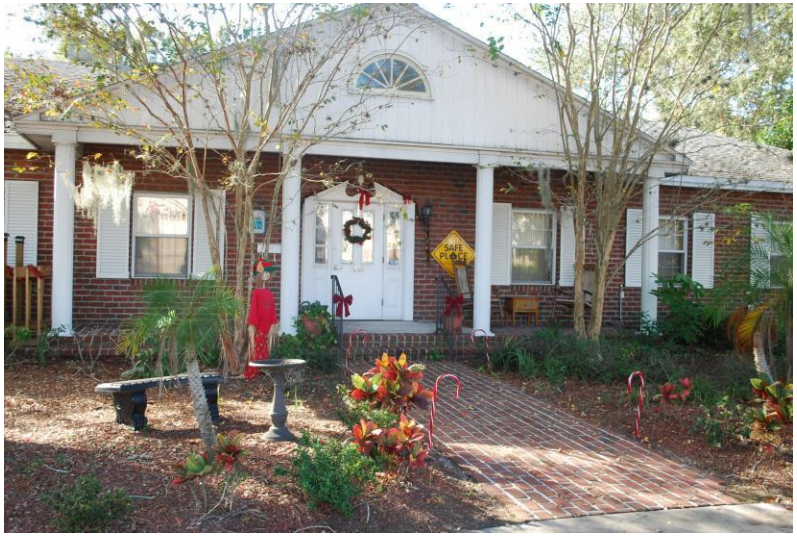
Florida Network for Youth and Family Services
Compliance Monitoring Report for



Family Resources - Manatee
1001 9th Avenue
Bradenton, FL 34205

August 12-13, 2020

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Introduction

Forefront LLC conducted a joint QI and Florida Network of Youth and Family Services (FNYFS) contract monitoring visit for the Family Resources Manatee CINS/FINS program located at the 1001 9th Avenue Bradenton, Florida location, for its FY 2020-2021 contract, on August 12-13, 2020. The contract monitoring review was conducted virtually. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. Family Resources Inc. 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 Marcia Tavares, Consultant for Forefront LLC and Peer Reviewers. Agency representatives from Family Resources present for the entrance interview were: Nicole Leslie - VP of Residential & RHY Services; Andy Coble - VP of Community Programs; Jenny Munoz - Shelter Supervisor; Jacklyn Belenky - Shelter Counselor; Diana Worley - Shelter Counselor; Lashawnna Randall - Administrative Assistant; Greta Jackson - Community Counselor; Patricia Oliver - Supervisor of Community Programs; and Diana Yengle - Community Counselor. The last onsite QI visit was conducted March 6, 2019.

In general, the Reviewer found that Family Resource Manatee is in compliance with specific contract requirements. Family Resources received an overall compliance rating of 100% for achieving full compliance with all twelve applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One of the thirteen (13) indicators was not applicable because the program does not have any inventory purchased with DJJ Florida Network funds. There were no corrective actions or recommendations made as a result of the monitoring visit.

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 08-12-2019-2020

Agency Name: Family Resources – Manatee	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 1001 9th Street, Bradenton, FL 34205**
Service Description: Comprehensive Compliance Monitoring I	**Site Visit Date(s): August 12-13, 2020**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The provider currently has four (4) certified DJJ-QI Peer Reviewers namely: Elizabeth Polifrone, Saxon Bowler, Julia Coley, and Patricia Oliver. Staff have participated and/or are scheduled to participate in QI Peer Reviews during the FY.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency provided a list of seven contracts in addition to the FN for FY 2019-2020. The list includes: the funder, service provided, and contract start and end dates for the following: DOH – Food; HHS-homeless shelter; HHS shelter CARES Act; YMCA; Manatee County; Manatee Community Foundation; and Manatee County School Board. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						agreements reviewed had current contract/agreement dates.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☐	☒	☐	Documentation: General Liability through Alliance of Nonprofits for Ins. RRG, for limits of coverage $1,000,000 each $3,000,000 aggregate and medical expenses of $20,000 for any one person, effective 6/1/2020-6/1/2021 Workers Compensation through Star Insurance Company with limits of $2,000,000 each and aggregate, effective 6/1/2020-6/1/2021 Automobile insurance through Alliance of Nonprofits for Ins. RRG with combined single limits of $1,000,000, effective 6/1/2020-6/1/2021 An umbrella policy through Allmerica Financial Benefits with limits of $4,000,000 each/aggregate, effective 6/1/2020-6/1/2021 Directors and Officers Liability insurance through Alliance of Nonprofits for Ins. RRG with limits of	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						$1 million each/ $2 million aggregate, effective 6/1/2020-6/1/2021 Florida Network is listed on the Worker's Compensation certificate as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☒	☐	☐	During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by any external funding source.	
Fiscal Practice 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 Section F- Financial Management of the Administrative Standard Operating Manual. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. Procedures are included for budget process, authorization levels, credit cards, donations, capital assets, petty cash, sales tax exemption, required vendor information, journal entries, investment policy, general ledger, cost allocation, internal controls, travel, and purchasing process.	
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the	☐	☐	☒	☐	☐	Documentation: General ledger for July 2019-May 2020 was reviewed. The agency maintains a detailed	

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activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**						ledger of financial activities with corresponding source documents. General ledger is structured to track all funding sources and there is a separate GL for the CINS/FINS cost centers 40 and 41.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (disbursements/invoices are approved & monitored by management). –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: Reviewed petty cash Policy and Procedure included in the Fiscal Manual. Petty cash is maintained by the Residential Supervisor and is stored in a secured cash box. The fund is $150. Petty cash is reconciled at least monthly by the custodian. All receipts are submitted to finance at the main office for reimbursement as needed. Reimbursement comes in the form of a check made out to the designee who will then cash it and place money in petty cash box.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements and Bank Reconciliations for the period January-June 2020 for account held with SunTrust. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month and are approved by two individuals. Checks disbursed over	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						$750 are signed by two individuals with signing authority. Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	**Not applicable** No DJJ inventory	
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: The agency provided EFTPS payment documentation for Tax periods Q1-Q3, 2020 showing payment of payroll taxes. Payroll taxes are paid bi-weekly via electronic payment through the IRS. These reports demonstrate submission of payroll taxes and deposits biweekly and status is indicated as “settled” for each payment.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided Budget to Actual statement for the eleven months ending May 31, 2020, with budget comparison for the current FY. A review of these documents was conducted. Report shows program budget and actual for the current	

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						month, YTD, as well as a comparison from last FY. Variances in budget are monitored on a regular basis and approved by management. No operating deficit was reported YTD for the shelter or counseling program.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2019 was completed by Assurance Dimensions CPA and Associates in a report dated September 13, 2019. A Management Letter was issued solely for the purpose of information by the auditor as there were no findings cited or question costs. A copy of the audit is on file with the Reviewer.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Policies and procedures for PA.6-Confidentiality/Release of Information, T.09-System Backup, and T.05-System Monitoring were reviewed. Policies are located in the Administrative Standard Operating Manual throughout various sections of the manual. A daily back-up is performed on all information saved on various servers throughout the agency. The Residential Supervisor reported no direct care employee has a program laptop.	

CONCLUSION

Family Resources Manatee has met the requirements for the CINS/FINS contract as a result of full compliance with all twelve applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One of the thirteen (13) indicators was not applicable because the program does not have any inventory purchased with DJJ Florida Network funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%**. There are no corrective actions cited or recommendations made during the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, all the 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 Family Resources - Manatee
CINS/FINS Program

August 12-13, 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	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, Gender 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 Special Populations	Satisfactory
3.08 Video Surveillance	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.

Reviewers

Members

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

Kamille Payne - Department of Juvenile Justice

Christine Cheshire – Youth and Family Alternatives

David Gray – Hillsborough County Children Services

Rosby Glover – Mount Bethel Human Services Corporation

Quality Improvement Review

Family Resources Manatee– August 12-13, 2020
Lead Reviewer: Marcia Tavares

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (CINS/FINS) Standards (July 2019).

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

Documents Reviewed

☒ Accreditation Reports	☒ Table of Organization	☐ Visitation Logs
☒ Affidavit of Good Moral Character	☒ Fire Prevention Plan	☒ Youth Handbook
☒ CCC Reports	☒ Grievance Process/Records	4 # Health Records
☒ Logbooks	☐ Key Control Log	4 # MH/SA Records
☒ Continuity of Operation Plan	☒ Fire Drill Log	15 # Personnel /Volunteer Records
☐ Contract Monitoring Reports	☒ Medical and Mental Health Alerts	8 # Training Records
☐ Contract Scope of Services	☒ Precautionary Observation Logs	18 # Youth Records (Closed)
☒ Egress Plans	☒ Program Schedules	8 # Youth Records (Open)
☒ Fire Inspection Report	☒ List of Supplemental Contracts	_____ # Other: _____
☒ Exposure Control Plan	☒ Vehicle Inspection Reports	

Surveys

2 # Youth	9 # Direct Care Staff	0 # Other: _____

Observations

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

Comments

Due to COVID-19, this review was conducted virtually/remotely.

Overview

Monitoring Purpose:

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and non-residential services.

Strengths and Innovative Approaches

Family Resources Inc. is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families through the Children In Need of Services/Families In Need of Services (CINS/FINS) program. The central office is located in Pinellas Park, Florida and CINS/FINS SafePlace2B shelters are located in Clearwater, St. Petersburg, and Bradenton, Florida. Family Resources serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The program is also contracted to provide services for staff secure shelter and is a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, domestic minor sex trafficking, and Family/Youth Respite Aftercare Services (FYRAC). The program is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to run away and homeless youth. The agency is currently accredited by the Council of Accreditation (COA) effective through December 31, 2020.

Since the last onsite QI review on March 7, 2019, the program hired a new supervisor, Jenny Munoz, in June 2019 to supervise the shelter operations. In addition to Ms. Munoz, the shelter program has replaced 9 Youth Development Staff and two new counselors.

The facility was renovated with a well -needed interior paint job in Fall 2019 complete with the renovations of all 9 bathrooms.

Unfortunately, Covid-19 has impacted the program in different ways but the agency’s focus has been the safety and well-being of its staff, youth and families served, as well the local community. Although staff were unable to take youth to the usual outings this summer, the team was creative and found new ways each week to engage youth and keep them active.

Narrative Summary

Family Resources Manatee provides both residential and non-residential CINS/FINS services for youth and their families in Bradenton, FL. The program located at 1001 9th Avenue, Bradenton, is under the leadership of a CEO, a Senior Director of Residential Services, Senior Director of Community and Clinical Services, and Senior Director of Quality Assurance. The shelter is licensed for 12 beds by the Department of Children and Families effective through May 31, 2021.

The overall findings for the QI review for HCCS is summarized as follows:

Standard 1 has a total of seven indicators regarding Management Accountability. Five of the seven indicators in Standard 1 were rated satisfactory with no exceptions (1.02, 1.03, 1.05, 1.06, and 1.07) and two were rated satisfactory with exceptions (1.01 and 1.04).

Standard 2 has a total of ten indicators that relate to intervention and case management. Eight of the ten indicators were rated satisfactory with no exceptions (2.01 - 2.08) and two were rated satisfactory with exceptions (2.09 and 2.10)

Standard 3 has a total of seven indicators regarding shelter care. Five of the seven indicators were rated satisfactory with no exceptions (3.02, 3.03, 3.05, 3.06, and 3.07) and two were satisfactory with exceptions (3.01 and 3.04).

Standard 4, Mental Health and Health Services, is comprised of five indicators. Four of the five indicators were rated satisfactory with no exceptions (4.01, 4.03, 4.04, and 4.05) and one (4.02) was rated satisfactory with an exception.

Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable):

None of the indicators in Standard 1-4 had a Limited or Failed rating.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators	Rating (Explain)					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
	Satisfactory	Non-compliant	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) Policy 1.01 was last reviewed July 2019 and signed by the CEO.	
a. Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth.	☒	☐	☐	☐	☐	The agency completed the Berke Assessment prior to the hire dates for all 14 new hires. All staff received a passing rate of medium or high on the prescreening assessment.	
b. Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	☐	☒	☐	☐	☐	A total of 14 new hire background screening files were reviewed. Thirteen of the 14 background screenings were completed prior to hire.	**Exception:** One of the fourteen background screenings was not obtained prior to hire. The employee's date of hire was 7/15/2019 and clearinghouse eligibility date was 8/23/2019.
c. Five-year re-screening completed every 5 years from initial date of hire	☒	☐	☐	☐	☐	One applicable 5-year rescreening was applicable for the review period. The agency's Clearinghouse roster shows the staff has an active current clearinghouse retained print date.	
d. Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	☒	☐	☐	☐	☐	Provider emailed the Annual Affidavit of Compliance with Level 2 Screening form to DJJ BSU on 1/6/2020 prior to the deadline.	
e. Proof of E-Verify for all new employees obtained from the Department of Homeland Security	☒	☐	☐	☐	☐	All 14 new hires had E-Verify work authorization on file.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							

Quality Improvement Indicators	Rating (Explain)					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ YES ☐ NO (explain) Policy 1.02 was last reviewed September 2019 and signed by the CEO.	
Abuse Free Environment							
a. Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	☒	☐	☐	☐	☐	All staff are required to sign an affidavit of compliance with the code of conduct acknowledging their awareness soon after employment.	
b. Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	☒	☐	☐	☐	☐	The Florida Abuse Hotline number is posted in numerous locations throughout the shelter. All calls to the Abuse Hotline are documented in their logbook.	
c. Youth were informed of the Abuse and Contact Number (see youth survey results)	☒	☐	☐	☐	☐	All youth are given a copy of the youth handbook during orientation which includes the abuse hotline information. Two youth surveyed indicated knowledge of the location of the abuse hotline number in the facility.	
d. Management takes immediate action to address any incidents of threats or abuse	☒	☐	☐	☐	☐	No incidents of abuse or threats by staff was identified and/or reported during the review period needing management action.	
Grievance Process							
a. Agency has a formal grievance process	☒	☐	☐	☐	☐	The agency has a written grievance policy and procedure 3.08, approved and signed by the CEO in July 2019.	
b. Locked box accessible to only management and available to youth in a common area	☒	☐	☐	☐	☐	During the video tour it was observed that the program has an accessible grievance box that is locked and located in each cottage alongside grievance forms. The residential coordinator keeps the key to the grievance box.	
c. Direct care does not handle the complaint/grievance unless assistance is asked for by the youth	☒	☐	☐	☐	☐	Only one grievance was reported during the review period. The grievance was retrieved and reviewed by the residential supervisor.	
d. 72-hour resolution requirement by management	☒	☐	☐	☐	☐	One grievance received during review period was responded to and resolved by the	

Quality Improvement Indicators	Rating Explain Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						residential supervisor within 24 hours of submission.	
e. Grievance maintained on file for a minimum of 1 year	☒	☐	☐	☐	☐	The agency's grievance policy 3.08 requires grievances to be maintained on file for a minimum of 1 year.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) Policy 1.03 and 1.03.A were last reviewed July 2019 and signed by the CEO.	
a. During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	☒	☐	☐	☐	☐	There were ten incidents reported during the review period as follows: (5) medical incidents, (1) inappropriate behavior/conduct, (1) mental health emergency, (1) bee/wasp sting, (1) abuse hotline call, and (1) excessively sleeping. All ten incidents were reported within the two-hour required timeframe.	
b. The program completes follow-up communication tasks/special instructions as required by the CCC	☒	☐	☐	☐	☐	One of the 10 CCC incidents required followed up and it was completed by the program.	
c. Incidents are documented in the program logs and on incident reporting forms	☒	☐	☐	☐	☐	All incidents were logged in program logbook.	
d. All incident reports are reviewed and signed by program supervisors/directors	☒	☐	☐	☐	☐	All 10 incident reports were reviewed by program supervisor and were signed.	
1.04: Training Requirements **Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☒ YES ☐ NO (explain) Policy 1.04 was last reviewed July 2019 and signed by the CEO.	
First Year Direct Care Staff							

Quality Improvement Indicators	Rating: Explain — Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
a. Direct care staff receives all mandatory training during the first 120 days of employment	☐	☒	☐	☐	☐	There were three (3) first year direct care staff files reviewed and all three had more than 80 hours of required trainings completed during the first 120 days (103.5, 100.5, and 90 hours). Two of the three first year staff had completed all the mandatory training topics required during the first 120 days of employment	**Exception:** One of the three first year staff was missing Understanding Youth Development training required during the first 120 days of employment
b. Direct care staff completes all mandatory Florida Network and SkillPro training during the first year employment.	☐	☒	☐	☐	☐	Two of the 3 first year staff completed all required annual training in the first year.	**Exception:** One of three first year staff did not complete mandatory DJJ SkillPro Suicide Prevention Part 2 and Fire Safety training required.
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
a. Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training	☒	☐	☐	☐	☐	There were two applicable non-licensed mental health clinical shelter staff hired during the review period. Both staff completed the Assessment of Suicide Risk Training	
b. Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	☒	☐	☐	☐	☐	The two non-licensed mental health files that were reviewed were observed to each have five (5) Suicide Assessments completed during the year, signed, and dated by a licensed mental health professional.	
In-service Direct Care Staff							
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	☐	☒	☐	☐	☐	The three in service staff files reviewed exceeded the 40hrs. required (75hrs.,119.5hrs., and 68.3 hrs.) Two of the three in-service staff completed all required annual training.	**Exception:** One staff completed Skillpro suicide part 1 but did not complete SkillPro part 2 as required.
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	☒	☐	☐	☐	☐	All 8 training files provided documentation of all trainings, date completed, and hours. Training certificates and training worksheets are also included in the training files.	

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
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) Policy 1.05 was last reviewed July 2019 and signed by the CEO. Agency also has a CQI plan effective for 2019.	
Quarterly Reviews							
a. Case record review reports demonstrate reviews are conducted quarterly, at a minimum	☒	☐	☐	☐	☐	Peer record reviews were conducted for the 1st and 2nd quarters 2020. A total of 13 residential files and 24 non-residential files were reviewed. Supervisor summaries indicate strength, deficiencies, and action steps.	
b. The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	☒	☐	☐	☐	☐	Incidents, accidents, and grievance data is collected and reviewed quarterly by the Risk Management Committee. Trend data is included in quarterly reports discussed at the meetings. Reviews of the past 4 quarterly meetings support practice is upheld by the agency.	
Annual Reviews							
a. The program conducts an annual review of customer satisfaction data	☒	☐	☐	☐	☐	Survey Monkey metrics report for FY2019-2020, quarters 3 and 4 were reviewed showing customer satisfaction data is collected for each program. Reviews of the reports are conducted quarterly at the CQI analysis meetings; the most recent was the 3rd quarter meeting.	
b. The program conducts an annual review of outcome data	☒	☐	☐	☐	☐	Program outcomes data are documented monthly by each program, incorporating the contract, Netmis, and program outcomes required by the Florida Network and DJJ QI. Quarterly Impact Management Committee	

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
						meetings are held to review/discuss the quarterly reports.	
Monthly Reviews							
The program conducts a monthly review of NetMIS data reports	☒	☐	☐	☐	☐	Monthly NetMIS data received from the Florida Network is emailed to management staff and reviewed at a minimum monthly at the supervisor outcome/data meetings. The last 3 meetings were held June 15, July 13 and August 3, 2020.	
Quality Improvement Process							
a. The program has a process in place to review and improve accuracy of data entry & collection	☒	☐	☐	☐	☐	Netmis and JJIS data quality checks are conducted twice per month at staff meetings.	
b. There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	☒	☐	☐	☐	☐	Reviews are conducted regularly at CQI Analysis, Risk Management, Impact Committee, and Supervisors meetings.	
c. There is evidence that strengths and weaknesses are identified, improvements are implemented or modified and staff are informed and involved throughout the process.	☒	☐	☐	☐	☐	Monthly supervisors, team/staff minutes were reviewed for the review period and were found to document discussion of QI activities, reports, and areas identified as needing improvements resulting from analysis of data collected.	
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) Policy 1.10 was last reviewed July 2019 and signed by the CEO.	
Approved agency drivers							
a. Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	☒	☐	☐	☐	☐	The agency provided a list of 18 staff approved by administration to drive clients in agency vehicles.	
b. Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	☒	☐	☐	☐	☐	The agency provides a commercial automobile insurance policy for those who drive agency vehicles. Human resources identify the employees eligible to drive on behalf of the	

Quality Improvement Indicators	Rating Explain Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						agency upon hire and is responsible for notifying the insurance carrier and receiving authorization for driving privileges. The agency conducts an annual check of all regular full time and part-time employees' motor vehicle history.	
Third party present in the vehicle							
a. Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	☒	☐	☐	☐	☐	Policy 1.10 addresses requirement to have a 3rd party present in vehicle transporting youth to prevent allegations of misconduct. Exceptions are also outlined in the policy.	
b. In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	☒	☐	☐	☐	☐	The agency had fifty single youth transports in February, ten in March, and two in July, all of which were approved by the supervisor prior to transport. The agency did not have any transports from March 16 until June due to the COVID-19 pandemic.	
c. The 3rd party an approved volunteer, intern, agency staff, or other youth	☒	☐	☐	☐	☐	Transportation logs for the past 6 months showed third party included agency staff or other youth.	
Transportation documentation							
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location	☒	☐	☐	☐	☐	Evidenced by transportation logs reviewed.	
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) Policy 1.11 was last reviewed July 2019 and signed by the CEO.	

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
a. The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	☒	☐	☐	☐	☐	The agency participates in the Manatee Juvenile Justice Council and showed demonstrated participation through February 2020. Documentation was provided the April and June meetings were cancelled due to the COVID-19 pandemic.	
b. Outreach and prevention services are provided by designated staff and include increasing community awareness, offering informational and educational CINS/FINS services to youth and families.	☒	☐	☐	☐	☐	Family Resources key staff offers informational and educational CINS/FINS services to youth and families, alcohol and drug treatment, adolescent behavior, parenting classes, youth education issues and information.	
c. The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	☒	☐	☐	☐	☐	Mous with 19 community agencies are on file that list the services provided and a comprehensive referral process between the agencies.	
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) Policy 2.01 was last reviewed July 2019 and signed by the CEO.	
Eligibility screening is completed within 7- calendar days of referral	☒	☐	☐	☐	☐	Ten applicable case files were reviewed for five (5) non-residential youth, three (3) open and two (2) closed, and five (5) residential youth, three (3) open and two (2) closed files.	
Youth and parents/guardians receive the following in writing: • Available service options • Rights and responsibilities of youth and parents/guardians	☒	☐	☐	☐	☐	Verified in all ten records reviewed.	
The following is also available to the youth and parents/guardians:	☒	☐	☐	☐	☐	Verified in all ten records reviewed.	

Quality Improvement Indicators	Rating: Explain — Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
• Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) • Grievance procedures							
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) Policy 2.02 was last reviewed July 2019 and signed by the CEO.	
Completion of Needs Assessment							
a. Shelter Youth: Needs Assessment initiated within 72 hours of admission	☒	☐	☐	☐	☐	Five residential youth records were reviewed. The Needs Assessment was initiated within 72 hours in all 5 records.	
b. Non-Residential youth: Needs Assessment is done within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	☒	☐	☐	☐	☐	Five non-residential youth records were reviewed. The Needs Assessment was completed within 2 to 3 face-to-face contacts in all 5 records.	
c. Needs Assessment is conducted by a Bachelor's or Master's level staff member	☒	☐	☐	☐	☐	All ten Needs Assessments were conducted by a Bachelor's or Master's level staff member.	
d. Needs Assessment includes a supervisor's review signature upon completion	☒	☐	☐	☐	☐	A supervisor's signature was present on all 10 Needs Assessments reviewed.	
Suicide Risk as a Result of the Needs Assessment							
a. Youth was identified with an elevated risk of suicide as a result of the Needs Assessment	☒	☐	☐	☐	☐	Applicable to 3 of the 5 residential youth records and 1 of 5 non-residential youth record. All 4 youth were identified with an elevated risk of suicide.	
b. If yes, the youth was referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional	☒	☐	☐	☐	☐	Proof of a completed Assessment of Suicide Risk, conducted by a qualified professional, was observed in the 3 residential records reviewed and the 1 non-residential youth was	

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
	Explain						
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
						referred to a local for mental health provider for assessment and services.	
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) Policy 2.03 was last reviewed July 2019 and signed by the CEO.	
Case/Service plan is developed within 7 working days of Needs Assessment	☒	☐	☐	☐	☐	Verified in all ten records reviewed.	
Case/Service Plan includes:							
• Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment • Service type, frequency, location • Person(s) responsible • Target date(s) for completion and Actual completion date(s) • Signature of youth, parent/guardian, counselor, and supervisor • Date the plan was initiated	☒	☐	☐	☐	☐	Case plans in all 10 files included all elements required by the indicator.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	☒	☐	☐	☐	☐	Applicable to and verified in 5 non-residential files and 3 residential files reviewed.	
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) Policy 2.04 was last reviewed July 2019 and signed by the CEO.	
Counselor/Case Manager is assigned	☒	☐	☐	☐	☐	Each of the 10 records reviewed showed a counselor was assigned to the youth.	

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
The Counselor/Case Manager completes the following as applicable: • Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs • Coordinates service plan implementation • Monitors youth's/family's progress in services • Provides support for families • Monitors out-of-home placement (if necessary) • Makes referrals to the case staffing to address problems and needs of the youth/family • Accompanies youth and parent/guardian to court hearings and related appointments • Refers the youth/family for additional services when appropriate • Provides case monitoring and reviews court orders • Provides case termination notes • Provides follow-up after 30 days of exit • Provides follow-up after 60 days of exit	☒	☐	☐	☐	☐	All 10 records reviewed demonstrated applicable case management services were provided as needed and progress is monitored.	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) Policy 2.05 was last reviewed July 2019 and signed by the CEO.	
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	☒	☐	☐	☐	☐	Service plans and case notes maintained demonstrated all 10 youth received individual counseling services as identified during the assessment.	

Quality Improvement Indicators	Rating: Explain — Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Shelter Program							
Shelter programs provides individual and family counseling	☒	☐	☐	☐	☐	Applicable to 5 residential records reviewed. All 5 demonstrated individual and/or family counseling was offered.	
Group counseling sessions held a minimum of five days per week	☒	☐	☐	☐	☐	Program/Group Schedule	
Group counseling sessions consist of: • Length of at least 30 minutes • Opportunity for youth engagement • Clear and relevant topic (informational/developmental/educational) • Clear leader or facilitator	☒	☐	☐	☐	☐	All (5) residential case files reflected that group counseling is provided at least (5) days per week at the shelter. The group schedule confirmed the frequency of group sessions and duration of at least 30 minutes each.	
Non-residential Program							
Non-residential programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, or the local provider's counseling office.	☒	☐	☐	☐	☐	Verified in all five non-residential records reviewed.	
Counseling Services							
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	☒	☐	☐	☐	☐	Coordination of services was observed in all 10 files reviewed.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	☒	☐	☐	☐	☐	Individual youth record is maintained for all 10 youth files reviewed.	
Case notes maintained for all counseling services provided and documents youth's progress	☒	☐	☐	☐	☐	Verified in all ten records reviewed.	
On-going internal process that ensures clinical reviews of case records and staff performance	☒	☐	☐	☐	☐	The supervisor and clinical director reviewed and signed off on review of files to document their case review.	
2.06: Adjudication/Petition Process							

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	**Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	**Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) Policy 2.06 was last reviewed July 2019 and signed by the CEO.	
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days	☒	☐	☐	☐	☐	Two applicable case staffing youth records were reviewed for the QI period. The case staffing was requested by staff in the two records.	
The youth, family and case staffing committee are contacted within a minimum of five working days • Notification to youth/family no less than 5 working days prior to staffing • Notification to committee no less than 5 working days prior to staffing	☒	☐	☐	☐	☐	Notification was sent via email to the committee and youth/family more than 5 days prior to the case staffing for each youth.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	☒	☐	☐	☐	☐	Each case staffing included a DJJ representative/ CINS/FINS provider and a local school district representative	
Other members may include: • State Attorney's Office • Others requested by youth/family • Substance abuse representative • Law enforcement representative • DCF representative • Mental health representative	☒	☐	☐	☐	☐	A mental health representative was also present at the case staffing meetings	
The program has an established case staffing committee, and has regular communication with committee members	☒	☐	☐	☐	☐	Members of the case staffing committee include representatives from: school district, DJJ, and program staff.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	☒	☐	☐	☐	☐	Outlined in policy 2.06	
As a result of the Case Staffing							

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
The youth and family are provided a new or revised plan for services	☒	☐	☐	☐	☐	Revised service plans for two applicable youth.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	☒	☐	☐	☐	☐	The parent/guardian is provided a report of the committee recommendations at the end of the case staffing meeting.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	☒	☐	☐	☐	☐	None of the two youth records reviewed was applicable for judicial intervention for the youth/family.	
Case Manager/Counselor completes a review summary prior to the court hearing	☒	☐	☐	☐	☐	No court intervention was required for the records reviewed.	
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) Policy 2.07 was last reviewed July 2019 and signed by the CEO.	
All records are marked "confidential	☒	☐	☐	☐	☐	All ten youth records reviewed were stamped confidential	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	☒	☐	☐	☐	☐	During the video tour, files were observed to be stored in locked file cabinets marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	☒	☐	☐	☐	☐	When the youth records are transported offsite, they are stored in an opaque, secured, box with a lock.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	☒	☐	☐	☐	☐	All ten files reviewed were observed to be organized and maintained in a neat order with cover pages for each section of the file.	
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)	

Quality Improvement Indicators	Rating Explain Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						Policy 5.08 was last reviewed July 2019 and signed by the CEO.	
Use of youth's preferred name/pronoun: a. Youth are addressed according to their preferred name and gender pronouns b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards	☐	☐	☒	☐	☐	Since the last QI visit the program has not served any youth who meets the criteria for this indicator. However, policies and procedures are established to meet the requirements.	
Youth in need of specialized support is referred to qualified resources (as applicable)	☐	☐	☒	☐	☐	N/A	
Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression	☐	☐	☒	☐	☐	N/A	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression	☐	☐	☒	☐	☐	N/A	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	☒	☐	☐	☐	☐	During video tour, signage was observed to be posted throughout the facility in common areas. Published materials providing information and education for SOGIE youth is accessible on a table in the building lobby and youth lounge.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09 for EACH special population served i.e. Staff Secure, DMST,DV, PR, ICM and FYRAC.						☒ YES ☐ NO (explain) Policy 3.07 and 3.07A (FYRAC) was last reviewed July 2019 and signed by the CEO.	
Staff Secure							

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☐Yes ☒ No			☐N/A			The provider has not served any youth meeting the criteria for staff secure since the last QI review.
Staff Secure policy and procedure outlines the following: • In-depth orientation on admission • Assessment and service planning • Enhanced supervision and security with emphasis on control and appropriate level of physical intervention • Parental involvement • Collaborative aftercare	☒	☐	☐	☐	☐	Policy 3.07	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	☐	☐	☒	☐	☐	No applicable youth files to review.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	☐	☐	☒	☐	☐	No applicable youth files to review.	
Agency provides a written report for any court proceedings regarding the youth's progress	☐	☐	☒	☐	☐	No applicable youth files to review.	
Domestic Minor Sex Trafficking (DMST)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☐Yes ☒ No			☐N/A			The provider has not served any youth meeting the criteria for DMST since the last QI review.
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements	☐	☐	☒	☐	☐	No applicable youth files to review	

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
Services provided to these youth specifically designated services designed to serve DMST youth	☐	☐	☒	☐	☐	No applicable youth files to review	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	☐	☐	☒	☐	☐	No applicable youth files to review	
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	☐	☐	☒	☐	☐	No applicable youth files to review	
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	☐	☐	☒	☐	☐	No applicable youth files to review	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	☐	☐	☒	☐	☐	No applicable youth files to review	
Domestic Violence							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☒Yes ☐ No			☐N/A			
Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	☒	☐	☐	☐	☐	Three closed DV youth records were reviewed. A DJJ Face sheet was present in all 3 files showing JAC screening and pending DV charge for each youth	
Data entry into NetMIS and JJIS within 24 hours of admission and 72 hours of release	☐	☒	☐	☐	☐	NetMIS youth listings report and JJIS data entry log for each youth.	**Exception:** One of three DV youth had a data entry lag of 2 days, exceeding the 72 hours required post discharge

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	☒	☐	☐	☐	☐	None of the DV youth exceeded 21 days in the DV program. Two of the three youth were transitioned to CINS/FINS on the 21st day with supporting documentation.	
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	☒	☐	☐	☐	☐	Case plans in two youth records reflect goals for reducing violence and coping skills. The 3rd youth was discharged prior to case plan implementation.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	☒	☐	☐	☐	☐	Case notes demonstrate all three youth received shelter services consistent with CINS/FINS program requirements.	
Probation Respite							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☒Yes ☐ No			☐N/A			
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	☒	☐	☐	☐	☐	The program had one applicable probation respite youth served during the review period. A DJJ Face sheet was present in the file showing probation status and approval by the Florida Network through the referrolator.	
Data entry into NetMIS and JJIS within 24 hours of admission and 72 hours of release	☐	☒	☐	☐	☐	NetMIS youth listings report and JJIS exit data entry.	**Exception:** One probation youth record had a data entry lag of 1 day for intake, exceeding the 24 hours required of intake requirement.
Length of stay is no more than fourteen (14) to thirty (30) days? (Placement beyond thirty (30) days requires the approval of the JPO and/or CPO)	☒	☐	☐	☐	☐	Verified in youth record.	
All case management and counseling needs have been considered and addressed	☒	☐	☐	☐	☐	Case plan reflect goals for reducing violence and coping skills.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	☒	☐	☐	☐	☐	Case notes demonstrate youth received shelter services consistent with CINS/FINS program requirements.	
Intensive Case Management (ICM)							

Quality Improvement Indicators	Rating – Explain: Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon – Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes – **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	☐Yes ☐ No			☒N/A			Family Resources Manatee is not contracted to provide Intensive Case Management services.
Youth receiving services was court ordered or referred by case staffing committee	☐	☐	☐	☐	☒	N/A	
Services for youth and family include: a. Six (6) direct contacts per month b. Six (6) collateral contacts per month	☐	☐	☐	☐	☒	N/A	
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable) b. An approved self-report assessment that was completed at intake c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)	☐	☐	☐	☐	☒	N/A	
Case plan demonstrates a strength-based, trauma-informed focus	☐	☐	☐	☐	☒	N/A	
Agency has evidence that ICMS has a strength-based perspective in one or more of the following areas; engaging the family, advocating on their behalf, initiating change agent activities, helping to access supports in the community, teaching problem solving skills, modeling productive behaviors, and/or successful completion of youth and family developmental milestones	☐	☐	☐	☐	☒	N/A	
Family and Youth Respite Aftercare Services (FYRAC)– Non-residential Only							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	☐Yes ☒ No			☐N/A			The provider has not served any youth meeting the criteria for FYRAC since the last QI review.
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on	☐	☐	☒	☐	☐	No applicable youth files to review	

Quality Improvement Indicators	Rating Explain Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
probation regardless of adjudication status and at risk of violating							
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	☐	☐	☐	☐	☐	No applicable youth files to review	
Intake and initial assessment sessions meets the following criteria: a. Face-to-face gathering of family history and demographic information b. Includes development of the service plan and is documented through signature of the youth and his/her parent/guardian as well as orientation to the program	☐	☐	☒	☐	☐	No applicable youth files to review	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning	☐	☐	☒	☐	☐	No applicable youth files to review	
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	☐	☐	☒	☐	☐	No applicable youth files to review	
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	☐	☐	☒	☐	☐	No applicable youth files to review	
2.10: STOP NOW AND PLAN (SNAP)							

Quality Improvement Indicators	Rating: Explain — Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☒ YES ☐ NO (explain) Policy 4.15 was last reviewed July 2019 and signed by the CEO.	
SNAP Clinical Groups							
Youth are screened to determine eligibility of services	☒	☐	☐	☐	☐	Four applicable SNAP youth records (3 closed and 1 open) were reviewed.	
Needs assessment is completed at initial intake, or within two face-to-face sessions	☒	☐	☐	☐	☐	Verified in 4 youth records	
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post)	☐	☒	☐	☐	☐	Pre-CBCLs were completed at intake in 2 of the 4 youth records and post-CBCLs in all 3 closed youth records	**Exception** The CBCL was not documented as completed at intake for 2 youth records. Staff interviewed stated it is completed at intake and but entered in the system at a future date; however, case notes did not provide validation of completed CBCLs at intake.
b. Teacher Report Form (TRF) completed by the teacher (pre & post)	☒	☐	☐	☐	☐	Pre and post TRF were completed by the teacher.	
c. TOPSE (pre & post)	☒	☐	☐	☐	☐	Pre-TOPSE was completed at intake in all 4 youth records and post-TOPSE in the 3 closed youth records	
d. Prevention Assessment Tool (PAT) (pre & post)	☐	☒	☐	☐	☐	Pre-PATs were completed at intake in 2 of the 4 youth records and post-PATs in all 3 closed youth records	**Exception** The PAT was not documented as completed at intake for 2 youth records. Staff interviewed stated it is initiated at intake but entered in the system at a future date; however, case notes did not provide validation of completed PATs at intake.
SNAP® discharge report summary	☒	☐	☐	☐	☐	Completed in 3 applicable closed youth records	
	☒	☐	☐	☐	☐	SNAP Evaluation records	

Quality Improvement Indicators	Rating: Explain — Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
SNAP® Boys/SNAP® Girls Child Group Evaluation Form SNAP® Boys/SNAP® Girls Parent Group Evaluation Form	☒	☐	☐	☐	☐	SNAP Evaluation records	
SNAP in Schools							
Weekly attendance sheet with youth names and/or identifying number completed with signatures of teacher and facilitator(s) (For a total of 13 attendance sheets)	☒	☐	☐	☐	☐	One (1) 3rd grade class beginning 11/22/19 and ending 3/6/2020. Total of 12 sessions as the 13th was canceled due to COVID 19	
"Class Shoot for Your Goal" sheet	☒	☐	☐	☐	☐	Completed 11/22/19	
Pre and Post Evaluations	☒	☐	☐	☐	☐	Pre evaluations were completed; post evaluations were impacted by the pandemic resulting in school closure.	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox	☒	☐	☐	☐	☐	Unable to complete due to school closure as a result of the pandemic	
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) Policy 3.01 was last reviewed July 2019 and signed by the CEO.	
Facility Inspection	☒	☐	☐	☐	☐	A video tour of the facility was conducted with the VP of Residential Programs and the shelter program manager. The tour of the facility included: facility lobby, all common/living areas, youth bedrooms, bathrooms, kitchen, laundry room, staff offices, and the exterior of the building. The tour of the facility revealed	

Quality Improvement Indicators	Rating Explain Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						that the furnishings were in good repair, the beds were neatly made in all rooms; they had different mural themes for each bedroom, and the atmosphere was inviting. There were no visible indication of insects or pests and the agency uses a regular exterminator to spray the facility. All bathrooms have been renovated since last review. Walls were free from graffiti, No lighting issues were observed. There were no observed hazards on the ground during the virtual tour. Egress plans, maps, client rules, hotline information, etc. were posted throughout the shelter in conspicuous places. Chemicals were kept in a locked cabinet and were labeled accordingly. All doors are secure throughout the shelter though some were opened for the virtual tour and in and out access was limited to staff and they exercised key control. On the exterior, no visible debris was observed on the exterior and the dumpsters and garbage cans were covered.	
Fire and Safety Health Hazards	☐	☒	☐	☐	☐	Video tour was conducted and Inspection documents were reviewed as follows: The shelter is licensed as a Child Caring Agency for 12 beds under the current DCF License with an expiration date of 5/31/21. **COA** Certificate-Accreditation through 12/31/20. **DOH** Group Care/Food Inspection completed a satisfactory inspection on 2/19/20 with no violations cited. The **Annual fire inspection** expired in May 2020. An email from the City of Bradenton Fire Chief stated the department has not been cleared by the state	**Exception** No fire drills were conducted monthly as required on the overnight shift (11pm – 7am) between February – April 2020 or in June 2020.

Quality Improvement Indicators	Rating Explain Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						to do regular inspections at this time and all facilities are operating on a provisional license. Fire drills for the past 6 months indicate the agency has completed a minimum of 1 fire drill per month within 2 minutes on all but the overnight shift. Episodic emergency drills were observed on all shifts for the past 2 quarters.	
Youth Engagement							
• Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. • At least one hour of physical activity is provided daily. • Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. • Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. • Daily programming schedule is publically posted and accessible to both staff and youth.	☒	☐	☐	☐	☐	As observed during the walking virtual tour on the posted activity schedule. The daily schedule was posted and accessible to both staff and youth.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) Policy 3.02 was last reviewed July 2019 and signed by the CEO.	

Quality Improvement Indicators	Rating (Explain)					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
Youth received a comprehensive orientation and handbook provided within 24 hours	☒	☐	☐	☐	☐	Orientation checklist was observed in all 4 residential records reviewed (2 open, 2 closed).	
Orientation includes the following							
a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	☒	☐	☐	☐	☐	Verified in 2 open, 2 closed residential records.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	☒	☐	☐	☐	☐	Orientation checklist was observed 2 open, 2 closed residential records. All the orientation checklists were signed by the youth and staff.	
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) Policy 3.03 was last reviewed July 2019 and signed by the CEO.	
A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth,	☒	☐	☐	☐	☐	Verified on the CINS/FINS Intake form for 2 open, 2 closed residential records.	

Quality Improvement Indicators	Rating (Explain)					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior							
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	☒	☐	☐	☐	☐	Alerts for the youth are marked with colored dots on the front of the 4 files reviewed and colored dots on the youth alert board in the shelter for 2 active youth reviewed.	
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) Policy 3.04 was last reviewed July 2019 and signed by the CEO.	
Log book entries that could impact the security and safety of the youth and/or program are highlighted	☒	☐	☐	☐	☐	Randomly selected one-week samples of the program logbook for each month during the past six months were reviewed. Dates reviewed are as follows: February 9-15; February 29-March 7; April 19-26; May 18-23, June 7-13, and July 18-25, 2020.The program maintains a bound paper logbook.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	☒	☐	☐	☐	☐	All entries reviewed were observed to meet the requirements of the indicator.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	☐	☒	☐	☐	☐	Review of 6 randomly selected weeks during the past 6 months.	**Exception** A few recording errors were not marked as required. Instead staff circled around the error and did not include their initials. These were observed on the following dates: Feb. 10th,

Quality Improvement Indicators	Rating: Explain — Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
							March 7, 2020, June 9, 2020, July 21, 2020.
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	☒	☐	☐	☐	☐	Program director or designee reviews the logbook every week and makes a note stating dates reviewed with signature.	
Supervisors and all staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	☒	☐	☐	☐	☐	Supervisors and all staff review the logbook at least the previous two shifts an include the dates they have reviewed.	
Logbook entries include: • Supervision and resident counts • Visitation and home visits	☒	☐	☐	☐	☐	Entries were observed for 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) Policy 3.05 was last reviewed July 2019 and signed by the CEO.	
The program has a detailed written description of the BMS and it is explained during program orientation	☒	☐	☐	☐	☐	The program uses four levels in their system whereby positive rewards are given in three and negative behavior results in a demotion. The behavior management description is clearly identified in the consumer handbook and given to youth at intake.	
Behavior Management Strategies must include:							
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program	☒	☐	☐	☐	☐	Policy 3.05, youth handbook, and BMS point sheets.	

Quality Improvement Indicators	Rating: Explain — Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges							
Program's use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	☒	☐	☐	☐	☐	Staff receive training during orientation. Training files for three new hires were reviewed.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	☒	☐	☐	☐	☐	Supervisors meet with staff to discuss use of positive and negative consequences with youth	
Supervisors are trained to monitor the use of rewards and consequences by their staff	☒	☐	☐	☐	☐	As observed in training files, supervisors are trained and monitor the use of behavioral interventions by their staff to include the point based and level based system.	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) Policy 3.06 was last reviewed July 2019 and signed by the CEO.	

Quality Improvement Indicators	Rating (Explain)					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	☒	☐	☐	☐	☐	Monthly staff schedules for February – July 2020.	
Overnight shifts must always provide a minimum of two staff present	☒	☐	☐	☐	☐	Monthly staff schedules for February – July 2020.	
The staff schedule is provided to staff or posted in a place visible to staff	☒	☐	☐	☐	☐	Posted in offices as observed during virtual walking tour.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	☒	☐	☐	☐	☐	There is a holdover overtime roster for staff available for on call including contact telephone number and preferred shifts.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	☒	☐	☐	☐	☐	A review of the video surveillance for 4 randomly selected overnight shifts, during the 30-day period prior to the QI review, was conducted. The dates selected were: July 18th, 11:59pm -6am; July 22nd, 11:59pm -6am; July 26th, 11:59pm -6am; and August 7th, 11:59pm -6am	
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) Policy 3.07 was last reviewed July 2019 and signed by the CEO.	
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days	☒	☐	☐	☐	☐	Video surveillance review was conducted via Teams conference and interview with residential supervisor. Video surveillance dates reviewed were; July 18th, 11:59pm -6am; July 22nd, 11:59pm -6am; July 26th, 11:59pm -6am; and August 7th, 11:59pm -6am	

Quality Improvement Indicators	Rating: Explain — Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible						The written notice of surveillance was observed to be posted during the video walking tour. It is a bright yellow sign indicating that there is 24 hour surveillance posted	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	☒	☐	☐	☐	☐	List of personnel designated to access the system is maintained by the VP of Residential Services.	
Supervisory review of video is conducted a minimum of once every 14 days and noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	☒	☐	☐	☐	☐	Supervisory reviews are done every 14 days and documented in the logbook. A review of logs from February through July provided confirmation.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	☒	☐	☐	☐	☐	Policy indicates that third party review can be made available during investigations and in conjunction with specific incidents.	
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) Policy 4.01 was last reviewed July 2019 and signed by the CEO.	
Preliminary Healthcare Screening							

Quality Improvement Indicators	Rating: Explain — Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc.; and g. Observation for presence of scars, tattoos, or other skin markings	☒	☐	☐	☐	☐	Four youth records (3 closed, 1 open) were reviewed and each had a healthcare screening completed on the day of intake.	
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	☒	☐	☐	☐	☐	One of the four youth was found to have a medical issue; however, the youth did not require a referral for further medical services.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	☒	☐	☐	☐	☐	Four youth records were reviewed and none of the records indicated the parent/guardian needed to be involved in healthcare services while the youth was in the program.	
All medical referrals are documented on a daily log.	☒	☐	☐	☐	☐	Each record indicated all healthcare referrals are documented on a daily log maintained in the youth's record.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	☒	☐	☐	☐	☐	The agency's policy states the program will work with the youth's parent/guardian and the provider's medical consultant, if needed, to ensure the youth receives proper medical care and follow-up.	
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) Policy 4.02 was last reviewed July 2019 and signed by the CEO.	
Suicide Risk Screening and Approval							

Quality Improvement Indicators	Rating: Explain — Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
a. Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	☒	☐	☐	☐	☐	Four applicable youth records (3 closed, 1 open) contained a suicide risk screening completed during the screening and initial intake screening process.	
b. The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	☒	☐	☐	☐	☐	The agency uses the Residential Suicide Assessment tool approved by the Florida Network.	
Supervision of Youth with Suicide Risk							
a. Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	☐	☒	☐	☐	☐	Four youth records were reviewed. Three were applicable for placement on constant sight and sound supervision and one should have been placed on One-on-One supervision but was not.	**Exception** One youth's screening indicated Baker Act procedures to be initiated and youth should have been placed on One-on-One supervision; however, the youth was placed on constant sight and sound and an Assessment of Suicide Risk was not completed until the following day
b. Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	☒	☐	☐	☐	☐	Observation logs documented youth were monitored every fifteen minutes while on constant supervision.	
c. Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement?	☒	☐	☐	☐	☐	Each of the 4 youth was not stepped down to standard supervision until the youth received a follow up Suicide Risk Assessment by the licensed clinician.	
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ YES ☐ NO (explain) Policy 4.03 was last reviewed July 2019 and signed by the CEO.	
Medication Storage							

Quality Improvement Indicators	Rating: Explain — Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Oral medications are stored separately from injectable epi-pen and topical medications c. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) d. Narcotics and controlled medications are stored in the Med-Station	☒	☐	☐	☐	☐	During the annual review, a video tour of the Pyxis Med-Station 4000 medication cabinet were conducted and the nurse was interviewed. The tour of the medication room verified all medication types are stored separately in the Pyxis system cart and controlled medications are stored in a separate section of the locked Pyxis system cart.	
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	☒	☐	☐	☐	☐	The agency maintains a list of staff who are trained in medication administration, sixteen of which are super users in the Pyxis Med-Cart. Only staff trained in the distribution of medications have access, which is limited by the Pxyis Med-Cart system. Training documents support all applicable staff were trained by the program's medical staff in medication distribution. A review of four youth records supported they took medication while in the program. All four records contained a Medication Distribution Log completed as required. Use of the epi-pen is acceptable as the agency does not accept youth with injectable medications except for epi-pens. The program reports that the nurse maintains the documentation for the training in the Medication Room on site for staff trained in the use of epi-pens.	
Medication Inventory							

Quality Improvement Indicators	Rating: Explain — Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	☒	☐	☐	☐	☐	Trained staff complete an inventory every shift of all the controlled substances. This is completed by two staff members and is documented on the youth's Medication Distribution Log (MDL). A perpetual inventory is maintained on the youth's MDL each time a medication is given. All OTC medications must come in with a youth, verified, and locked in the Pyxis Med-Cart. The OTC medications are then inventoried on a perpetual basis on the youth's Medication Administration Record (MAR). The tour with the nurse found all sharps and syringes are secured in either the locked medication room in a locked cabinet, or in the locked cabinet by the census board. All sharps are inventoried on a perpetual basis.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	☒	☐	☐	☐	☐	Documentation was reviewed with the nurse supporting monthly reviews of medication management are conducted in the Pyxis Med-Cart system.	
Medication discrepancies are cleared after each shift.	☒	☐	☐	☐	☐	An interview with the nurse found all discrepancies are cleared on each shift in the Pyxis system. Additionally, the nurse requires all discrepancies to be logged in a separate notebook to verify all discrepancies and provide feedback.	
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) Policy 4.04 was last reviewed July 2019 and signed by the CEO.	

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	☒	☐	☐	☐	☐	Documentation – 4 youth records reviewed (3 closed, 1 open).	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	☒	☐	☐	☐	☐	Documentation – 4 youth records reviewed (3 closed, 1 open).	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	☒	☐	☐	☐	☐	Documentation – staff training Three new staff training record reviewed provided documentation of training in MHSA, CPR and First Aid	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	☒	☐	☐	☐	☐	Documentation – policy & youth records. The program uses a color-coded alert system with specific colors to address the following topics: mental health/suicide alert, medical issues, substance abuse issues, behavioral issues, domestic violence, and exigent youth.	
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ YES ☐ NO (explain) Policy 4.05 was last reviewed July 2019 and signed by the CEO.	
Off-site Emergency Services							
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	☒	☐	☐	☐	☐	Documentation – 2 closed youth records were reviewed. Both youth required off-site emergency services. Documentation supported parental notification was made in the two incidents. One of the youth was discharged home from the hospital and one youth returned to the shelter. The youth who returned to the shelter was found to have discharge and follow-up paperwork in the youth record as required. Both incidents were documented on the episodic log.	

Quality Improvement Review

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
All staff are trained on emergency medical procedures	☒	☐	☐	☐	☐	All 6 training records reviewed included certifications in Basic First Aid support, Automatic External Defibrillator (AED), and Cardiopulmonary Resuscitation (CPR).	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	☒	☐	☐	☐	☐	The agency has a knife-for-life which is kept in the locked sharps closet next to the census board.	
First aid kit/supplies are fully equipped and inventoried	☒	☐	☐	☐	☐	The agency maintains four first aid kits on-site, one is in a locked black box in the locked medication room, one is in the confidential closet in the shelter, one is in the kitchen, and one is in the van. Documentation was found there is an approved list of items for the first aids kits and the kits are inventoried appropriately.	