Florida Network for Youth and Family Services
Compliance Monitoring Report for

BOYS TOWN

975 Oklahoma Street
Oviedo, FL 32765

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the Boys Town CINS/FINS program for the FY 2020-2021 at its program office located at 975 Oklahoma Street, Oviedo, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Boys Town 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 2020 through June 30, 2021.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewers. Agency representatives from Boys Town present for the entrance interview were: Greg Zbylut, Executive Director, Telma Favors, Senior Director of Program Operations; Catherine Melendez, Financial Officer; Rochelle Davis, Program Support Services Coordinator; Erica Vagle, Program Director (IHFS); Al McCray, Program Director; Melissa Quinn, Clinical Support Manager; and Tonya Zelk, Compliance Specialist. The last onsite QI visit was conducted October 9, 2019.

In general, the Reviewer found that Boys Town is compliant with specific contract requirements. **Boys Town received an overall compliance rating of 100% for achieving full compliance with all thirteen (13) indicators** of the CINS/FINS Monitoring Tool. 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

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 2-03-2020-2021

Agency Name: Boys Town	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 975 Oklahoma Street, Oviedo, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): February 3-4, 2021**

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 three (3) certified DJJ-QI Peer Reviewers: Melissa Quinn; Rochelle Davis; and Al McCray. Melissa Quinn and Rochelle Davis participated in QI Peer Reviews during the current 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**	☐	☐	☒	☐	☐	The agency maintains a list of 16 additional contracts for FY 2020-2021. The list includes: the company, contract number, contract expiration date, and contact information. The program also maintains 19 interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed during the QI visit had current contract/agreement dates.	
Limits of Coverage	☐	☐	☒	☐	☐	General Liability through Philadelphia Indemnity Insurance Company, for	

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a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						limits of coverage $1,000,000 each $3,000,000 aggregate, and medical expense for $5,000, effective 10/01/20 – 9/01/2021. Automobile insurance through Philadelphia Indemnity Insurance company for combined limits of liability/property damage for $1,000,000. Policy effective date 10/01/20 – 9/01/2021. Workers Compensation through Sentry Casualty Company with limits of $1,000,000 each/aggregate, effective 12/31/2020 – 12/31/2021 Umbrella liability through Philadelphia Indemnity Insurance Company with limits of $10,000,000 each/aggregate, effective 10/01/20 – 9/01/2021.. E&O – MPL – Primary through Philadelphia Indemnity Insurance Company for Professional Liability of $1,000,000 each and $3,000,000 aggregate, effective through 10/01/20 – 9/01/2021. Florida Network is listed as certificate holder.	

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
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 an 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**	☐	☐	☒	☐	☐	The agency maintains Accounting Policies and Procedures in place for: fiscal management, cash, petty cash, support, program service fees, revenue, and receivables, expenses for program and supporting services and accounts payable, payroll and related liabilities, governmental financial assistance programs, property and equipment, debt and other liabilities. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls and review dates are indicated for each procedure.	
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Boys Town provided a detailed General Ledger for accounts 81270 (IHFS) and 81240 (I&A) for the period January 1 – December 31, 2020. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program.	

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						It appears that the agency is allocating cost per each program separately from other funding sources. The GL uses a chart of accounts and each entry includes the type of transaction, date, document number, description, and budget/transaction activity.	
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**	☐	☐	☒	☐	☐	Boys Town has procedures for petty cash. Petty cash is stored in a locked box in the Supervisors office. All receipts are submitted for accounting and requesting reimbursement as needed and the fund is reconciled. Reimbursement comes in the form of a check made out to the Program Director who will then cash it and place money in petty cash box. The fund does not exceed $150. In addition to petty cash, Supervisors and 3 of 4 Senior YCWs have purchasing cards.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation and Observation: Bank Statements and Bank Reconciliations were reviewed for the period July-December 2020 for two accounts, depository and disbursement, held with Bank of America. Financial Statements are	

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						reported on a monthly basis and were found to be current. Bank reconciliations are conducted within 2-3 weeks of the end of each month for the preceding month's activities. Invoices are submitted on a monthly basis with supporting documentation and are signed by comptroller.	
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**	☐	☐	☒	☐	☐	Documentation: No new inventory was purchased in the past year. However, Boys Town maintains an inventory list of items purchased with DJJ funds. These items include 3 Surface Pro Laptops purchased in May 2016; inventory numbers are on file for each.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided evidence of payroll taxes being paid to the IRS as reported on 941s submitted for the 3rd quarter 2020. The 941s document the amount of payroll taxes that were submitted for Federal and FICA taxes with minimal balance $27.92 due, resulting from underpayment.	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
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 year-to-date report as of December 31, 2020 for accounts 81240 and 81270. The report shows Actual, Budget, Over/Under, Annual Budget, and Balance Remaining. A review of these documents was conducted. Report shows program budget and variances. Variances in budget are monitored on a regular basis and are discussed with the Board.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. 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 as of December 31, 2019 was completed by KPMG LLP in a letter dated June 17, 2020. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor.	

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	Explain Rating						
Major Programmatic Requirements	**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. 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: Provider has policies and procedures for: Confidentiality and Privacy, Information Management, Storage, Retention, Destruction and Transfer of Files, Personnel Records and Information, Risk Management and Insurance, Technology Users' Security Responsibilities, Mobile Devices: Use and Security, and Acceptable Use of Boys Town Technology.	

CONCLUSION

Boys Town has met the requirements for the CINS/FINS contract as a result of full compliance with all thirteen (13) indicators of the Administrative and Fiscal Contract Monitoring Tool. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited but or recommendations made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority all of 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 Boys Town
Oviedo, Florida
Residential Program

February 3-4, 2021

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%
Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Reviewer

Members

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

Amanda Nelson - Department of Juvenile Justice

Raylene Coe – Crosswinds Youth and Family Services Inc.

Christine Morgan – Orange County Youth Shelter

Sebastian Roth – Youth and Family Alternatives Inc.

Quality Improvement Review

Boys Town – February 3-4, 2021
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 (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2020/January 2021).

Persons Interviewed

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

Documents Reviewed

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

Surveys

- **2** # Youth
- **23** # Direct Care Staff
- **0** # Other: _____

Observations During Review

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

Comments

Due to COVID-19, this review was conducted **on-site and virtually**.

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

Boys Town of Central Florida (Boys Town) is located in Oviedo, Florida. The program is an affiliate of its national non-profit agency Father Flanagan's Boys Home with headquarters located in the Village of Boys Town, Omaha, Nebraska. Boys Town provides a variety of services from its main campus as well as in the surrounding community. Services include: intervention and assessment; treatment family homes; in-home family services (IHFS); a national hotline; free online resources; parenting; project Safe Place; a comprehensive behavioral health clinic; and behavioral assessments. Community support services enable children and parents to tap in to a wide variety of resources from agency experts or through direct specialized services. The Boys Town National Hotline® (800-448-3000) is a free resource and counseling service that assists youth and parents 24/7, year-round, and nationwide. Boys Town Press® produces books, audio products, DVDs, display materials and other resources to assist children, parents, caregivers, educators, and other professionals. YourLifeYourVoice.org is a special website that enables and encourages teens to share their problems and concerns in positive ways and provides access to immediate help in a crisis.

Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides specialized services to youth who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). The youth census during the QI visit was 2 CINS/FINS and 5 DCF youth.

Boys Town is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through August 31, 2021.

The following programmatic updates and highlights since the last Quality Improvement review in October 2019 were reported to the QI team during the visit:

Successes

- After ceasing intakes for 45 days in 2020 (prep-time), shelter resumed services

with new intakes under partnership with DCF for quarantine purposes. First program in its region to receive new intakes.

- Development continues to meet the Demetree Match Challenge Criteria. The Challenge is $500,000.00; $166,666 yearly for three years and ends June 30, 2021.

- The Demetree Golf Classic was held on October 2, 2020. Despite the pandemic, the turnout was good and the agency raised $17k

- Agency secured $100,000.00 in Seminole County Cares funding due to unexpected expenses due to COVID 19. These expenses include, but are not limited to PPE, meals for youth during virtual schooling, facility upgrades for social distancing, remote technology needs, staff salaries relevant to new/enhanced services.

- Agency finalized MOU for Common Sense Parenting, Orange County, with St. Peter Carver Prison Ministries - $25,000.

- Margret and R. Parks Williams Foundation provide $10,000 in support of the Demetree Challenge and Sarasota Community Foundation provided $50,000 to assist with unexpected COVID-19 expenses.

- Despite COVID challenges, the agency surpassed fundraising target by $43k.

- Tijuana Flats provides 20% discount on meals ordered for the Family Home Program.

- All Family Home Program staff passed all of Boy Town's internal evaluation of program implementation.

- 5 youth graduated/obtained GEDs in 2020.

Obstacles

- COVID-19 pandemic introduced the need to comply with CDC recommendations which has resulted in implementing restrictive protocols that add to workload of staff. The organization is continuously providing resources and supports for staff to reduce burnout.

- COVID-19 caused some delays and changes in administrative tasks/processes as the focus shifted to managing youth behaviors and the safety of staff and youth. Both staff and youth have displayed flexibility and resilience during this time and everyone is making efforts to get back on track with any area that may have fallen behind.

- Fourth quarter fundraising events: 5k and tree lighting became “virtual events”.

Staff Updates

- In-Home Family Services staff are all trained to offer Common Sense Parenting.
- Family Home Program had 6 positions turnover. Four of the six remained within Boys Town.

Narrative Summary

Boys Town, located at 975 Oklahoma Street, Oviedo, FL 32765, is under the leadership of a management team that consists of an Executive Director, Senior Director of Program Operations, Psychiatrist, Program Support Coordinator, Clinical Support Coordinator, Shelter Program Director, and IHFS Director. At the time of the onsite visit, there were three vacant youth care staff positions pending offers and 1 administrative assistant position that was frozen. The program has not reported any major challenges, incidents, administrative review, or current external investigations.

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

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

Standard 2 has a total of ten indicators that relate to intervention and case management. One of the indicators – SNAP is not applicable as Boys Town is not a SNAP provider. Seven of the nine applicable indicators were rated satisfactory with no exceptions (2.01, 2.02, 2.04, 2.05, 2.06. 2.07, and 2.08) and two were rated satisfactory with exceptions (2.03 and 2.09).

Standard 3 has a total of seven indicators regarding shelter care. All seven indicators were rated satisfactory with no exceptions.

Standard 4, Mental Health and Health Services, is comprised of five indicators. Two of the five indicators were rated satisfactory with no exceptions (4.01and 4.04) and three were rated satisfactory with exceptions (4.02, 4.03, and 4.05).

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon Document Source For example: 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*
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 X NO (explain)** Provider has required policy and procedure IAP 19 for Background that was last reviewed and signed by the executive director (ED) on December 28, 2020.	
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 or the agency has provided an explanation to for staff hired with a non-passing/low score.	X					Boys Town uses the Hiring Manager Interview (HMI) pre-assessment tool to determine eligibility rating for employment that was implemented prior to the last onsite review October 9, 2019. An eligible pass rate for a youth care worker is a minimum of 26 and 24 for an In Home Consultant. The tool was utilized to screen 4 eligible new hires all of whom received passing scores.	
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	X					A total of five new staff were hired and one intern provided volunteer services since the last onsite QI visit. All six background screenings were initiated prior to hire/start dates with eligibility documented on the Clearinghouse results. No exemptions were applicable.	
Five-year re-screening completed every 5 years from initial date of hire	X					The program had seven eligible staff met the criteria for 5-year re-screening. All seven were re-screened and/or had valid retained prints in the clearinghouse.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed	X					The program had a signed and notarized Annual Affidavit of Compliance with Level 2 Screening Standards that was completed	

and sent to BSU by January 31st?						and notarized on January 8, 2019 and sent to the Background Screening Unit on January 12, 2021, prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Proof of E-Verify work authorizations were maintained in all five new hire files.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						**YES NO (explain) X** IAP 31/Standards of Conduct for Program Staff; FFBH #13275 Code of Ethics and Professional Conduct; IAP 5/CINS FINS I-21- Client Contact & Communication; IAP 22/CINS FINS Protocol 12 Grievance; All polices were signed by the Executive Director and approved on 1/14/2021	None of the current policies reviewed specifically addressed not depriving youth of basic needs such as food, shelter, clothing, security, and medical care.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Abuse Free Environment							
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	X					Reviewed policies and training materials. There is a code of conduct policy that employees acknowledge via signature onto the agency's "New Employee Orientation Acknowledgment and Professional Boundaries form, which, upon inquiry, reviewer was advised is maintained in each employees' file.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					The child abuse registry telephone number is visible to youth in the shelter and is posted in the common areas of the facility on the hallway walls leading into each gender-specific dorm.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					The abuse hotline number is reviewed with youth during intake.	
Management takes immediate action to address any incidents of threats or abuse	X					The provider's policy states management will take immediate action to address any excessive force, use of profanity by staff or physical or psychological abuse toward any youth. The agency's incident and grievance records did not contain any instances or complaints of staff threat or abuse of youth during the reporting period.	
Grievance Process							
Agency has a formal grievance process	X					There is a formal grievance process that is provided to youth at intake. Youth sign an	

						acknowledgement receiving the grievance policy.	
Locked box accessible to only management and available to youth in a common area	X					During tour of the facility, it was observed the grievance box was locked and available to youth in the common area of the dining room.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	X					According to policy and interview with the agency's shelter manager, no direct care staff handle grievance complaints. Only management have access to the locked grievance box and, if that manager is the subject of the grievance, it is handled by their superior.	
72-hour resolution requirement by management. If this does NOT occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution.	X					There were two youth grievances submitted during the reporting period and both were resolved the same date of submission. The program's Grievance Policy provides for resolution within 72 hours or written documentation for any delay.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES X NO (explain)** The provider has a policy and procedures IAP 21 that was approved and signed by the Executive Director on 1/14/2021.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
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	X					The reviewer was provided internal incident forms that show the program made at least 21 reports to CCC during the reporting period August 1, 2020–January 31, 2021. The CCC only accepted 7 of the incidents reported. The documentation provided by the program shows that a first attempt to report each of the 21 incidents occurred within 2 hours of learning of the matter to be reported. There were 2 staff Covid-19 positive test result incident reports accepted by the CCC where no internal incident report form was provided; however, the CCC report indicates timely reporting.	

The program completes follow-up communication tasks/special instructions as required by the CCC	X					There was documentation on 5 of the 7 accepted CCC incident reports during the reporting period (August 1, 2020 through January 31, 2021) that program staff completed follow-up communication tasks/special instructions as required by the CCC.	
Incidents are documented in the program logs and on incident reporting forms		X				There were 7 incidents timely reported to CCC during the reporting period (August 2020 – January 2021). Of those 7 Incidents accepted by the CCC, only one (#20205741) was noted in the program logbook. Of the 7 reported and accepted incidents, 5 were documented on the program's incident reporting forms as required by the indicator; however, the other 2, concerning staff Covid-19 positive test results, were not documented on the agency's incident reporting form or logbook for confidential reasons.	**Exception** Four incidents reported to CCC, related to missed medications, were not documented in the program logbook.
All incident reports are reviewed and signed by program supervisors/directors	X					All incident reporting forms provided by the program for the review period August 1, 2020 – January 31, 2021 were signed by a program supervisor or director.	
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 X NO (explain)** The provider has policies and procedures FFBH CINS/FINS Protocol 5 and IAP Protocol 37 that were approved and signed by the Executive Director on 1/14/2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*	X					The program's newly hired staff were all hired prior to January 1, 2021. According to the training files reviewed, all four completed the United States Department of Justice Civil Rights & Federal Funds training prior to December 31, 2020.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				Three of 4 program's new hires have documentation in their training files indicating completion of all their mandatory training within their first 120 days of employment as required prior to January 1, 2021. Although the agency provided new hire training records for the 4th new staff, prior to her transfer/hire into the CINS/FINS program, those former trainings could not be considered for this review.	**Exception** One of four new hire did not complete CIN/FINS orientation, Suicide Prevention, CINS/FINS Core, Youth Development, and Confidentiality training within 120 days of her CINS/FINS hire date which was prior to January 1, 2021**.**
All staff completes all mandatory Florida Network and SkillPro training during the first-year employment.	X					Three of the four new hires' training files contained certificates of completion for all of the mandatory Florida Network and Skill Pro training dated within their first year of employment. The fourth new hire still has nearly 6 months remaining in her first year of employment in the CINS/FINS program to complete Fire Safety and Cultural Humility training.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training			X			The program did not hire a non-licensed clinical staff during the review period.	
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).			X			The program did not hire a non-licensed clinical staff during the review period.	
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).*		X				Review of three in-service direct care staff training files showed that each had over 40 hours of mandatory refresher Florida Network, Skill Pro, DCF and in-service job-related training records; however, one of the three is missing a required fire safety course.	**Exception** One of the three in-service staff appears to be late on retaking Fire Safety training within the required timeframe.
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.	X					Each of the seven training files (4 new hires and 3 in-service direct care staff) contained a cumulative listing of all trainings/courses each employee had completed. The list is in completion date order and provides the course/training name and number of training hours earned. However, since the Skill Pro and Florida Network mandatory courses were combined into this master list, it was challenging to locate the requisite courses and come up with annual totals. Although a separate list of the required in-service Skill Pro courses completed was in each training file, it did not provide complete annual employee training hours tracking which is a requirement; thus necessitating a manual count of annual training hours. Each file reviewed contained certificates of completion for each Skill Pro and DCF training, as well as sign-in sheets for trainings attended.	**Exception** Trainings that are not completed in Skill Pro do not have an annual training hours tracking sheet as required per QI Standard 1.04 and requires a manual count of annual training hours.
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES** **NO (explain) X** Program has two policies in place: 1) protocol 16, (IAP 53) – Data Collection, and 2) protocol 6, (IAP 41) for Risk Management that were approved on 1/14/2021 and signed by the Executive Director.	The provider's current policy IAP 53 does not address data entry into JJIS and NetMIS within 3 business days of discharge, only intake is mentioned.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	X					Peer record reviews are conducted for the residential and non-residential CINS/FINS programs separately on a quarterly rotation basis by the record review committee. Peer record reviews were conducted quarterly by the Youth and Family Records Review and Service Review committee members for the 3rd and 4th quarter of 2020 and 2nd and 3rd quarters 2020 for the IHFS program.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					Risk management meeting minutes for the review period demonstrate activities and meetings held regarding compliance with licensing; abuse calls reported; grievances; safety holds; incidents/accidents; and	

						medication errors. The Safety Committee conducts monthly analysis of the data and submits the necessary documentation to QMC for discussion. Data is submitted to the Program Support Coordinator for compilation on a Risk Management Review report monthly.	
The program conducts an annual review of customer satisfaction data	**X**					Consumer Satisfaction Surveys are completed directly by CINS/FINS youth upon discharge and by the Home Campus in Nebraska. Survey results for Q4 2019 were rolled up into an annual consumerism report.	
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	**X**					Outcomes data for the program is monitored in a variety of ways and were observed to be included on the agency's Scorecard. Documentation and discussion of outcomes is included on the quarterly QMC meeting agenda as well as management meetings.	
The program conducts a monthly review of NetMIS data reports.	**X**					The IHFS program manager emails Netmis Data to the management team upon receipt from the Florida Network (FN). NETMIS data is reviewed on a monthly basis by the program directors who correspond mainly via email to communicate areas of performance met and/or deficient. Data is reviewed at management meetings and quarterly CINS meetings.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	**X**					Data reconciliation is resolved by the Administrative Assistant who reports status to the program manager upon completion.	
The program has a process in place to review and improve accuracy of data entry & collection	**X**					Data entered into JJIS and NETMIS is reviewed, compared, and assessed with contract compliance outputs, outcomes, and target populations. Boys Town conducts a diligent search prior to data entry to avoid duplication of records and to avoid errors, JJIS and NETMIS face sheets will be printed and compared for accuracy.	

						Data reconciliation is done upon receipt of information from the FN and is also discussed at quarterly QMC meetings and CINS Meetings.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**X**					The QMC meets to review all data areas including safety trends, evaluation trends, program updates, peer record review, data collection, audits, and committee updates. Corrective actions plans are implemented to address areas of concern which are also addressed at quarterly CINS team meetings.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**X**					Areas of concerns are identified and followed up with the program managers. The program support coordinator identifies issues that need to be addressed at these meetings and implements the PDCA process as needed. Evidence of discussion of the results of the surveys at the monthly QMC meetings is documented on the agendas.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES X NO (explain)** The provider has policies and procedures FFBH Policy #2600-Motor Vehicle Safety, CINS/FINS Protocol 2 and IAP Protocol 10 that were approved and signed by the Executive Director on 1/14/2021.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**X**					The program provided a list of agency staff approved by administrative personnel to drive clients in agency or approved private vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**X**					The agency maintains a photocopy of the valid Florida driver's license of each agency staff approved to drive clients. The program provided a list of agency staff covered under the agency's business insurance policy which matches the list of agency staff approved to drive clients.	
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	**X**					The agency policy "strives to have a third party (staff, youth, volunteer, and intern) in the vehicle as best practice" when transporting youth at all times. The policy does provide for exceptions in the event a 3rd party is not present in the vehicle while transporting.	

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		**X**				The agency's policy states, "if a third party cannot be obtained for transport, the client's history, evaluation, and recent behavior is considered." Furthermore, the policy requires evidence that the program director or supervisor is aware (prior to the transportation) and consent is documented accordingly. Such evidence is to be the supervisor approval and time of approval. Review of the vehicle transport logs revealed that in August 2020, the program performed 13 single youth transports and all were pre-approved by a supervisor. In September 2020, there were 11 single youth transports recorded, but only 3 were pre-approved by a supervisor. In October 2020, there were only 6 single youth transports and all were pre-approved by a supervisor. In November 2020, the agency performed 5 single youth transports and all were pre-approved by a supervisor. In December 2020, the agency logs reveal only 3 single youth transports and all were pre-approved, as were the 6 single youth transports logged in January 2021.	**Exception** In September 2020, the agency documented 11 single youth transports in its vehicle transportation log. Eight of those single youth transports lacked prior approval as indicated by the time supervisory approval was acquired.
The 3rd party an approved volunteer, intern, agency staff, or other youth	**X**					All of the non-single youth transportation records reviewed included staff or other youth as 3rd party in the vehicle.	
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.	**X**					The program maintains a vehicle transportation log for each vehicle where drivers identify themselves, note the date, time, mileage, number of passengers, purpose of travel and location, as well as any supervisory approval and the time of such approval.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES NO (explain)** The provider has policies and procedures CINS/FINS Policy I-7 and IAP Protocol 49 that were approved and signed by the Executive Director on 1/14/2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that	**X**					Program policies designate which staff will participate and/or attend the DJJ Advisory Board and Council meetings.	

includes minutes of the event or other verification of staff participation						The program provided meeting minutes/ announcements for DJJ Advisory Board Meetings held July 9, 2020 and September 10, 2020. The DJJ Advisory Board meeting for November 2020 was canceled per the notice provided by the agency. No materials were available for the January 2021 meeting at the time of this review. Email correspondence provided by the agency indicates that meeting minutes for the DJJ Advisory Board accompany the next quarterly meeting announcement. So, although only two meetings were held during the reporting period, this reviewer was able to verify program staff attendance at the meetings.	
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.	**X**					The program provided a list of 41 Outreach events it performed during the reporting period that indicated the date and description of outreach activity. The list did not provide the name or designation of staff attending, general location/site, materials provided, or identification as to whether the event was to increase community awareness (informational, educational, for youth or adults).	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**X**					The agency has policies in place to establish a referral process and maintain written agreements with other community partners. The reviewer reviewed a list of organizations with which the agency maintains such agreements.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES X NO (explain)** The Agency has policies and procedures IAP 2 and Central Florida Practice entitled CINS/FINS Screening Eligibility and Intake Assessment (effective 1/1/2021) in place for this indicator. IAP 2 was signed January 14, 2021 and approved by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries. If staff on duty cannot complete the	**X**					Five residential files were reviewed (3 closed and 2 open). Two of the five screenings did not have a date indicating when the screening was completed. However, the residential supervisor	

screening, an on-call supervisor is contacted and eligibility is determined within 30 minutes from initial inquiry.						provided emails showing timely dates when the screenings were completed by the shelter.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	**X**					Five community counseling files (2 closed and 3 open) were reviewed. All five files documented an eligibility screening within three days of referral.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**X**					All ten files documented the youth and parent/guardian received, in writing, available services options and rights and responsibilities	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**X**					All ten files also documented the youth and parent/guardian were provided information on possible actions occurring through involvement with CINS/FINS services and the grievance procedure.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES X NO (explain)** The agency has policies and procedures identified as IAP 50 and IHFS Protocol I-16, with an approval date of 1/14/2021 and signed by the ED.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Completion of Needs Assessment							
Shelter Youth: Needs Assessment initiated within 72 hours of admission	**X**					All five residential files included a Needs Assessment initiated within seventy-two hours of admission.	
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	**X**					All five community counseling files included a Needs Assessment initiated within two to three face-to-face contact after intake.	
Needs Assessment is conducted by a bachelor's or master's level staff member	**X**					All ten files had Needs Assessments that were conducted by a bachelor's or master's	

						level staff member. Staff degrees were listed on the staff roster	
Needs Assessment includes a supervisor's review signature upon completion	X					All ten files were signed by a supervisor upon review.	
Suicide Risk as a Result of the Needs Assessment							
Youth was identified with an elevated risk of suicide as a result of the Needs Assessment	X					Eight files were identified with an elevated risk of suicide as a result of the Needs Assessment.	
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	X					Eight files were referred for an Assessment of Suicide Risk conducted by staff under the direct supervision of a licensed mental health professional.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES X NO (explain)** The agency has policies and procedures FFBH I-10 and IAP 38 in place for this indicator. The policies and procedures were approved on 1/14/2021 by the ED.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case/Service plan is developed within 7 working days of Needs Assessment	X					All ten files reviewed documented a Service Treatment Plan developed within seven working days.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated		X				All ten Service Plans reviewed included individualized and prioritized needs and goals identified by the Needs Assessment, service type, frequency, location, person responsible, and target dates for completion. Of the ten files reviewed two community counseling files included actual goal completion dates. Five cases are still open in residential (2) and community counseling (3). Three residential files did not show completion dates due to youth discharging before target date. Five of the ten Service Plans reviewed had the signature of the youth, parent/guardian, counselor and supervisor, and include a date the Service Plan was initiated. Two residential files show the parent was sent the treatment plan via mail. One residential file was recently opened with notes indicating an upcoming review and one file does not have a youth signature due to youth refusing to sign.	**Exception** One Residential file was open for 3 weeks with no plan reviewed by parent. No follow up documentation of a review could be found.

						One community counseling treatment plan was not signed by counselor who no longer works for the agency and left prior to signing the plan. The notes indicated the counselor reviewed the plan with the parent.	
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	**X**					Six applicable files were reviewed with parent or child within the time frame. Reviews were conducted virtually and noted in 5 of the files. The youth/parent was not accessible despite attempts noted by staff for one case.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES X NO (explain)** The agency has policies and procedures IHFS I-14, IAP 51 (Mental Health Services); IAP 6 (Substance Abuse Education and Referral); IAP 40 (Discharge Plan); and Referrals to Community- Based Services/Youth Based Services policy has been identified as # 13525 in place for this indicator. The policies and procedures were approved on 1/14/2021 by the ED.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Counselor/Case Manager is assigned	**X**					All ten files reviewed were assigned a counselor/case manager.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family	**X**					Seven files establish referral needs and coordinated referrals to services based upon the ongoing assessment of the youth's/family's problems and needs, coordinated service plan implementation, monitored youth's/family's progress in service, and provided support to families. Five out of ten files were applicable and documented monitoring out-of-home placement. No files were applicable for referrals to case staffing committee or accompanying youth/guardian to court hearings and related appointments. Seven out of ten files referred the youth/family for additional services.	

7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit						All ten files provided case monitoring and reviews. Five of ten files provided case termination documentation. Three applicable closed files included 30/60 day follow up calls after exit.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**X**					The agency maintains a total of 19 written agreements with community partners including services for emergency shelter, runaway hotline, food, interpretation, behavioral health, mental health, and counseling. Six additional agreements are listed as pending.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES X NO (explain)** The agency has policies and procedures IAP 4 and IAP 43 in place for this indicator. The policies and procedures were approved on 1/14/2021 by the ED.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	**X**					All ten files reviewed documented coordination between the youth's presenting problems and the Needs Assessment.	
Shelter Program							
Shelter programs provides individual and family counseling	**X**					All 5 residential files indicated counseling sessions were included in treatment plan and provided.	
Group counseling sessions held a minimum of five days per week	**X**					Review of family meeting sessions held separately for the girls (July-December 2020) and boys (June 2020 – January 21, 2021) shows the program meets a minimum of 5 days/week with youth to provide life skills and education groups.	

Group counseling sessions consist of: a. Length of at least 30 minutes b. Opportunity for youth engagement c. Clear and relevant topic (informational/developmental/ educational) d. Clear leader or facilitator	X					The family meeting forms include subject matter, facilitators/staff present, purpose for presenting topic, date, and beginning and ending times. It appears youth are involved in selecting topics by being asked what subjects they want to discuss at the family meetings.	
Community Counseling							
Community counseling 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.	X					All five files showed interventions offered to the family to stabilize the home.	
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	X					All five files documented counseling services in accordance with the case/service plan.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	X					All case files are maintained separately and adhered to confidentiality of client records	
Case notes maintained for all counseling services provided and documents youth's progress	X					Case notes were maintained in all files indicating the youth's progress	
On-going internal process that ensures clinical reviews of case records and staff performance	X					The supervisor has an ongoing internal process that ensures clinical reviews of case records and staff performance. All files indicated reviews were conducted with supervisor as evidenced by signatures on key assessments completed by staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES X NO (explain)** The agency has procedures effective 4/2/18 labeled as Central Florida Practice for Case Staffing that is not governed by a policy or signed. A review of the procedures shows they address the requirement of the indicator.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		

Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days			X			Two case staffings were held during the review period. The staffings were initiated by the CINS provider and not the parents in both cases.	
The youth, family and case staffing committee are contacted within a minimum of five working days a. Notification to youth/family no less than 5 working days prior to staffing b. Notification to committee no less than 5 working days prior to staffing	X					All parties were notified via email more than five working days prior to the staffing.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					DJJ representative, CINS provider and school representative were present for the two staffing dates.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	X					In addition to the case staffing committee, a DJJ attorney and DCF representative were present for the two staffing dates.	
The program has an established case staffing committee, and has regular communication with committee members	X					The program has an established case staffing committee and maintains communication with the members predominantly via email.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					Internal procedures including notifications, meeting agenda, and form for committee recommendations were shown along with a schedule for both staffing dates.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	X					In both staffing dates, the family was provided a new plan of services.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and	X					The family in both staffing dates were provided a written report outlining recommendations.	

reasons behind the recommendations							
If applicable, the program works with the circuit court for judicial intervention for the youth/family			X			Staffing did not lead to court intervention.	
Case Manager/Counselor completes a review summary prior to the court hearing			X			No summary was needed.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES X NO (explain)** The agency has a written policy and procedure IAP 27 that was approved on 1/14/2021 by the ED.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
All records are clearly marked 'confidential'.	X					All files reviewed in virtual platform were clearly marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X					During tour of facility it was observed files are kept in a secured locked room in black file cabinets marked confidential with the ability to lock the cabinet.	
When in transport, all records are locked in an opaque container marked "confidential"	X					When files are in transport they are placed in an opaque locked container that has a lock and is marked confidential.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					Files appeared to be neatly organized and maintained in a consistent order with section dividers separated by cover pages that list the content of each section.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES X NO (explain)** The agency has a written policy and procedure IAP 54 that was approved on 1/14/2021 by the ED.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
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			X			Per the residential and community counseling program directors, the program has not served any SOGIE youth since the last onsite QI visit.	
Youth in need of specialized support is referred to qualified resources (as applicable)			X			Per the residential and community counseling program directors, the program	

						has not served any SOGIE youth since the last onsite QI visit.	
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			X			Per the residential and community counseling program directors, the program has not served any SOGIE youth since the last onsite QI visit.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			X			Per the residential and community counseling program directors, the program has not served any SOGIE youth since the last onsite QI visit.	
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	X					During the virtual tour, LGBTQ information was observed to be posted on wall in each youth dorm, hallways, and in common areas of the facility. The four new staff received FN SOGIE training evidenced by training certificates. Program has LGBTQ pamphlet from National Runaway Safeline and the FN Zine brochure to distribute to youth and family as needed.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES X NO (explain)** The agency has a written policies and procedures Staff Secure and Special Populations policy IAP 26 and CINS/FINS Protocol 15 addressing Family and Youth Respite Aftercare Services (FYRAC) that were approved on 1/14/2021 by the ED.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Staff Secure							
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** **X**	**N/A**			The program has not served any Staff Secure youth since the last onsite QI visit and has no eligible items for review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on	X					Staff secure policies and procedures were found to address the requirement of the indicator.	

control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare							
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services			**X**			The program has not served any Staff Secure youth since the last onsite QI visit and has no eligible items for 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			**X**			The program has not served any Staff Secure youth since the last onsite QI visit and has no eligible items for review.	
Agency provides a written report for any court proceedings regarding the youth's progress			**X**			The program has not served any Staff Secure youth since the last onsite QI visit and has no eligible items for 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** **X**	**N/A**				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements			**X**			The program has not served any DMST youth since the last onsite QI visit and has no eligible items for review.	
Services provided to these youth specifically designated services designed to serve DMST youth			**X**			The program has not served any DMST youth since the last onsite QI visit and has no eligible items for 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?			X			The program has not served any DMST youth since the last onsite QI visit and has no eligible items for 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.)			X			The program has not served any DMST youth since the last onsite QI visit and has no eligible items for 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			X			The program has not served any DMST youth since the last onsite QI visit and has no eligible items for review.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements			X			The program has not served any DMST youth since the last onsite QI visit and has no eligible items for 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** **X**	**NO**	**N/A**				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
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	**X**					Three applicable closed Domestic Violence (DV) Respite files were reviewed. All three files had pending DV charges, were screened by JAC, and did not meet criteria for secure detention.	

Data entry into NetMIS and JJIS within (3) business days of intake and discharge		**X**				Reviewed NetMIS data entry lag and JJIS prevention service record for 3 DV youth records reviewed. Data entry lags were observed.	**Exception** Per NetMIS data entry lag report, intake and discharge lags were observed for all 3 DV youth files reviewed. Entry lag was 1 day for 1 youth and 2 days for 2 youth. Exit lag was observed as 1 day for 2 youth and 7 days for one youth. JJIS for one youth (8/18/2020-9/8/2020) did not show local shelter discharge. During the QI review the program realized the residential intake was not entered in JJIS and required JJIS support which was subsequently resolved on 2/8/2021. Consequently, the data exit timeframe is late for this youth.
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.	**X**					The length of stay did not exceed 21 days in the DV program for the 3 youth but 2 of the 3 youth transitioned to CINS/FINS when they had reached the cap for DV. Documentation in the file showed the youth were transitioned to CINS/FINS.	
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	**X**					All 3 case plans reflected goals that were appropriate such as aggression management, coping skills, and communication.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**X**					All other services provided to DV youth were found to be consistent with the general CINS/FINS program service requirement.	
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** **X**	**N/A**				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

All probation respite referrals are submitted to the Florida Network.			X			The program has not served any probation respite youth since the last onsite QI visit and has no eligible items for review.	
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status			X			The program has not served any probation respite youth since the last onsite QI visit and has no eligible items for review.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge			X			The program has not served any probation respite youth since the last onsite QI visit and has no eligible items for review.	
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)			X			The program has not served any probation respite youth since the last onsite QI visit and has no eligible items for review.	
All case management and counseling needs have been considered and addressed			X			The program has not served any probation respite youth since the last onsite QI visit and has no eligible items for review.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements			X			The program has not served any probation respite youth since the last onsite QI visit and has no eligible items for review.	
Intensive Case Management (ICM)							
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** **X**			The program is not contracted to provide Intensive Case Management services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth receiving services was court ordered or referred by case staffing committee					X		
Services for youth and family include: a. Four (4) direct contacts per month b. Four (4) collateral contacts per month					X		
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14					X		

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)							
Case plan demonstrates a strength-based, trauma-informed focus					**X**		
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					**X**		
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** **X**	**N/A**				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating			**X**			The program has not served any FYRAC youth since the last onsite QI visit and has no eligible items for review.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office			**X**			The program has not served any FYRAC youth since the last onsite QI visit and has no eligible items for 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			X			The program has not served any FYRAC youth since the last onsite QI visit and has no eligible items for 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			X			The program has not served any FYRAC youth since the last onsite QI visit and has no eligible items for 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			X			The program has not served any FYRAC youth since the last onsite QI visit and has no eligible items for 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			X			The program has not served any FYRAC youth since the last onsite QI visit and has no eligible items for review.	
2.10: STOP NOW AND PLAN (SNAP)							

Provider has a written policy and procedure that meets the requirement for Indicator 2.10						**YES NO (explain) N/A X** **Boys Town is not a contracted SNAP provider.**	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
SNAP Clinical Groups							
Youth are screened to determine eligibility of services					**X**		
Needs assessment is completed at initial intake, or within two face-to-face sessions					**X**		
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post) d. Prevention Assessment Tool (PAT) (pre & post)					**X**		
SNAP discharge report summary					**X**		
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form					**X**		
SNAP Boys/SNAP Girls **Child** Group Evaluation Form					**X**		
SNAP in Schools							
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
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)					**X**		
"Class Goal" sheet					**X**		

Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.					X		
Pre and Post Evaluations					X		
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox					X		
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES X NO (explain)** There are several policies in place to ensure a shelter environment that is safe: IAP 52, Shelter Services; IAP 32, Fire Drills; IAP 23 Recreational and Cultural Enrichment Activities; IAP 10 Vehicle Maintenance, Use and Transportation of Youth; IAP 20 Flammable, Poisonous and Toxic Control; IAP 17 Fire Prevention; IAP 9 Control and Use of Keys; IAP 46 Emergency/Disaster Preparedness; IAP 12 Meals. All of the policies were approved by the ED on 1/14/2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection	X					The virtual tour of the facility showed a safe, clean and well maintained building and grounds. There was no graffiti on the walls, lighting was adequate and garbage cans were covered. All door to the facility were limited to staff members with key control and secured access. Both vehicles were locked upon inspection only one van was equipped with safety equipment including first aid kit, fire extinguisher, flashlight, glass breaker, seat belt cutter and air bag deflator. There were boards in each dorm hallway displaying grievance forms, abuse hotline information general client rules, daily schedule as well as activities for the month. The egress maps were located in both dorm	

						hallways as well as the dining area. All chemicals were listed and approved for use and MSDS sheets for each one. Washer and dryers were operational and free of clutter and lint. The dorm rooms were clean, each bed had a clean linen, blanket and pillow. There is a locked closet available with bins to keep youth's belongings in. The agency's DCF license is issued for 18 beds effective through December 4, 2021 and is displayed in the staff office.	
Fire and Safety Health Hazards	**X**					Date of fire inspection(s) reviewed: The annual fire inspection was completed 9/18/20 with no violations for the administrative office and shelter. Fire drills were completed on the following days: July 2, 8 and 14; August 7(2 drills conducted), and 15; September 10, 17 and 18; October 12, 14 and 16; November 13, 20 and 22; December 20 and 25. Mock emergency drills were completed for the following dates and shifts: 7/2 (3rd shift) 7/8 (1st Shift) 7/21 (2nd Shift) 8/7 (1st shift) 8/15 (2nd shift) 9/10 (3rd shift) 9/17(2nd shift) 10/12(1st shift) 10/14(3rd shift) 11/13(1st shift 11/20(2nd shift) 12/25 (3rd shift). There were 2 extinguishers in each dorm 2 in the kitchen and 2 in the dining area. All fire extinguishers were inspected 12/2020 and good for one year. The sprinkler system was inspected 6/12/2020 and 12/20/2020. The fire alarm was inspected 12/11/2020. The kitchen overhead hood was cleaned and inspected on 2/28/2020. Health and Food inspections were observed posted in the kitchen with dates of 11/20/2020. The refrigerator and freezer were clean and well maintained with temperatures as follows: fridge Temperature 40 degrees, freezer Temperature 0 degrees.	
Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days	**X**					Activity and daily schedules are posted in both the dorm hallways. According to these postings the youth are engaged in structured activities and idle time is minimal. Physical education is offered each day at 10:30am for youth. All youth	

a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. 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. d. 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. e. Daily programming schedule is publicly posted and accessible to both staff and youth.						are provided faith-based activities with non-punitive activities offered for youth who do not choose to participate each week. Youth have 2 hours and 15 minutes each weekday they can use for homework or reading.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES X NO (explain)** The program has policies and procedures in place IAP 2 Program Orientation and IAP 42 Classification; both were approved by the ED on 1/14/2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth received a comprehensive orientation and handbook provided within 24 hours	**X**					A total of three files were reviewed, two closed and one open. Each file included an orientation checklist that was signed by youth and staff within 24 hours of admission.	
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	**X**					All three files reviewed demonstrated that youth received a handbook and comprehensive orientation was conducted upon intake to include list of contraband, disciplinary action, dress code, review of access to mental health services, visitation mail and telephone procedures, grievance procedure, disaster preparedness instructions, tour of facility, room	

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						assignment, and suicide prevention information.	
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	**X**					All three files (two closed and one open) reviewed contained documentation of each orientation topic which is dated and signed/initialed by youth and staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES X NO (explain)** Program has a policy and procedures in place IAP 42 – Classification, that was approved by ED on 1/14/2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
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,	**X**					A review of three files, two closed one open, shows the program demonstrates that youth are protected through a classification system that ensures an appropriate sleeping room assignment. All classifications as outlined by the CINS/FINS standards have been demonstrated.	

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 j. Sexual orientation gender identity/ expression k. Acute health symptoms requiring quarantine or isolation							
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	**X**					Three files, two closed and one open, were reviewed. All three contained mental health and medical alerts for the youth dated the same day as intake.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES X NO (explain)** The program has a policy and procedures for Logbook - IAP 11, approved by the ED on 1/14/2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**X**					In reviewing the logbook entries for 4 randomly selected weeks during the review period, information that could have an impact on the safety and security of the youth and/or program were highlighted.	
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	**X**					A review of the logbook entries for weeks (female) 11/29, 10/11, 11/22 and male 10/11 showed all entries were brief, legible, and written in ink. All entries included date, time, name of staff or youth involved and a brief statement giving pertinent information. All entries were signed by the person making them.	

• Brief statement providing pertinent information • Name and signature of person making the entry							
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.	X					All errors were struck through with a single line and the staff initialed and dated the correction. There was no indication of white-out or erasures present in the reviewed timeframe.	
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	X					In the review of the logbook entries for the selected weeks, the program director reviewed the logbook weekly and made chronological notes indicating the dates of the review, any corrections, recommendations or follow up that was required. The entries were signed and dated.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	X					Staff signed entries that they reviewed the logbook indicating the dates reviewed back to their previous shift.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	X					Oncoming supervisors and shelter counselors reviewed the logbook of all shifts since their last log entry. These entries are signed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	X					A head count and alerts of each youth are documented in the logbook at the beginning of each shift. All youth who are off campus are also noted in the logbook at that time.	

Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES X NO (explain)** The program has a policy and procedures for Behavioral Redirection and Safety Holds, IAP 39, approved by the ED on 1/14/2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program has a detailed written description of the BMS, and it is explained during program orientation	**X**					The program has a detailed written description of the Behavior Management System, which is explained, and a copy given to parent and youth during orientation.	
Behavior Management Strategies MUST include: a. Supervisors are trained 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 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	**X**					Staff and supervisory staff engage in motivational system overview and point card mechanics training. They are also trained in observing and describing behaviors and non-crisis intervention. The application of all behavioral interventions is applied immediately and reflect the severity of the behavior. The BMS utilizes a wide variety of incentives to encourage the youth to participate and complete the program. The use of Behavior Management strategies such as positive incentives and appropriate interventions are used to teach youth new behaviors and help youth understand the natural consequences for their action. The use of physical intervention is used as a last resort and staff are trained in Crisis Prevention Intervention, approved by the Florida Network, yearly. The staff of the program do not impose group discipline and do not allow anyone else to discipline youth. The use of room restriction is not used as part of the Behavior Management System.	

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						Youth are never denied basic rights such as meals, clothing, sleep, services, exercise or correspondence privileges as part of a consequence.	
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	**X**					Seven training files were reviewed: three new hires two supervisory staff and two Family Teachers. All seven were trained in behavior awareness as well as the Behavior Management System.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**X**					Feedback and evaluation of staff regarding their use of BMS rewards and consequences are given during staff meetings, yearly evaluations and immediately if needed.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**X**					Two supervisor training files were reviewed and both were trained to monitor the use of rewards and consequences by their staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES X NO (explain)** The program has a policy and procedures IAP 18, Security Youth Counts and Staff Ratios, that was approved by the ED on 1/14/2021.	
Rating Criteria	**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	**X**					The agency maintains a minimum staffing ratio required by Florida Administrative Code and contract of 1 staff to 6 youth during awake hours and community activities and 1 staff to 12 youth during sleep hours.	

• 1 staff to 12 youth during the sleep period							
All shifts must always provide a minimum of two staff present	X					Six months of staff schedules (7/1/2020 to 12/31/2020) were reviewed. A minimum of two staff is always scheduled on each shift for the period reviewed.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	X					The staff schedules only included youth care staff hired and trained for youth supervision.	
The staff schedule is provided to staff or posted in a place visible to staff	X					The staff schedule is posted in the youth care office and visible to staff.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	X					The program director has a roster which includes home telephone numbers of staff who are available when additional coverage is needed. This is kept in the youth care office.	
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	X					Bed check logs for 8/30/20, 9/5/20 on male checks and 10/15/20 and 12/29/20 for female bed checks were reviewed. Video and logbook entries were checked and matched for the following dates and times: Male dorm 1/6/21 from 12am to 2am; 1/23/21 from 4am to 6am and 2/1/21 from 3am to 5am; Female dorm 1/10/21 from 2am to 4am and 1/29/21 from 1am to 3am. There were no inconsistencies in documentation of bed checks and all checks were done within a 15-minute timeframe. On each wing, each bedroom has two beds, with the exception of one room that has three beds.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES X NO (explain)** The program has a policy and procedures # 13950 for Video Monitoring that was approved by Boy's Town Corporation as of 1/1/21.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

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 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	**X**					A written notice is posted conspicuously in the dining room stating that the building and property are recorded for safety. The video system can capture and retain video photographic images which are stored a minimum of 30 days. The system records date, time and location while maintaining resolution that enables facial recognition. There is a back-up to keep the cameras' ability to operate consistently during a power outage. Cameras are visible and placed in interior and exterior locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are not placed in any sleeping quarters or bathroom.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**X**					Only the I&A program director has access to the video surveillance system.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**X**					The program director reviews cameras daily and documents the timeframe and any comments in a separate logbook. All entries are dated and signed. The reviews include a random sample of overnight shifts as well as daytime activity.	
Grant the requesting of video recordings to yield a result within	**X**					The program has a policy in place which ensures that requests from program quality	

24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident						improvement visits or as the result of an investigation due to an allegation of an incident will be granted within 24-72 hours from request.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**X**					The program has a policy in place which requires all efforts be made to obtain repairs when camera malfunctions or becomes inoperable. All efforts made must be documented and maintained.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES X NO (explain)** IAP Protocol 28 was revised on December 28, 2020 and approved by the Executive Director on January 14, 2021 addressing the requirements outlined in the indicator.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Preliminary Healthcare Screening							
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. **g.** Observation for presence of scars, tattoos, or other skin markings **h.** Acute health symptoms requiring quarantine or isolation	**X**					Two closed files and two open files were reviewed. All four youth were on medications. Two of the four youth had asthma, two out of four had allergies, and none had recent injuries or illnesses, presence of pain or other physical distress at the time of admission. There was no observation of illness, injury, pain or physical distress for any of the youth reviewed. Three of the four youths had scars, tattoos or other skin markings; the other youth did not. Two youths had a chronic medical condition (asthma). No youth reviewed had a head injury in the previous two weeks.	
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.)	**X**					Two youth had previous chronic medical condition (asthma) documented and did not need referral/follow-up as they were already receiving medical care. One youth had a follow up previously scheduled psychiatrist appointment which the parent	

						helped facilitate via zoom while youth was at the shelter.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	X					The parent was involved with the coordination and facilitation of a psychiatric appointment while her child was receiving shelter care.	
All medical referrals are documented on a daily log.	X					The program documents doctor's appointments and other medical referrals in the program logbook.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	X					The program has a procedure including a thorough referral process and mechanism for necessary follow-up medical care for youth admitted with chronic medical conditions.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES X NO (explain)** The program has an At Risk Screening and Assessment policy, IAP Protocol 5, which revised on December 28, 2020 and signed by the ED on January 14, 2021	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Suicide Risk Screening and Approval							
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.	X					Two closed and two open residential files were reviewed. All four youth received a suicide risk screening during the initial intake and screening process and the results were reviewed and signed by the supervisor and documented in the youths' files.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The program uses the SPS assessment of suicide risk tool that is approved by the Florida Network.	
Supervision of Youth with Suicide Risk							
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	X					All four youth were placed on constant sight and sound, the appropriate level of supervision, based on the results of the suicide risk assessment. One youth was later stepped up to one-on-one supervision by a master's level staff.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals		X				All four youth placed on constant sight and sound had observation logs reflecting staff documented youths' behavior, activities, etc. at least once every thirty minutes. However, some sections of the observation	**Exception** Some of the observation logs were missing dates, times (am or pm), and staff signatures as well as

						logs were not consistently fully completed to include: staff or supervisor signatures, dates, and am/pm on times.	missing supervisory authorization signatures on some of the logs.
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		**X**				In three of the four files the youth was stepped down to precautionary monitoring by a master's level staff until removed with the recommendation of. The remaining youth was initially placed on sight and sound at intake when suicide risk was determined upon completion of the Child Suicide Risk Assessment; however, the master's level staff did not review the suicide risk assessment within 24 hours as required. Youth was stepped up to one-on-one supervision when upon review by the master's level staff and consultation with licensed professional.	**Exception** For one of the four youth records, the master level therapist did not review the suicide risk assessment within the 24 hours of suicide risk screening results as required.
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES X NO (explain)** Medication Storage, Access, and Distribution policy and protocol, IAP Protocol 13, was revised on December 28, 2020 and signed on January 14, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications **d.** 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	**X**					The program maintains the youth prescription medications, narcotics, controlled medication, as well currently used over-the-counter medications all separated in the Pyxis Medication Station in single locked containers which are only able to be opened when an authorized user uses their fingerprint to open the cart for a specific medication to distribute or inventory. The Pyxis machine is located in a locked room accessible only to authorized staff. Oral and topical medication is stored in separate containers in the Pyxis Medication Station. The program had a locked medication refrigerator, which was currently empty and is only being used for medications; the temperature was forty degrees Fahrenheit, within the required storage temperature. The nurse confirmed there have been no	

F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) **e.** Narcotics and controlled medications are stored in the Med-Station						refrigerated medication since she started working at the facility in March 2020.	
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	**X**					The program maintains four Super Users for the Med-Station (program director, nurse, one senior youth care worker, and one youth care worker). Only authorized staff have access to secure medication and access to controlled substances (narcotics) is witnessed by a second staff. A Medication Distribution Log is used for distribution of medication by non-licensed and licensed staff. Two closed files and two open files were reviewed. All four youth had medications and a medication distribution log for each medication they received. In all four records the medication delivery process was consistent with the FNYFS medication management and distribution policy. When on site (Monday-Thursday 3pm-8pm), the nurse conducts medication processes. When not on-site certified staff dispense medication. The program does not admit youth with injectable medications, other than epi-pens. None of the youth reviewed had any injectable medications prescribed. Staff received Epi-Pen training from nurse on 10/27/20. All sharps/syringes are kept in the Pyxis and once used is disposed of in a red sharps container.	
Medication Inventory							
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	**X**					Two youth had controlled substances prescribed and both had a perpetual inventory with running balances maintained. In all four records, shift-to shift counts were 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						Over-the-counter medications are inventoried perpetually as accessed and are also inventoried weekly.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.		**X**				Super Users for the Med-Station (program director, nurse, one senior youth care worker, and one youth care worker) are all capable of running monthly knowledge portal reports; however, at the time of the onsite visit, no documentation was provided to support there are monthly reviews of medication management practice via knowledge portal.	**Exception** The program was unable to demonstrate if monthly reviews of medication management reports were conducted.
Medication discrepancies are cleared after each shift.	**X**					The program conducts daily clearing of medication discrepancies.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES X NO (explain)** Medic Alert Process and Medical/Mental Health Follow-up policy and protocol, IAP Protocol 3, was revised on December 28, 2020 and signed on January 14, 2021 by the Executive Director addressing the requirements outlined in the indicator.	
Rating Criteria	**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	**X**					Four residential youth files were reviewed. All four youth had mental health alerts at the time of admission, as well as two allergies. They were appropriately placed on the alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**X**					The alert system includes precautions concerning prescribed medications and medical/mental health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**X**					All 7 training files reviewed demonstrate staff are trained in CPR/First Aid to recognize/respond to the need for emergency care and also receive training to recognize/respond to the need for mental health problems.	

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	X					The program has an alert board in the shelter's front office and when applicable alerts are documented including other essential information pertaining to the youth. The board is inaccessible to youth in the shelter. Observation of the alert board reflected all alerts were accurate and up-to-date.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES X NO (explain)** First Aid and Episodic/Emergency Care policy and protocol, IAP Protocol 16, was revised on December 28, 2020 and signed on January 14, 2021 by the Executive Director addressing the requirements outlined in the indicator.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
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	X					Three closed files were reviewed. In all three files no youth was taken off-site requiring medical care, and the incident report was submitted. The three files did reflect instances of episodic care. All episodic care incidents were located on an episodic log. Parent/guardian notification occurred in two out of three episodic incidents reviewed.	**Exception** Parent/guardian notification did not occur for one of the three episodic emergency care incidents that occurred on 11/23/20.
All staff are trained on emergency medical procedures	X					All seven training files reviewed show staff are trained on emergency medical procedures and Epi-Pen training.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					The program has two knife for life and wire cutters; one in the front office next to the alert board and one in boys' file room. The program has three first aid kits with current supplies: two for the transport vehicles and one in medical office.	

First aid kit/supplies are fully equipped and inventoried	X					First aid kits are inventoried weekly and were fully equipped during the QI visit.	