FLORIDA NETWORK
*of youth and family services*

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

## Florida Keys Children Shelter
**Jelsema Shelter**

73 High Point Road
Tavernier, FL 33070

**Compliance Monitoring Services Provided by**

FOREFRONT

## EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the Florida Keys Children's Shelter (FKCS) for the FY 2020-2021 at its program office located at 73 Highpoint Road, Tavernier, 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. FKCS 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 Reviewer(s). Agency representatives from FKCS present for the entrance interview were: Ben Kemmer, CEO; Alvin Bentley, COO; Alana Corradi, Residential Coordinator; Katherine Raskob, Counseling Services Coordinator; Erin Flannery, Residential Counselor; Madison Nielson, CBC Counselor; and Katya Andrade, Office Manager. The last onsite QI visit was conducted November 20-21, 2019.

In general, the Reviewer found that the FKCS is in compliance with specific contract requirements. **FKCS received an overall compliance rating of 100% for achieving full compliance with all twelve (12) applicable indicators** of the CINS/FINS Monitoring Tool. One of the indicators was rated Not Applicable because the provider does not have any program inventory or recent computer purchases made with DJJ funds. There are no corrective actions cited or recommendations made as a result of the contract 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 01-20-2020-2021

| | |
|---|---|
| **Agency Name: Florida Keys Children Shelter** | **Monitor Name: Marcia Tavares, Lead Reviewer** |
| **Contract Type : CINS/FINS** | **Region/Office: 73 High Point Rd., Tavernier, FL 33070** |
| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): January 20-21, 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**<br>a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested. | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: The provider currently has four certified DJJ-QI Peer Reviewers: Ben Kemmer, Alvin Bentley, Katherine Raskob, and Paivi Johnson. Ms. Johnson has already participated in a QI Review for the FY 2020-2021 and additional staff is also scheduled to participate prior to the end of the FY. | |
| **Additional Contracts**<br>a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: A list of fourteen additional contracts for FY2020-2021 was provided for funding from federal, state, and county government. The provider receives funding from DCF (for residential/group home services), DHHS-Basic Center grant, DHHS-Street Outreach grant, Monroe County, State of Florida Nutrition, Sheriff Shared Asset, All Stars Program, Guidance Clinic, United Way, Keys Children's Foundation, Katherine Wells Foundation, ORC Foundation, Community Foundation, | |

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| | | | | | | and Helen's Hope Foundation. The listing includes: name of program, description of services, amount funded, source, and date.<br><br>The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed were active. | |
| **Limits of Coverage**<br>a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as 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- | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation:<br>General Liability through Beazley Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, effective 3/1/20-3/1/21<br><br>Workers Compensation through Ascendant Commercial Insurance Company with limits of $100,000 each and $500,000 policy limit, effective for 4/30/20 through 4/30/2021.<br><br>Automobile insurance through Progressive American Insurance company for combined limits of liability/property damage for | |

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| $10,000 per person. Florida Network is listed as payee or co-payee. **PTV** | | | | | | $1,000,000. Policy effective for 3/1/20-3/1/21.<br><br>Florida Network is listed on the Insurance Certificate as certificate holder. | |
| **External/Outside Contract Compliance**<br>a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Interview: During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by any external funding sources. | |
| **Fiscal Practice**<br>a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Fiscal Policies and Procedures are contained in the agency's Accounting Policy and Procedures Manual with a review date of May 2, 2019. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for: general accounting procedures including general ledger and computer back-up; cash management procedures: accounts receivable; payroll; property, plant, and equipment procedures; accounts payable; procedures for liability; and management reporting. | |

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|---|---|---|---|---|---|---|---|
| b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Detailed General Ledger for the current FY, for the period July 2020 – December 31, 2020. The agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program. The GL includes the following items: type of transaction, date, account number, name, memo, split, amount, and balance. | |
| 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** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Reviewed petty cash Policy and Procedure 2.03 which is included in the Fiscal Policies and Procedures manual. The fund which does not exceed $500 is utilized for purchases under $50 unless approval is granted by Management. Petty cash is stored in a safe in the Residential Coordinator's office. The fund is reconciled weekly and submitted to the Executive Administrative Assistant/Human Resources for refunding. Disbursements and invoices are approved by the residential program coordinator. | |

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| d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Reviewed Bank Statements and Bank Reconciliations for July- December 2020 for the program's operating account and Cash/Bank Savings account held with Centennial Bank. Bank reconciliations are conducted by the Finance Manager each month for the activities and bank statements for the preceding month. The bank statements were all found to be reconciled consistently within six weeks of receipt and were signed by the CEO and COO. Financial Statements are reported monthly and were found to be current. Checks disbursed are signed by two designees. Invoices are submitted monthly with supporting documentation. The agency maintains individual vendor files which are kept in secure file cabinets in the Executive Admin Assistant's office. | |
| e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an | ☐ | ☐ | ☐ | ☐ | ☒ | **Not applicable**<br>No DJJ inventory | |

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| Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE** | | | | | | | |
| f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Provider contracts with ADP for its payroll services. Electronic filings of the 1099 Tax Return and 941s are conducted by ADP. The most recent 941 filings for the 2nd and 3rd quarters of 2020 were reviewed. The 941 reports demonstrate that the provider is submitting its payroll taxes as required in a timely manner with no balances due indicated on the returns. | |
| g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Agency's budget to actual report for the period July 1-January 13, 2021 was reviewed. The reports demonstrate that the provider tracks budget variances for the CINS/FINS program separately on a monthly basis. Variance to date indicates a net income in the program. Financial reports are sent to the Board Treasurer monthly for review and the CEO/Finance Manager presents the same at the agency's Board meetings. Meeting minutes and agendas demonstrate this practice. | |

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| 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: The most recent completed Financial Audit was reviewed. Accounting firm, Verdeja, DeArmas, Trujillo issued a letter on 12/18/20 stating they reviewed the provider's accounting policies and found them to be adequate. The financial audit was completed for the year ending 6/30/2020 and 2019. The audit disclosed no matters that are reportable for the current year. A copy of the financial audit is on file with the Reviewer. | |
| i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Policy and Procedure number: 1.17 (Confidentiality-HIPAA), E.2 (Confidentiality), 1.04 (Computer Back-Up), and 8.04 (Record Retention) were reviewed. Daily back-ups are made to keep data back-up current and monthly offsite storage of the back-up disk is maintained be the CFO during ordinary circumstances. | |

## CONCLUSION

FKCS has met the requirements for the CINS/FINS contract as a result of full compliance with all twelve (12) applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One (1) of the thirteen (13) indicators was rated Not Applicable because the provider does not have any program inventory or recent computer purchases made with DJJ funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited 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 of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

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

# Florida Network of Youth and Family Services
# Quality Improvement Program Report

Review of Florida Keys Children's Shelter

Tavernier, Florida

Residential Program

January 20-21, 2021

**Compliance Monitoring Services Provided by**

FOREFRONT

## Quality Improvement Review

Florida Keys Children's Shelter- January 20-21, 2021
Lead Reviewer: Marcia Tavares

# 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 | Limited |
| 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: 88.89%**
**Percent of indicators rated Limited: 11.11%**
**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 | Limited |
| 3.07 Video Surveillance System | Satisfactory |

**Percent of indicators rated Satisfactory: 85.71%**
**Percent of indicators rated Limited: 14.29%**
**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 | Limited |
| 4.04 Medical/Mental Health Alert Process | Satisfactory |
| 4.05 Episodic/Emergency Care | Satisfactory |

**Percent of indicators rated Satisfactory: 80.00%**
**Percent of indicators rated Limited: 20.00%**
**Percent of indicators rated Failed: 0.00%**

## Overall Rating Summary

**Percent of indicators rated Satisfactory: 89.29%**
**Percent of indicators rated Limited: 10.71%**
**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

Paula Friedrich - Department of Juvenile Justice

Lashonda Chavis – Miami Bridge Youth and Family Services Inc.

Kali Fabal – Lutheran Services Florida Southeast

Mary Williams – Center for Family and Child Enrichment

**Quality Improvement Review**

Florida Keys Children's Shelter- January 20-21, 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 21).

## 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
- **2** # Program Supervisors
- **0** # Food Service Personnel
- **1** # 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
- **3** # MH/SA Records
- **11** # Personnel /Volunteer Records
- **8** # Training Records
- **21** # Youth Records (Closed)
- **10** # Youth Records (Open)
- _ # Other:

## Surveys

- **1** # Youth
- **11** # 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 **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

Florida Keys Children's Shelter (FKCS) contracts with the Florida Network to operate the Child in Need of Services and Family in Need of Services (CINS/FINS) program in Monroe County, Florida. The program is located at the Tavernier's Jelsema Center, at the north-end of the County next to the Tavernier Government Center. 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 services to special populations 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). FKCS is not contracted to provide Intensive Case Management (ICM) services or SNAP.

In addition to the CINS/FINS Program, the agency operates the Poinciana Emergency Shelter (birth through 10 years) and Poinciana Group Home (11-17 years old) in Key West, for children who have been removed from their families/homes as a result of abuse or neglect. It also provides street outreach through Project Lighthouse where staff conducts outreach in areas where homeless youth congregate with the goal of getting these youth help and providing a safe shelter.

FKCS is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through July 31, 2024. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

Per the agency's strategic plan, it launched the residential coaching program last year with the addition of three coaches: Life Skills, Education, and Recreation which even during the current COVID-19 pandemic, proven to be truly effective. All coaches have college degrees and specific expertise that empower the organization to better support the youth served to live up to their fullest potential. With the retention of a higher pay scale, FKCS has retained these qualified professionals on its team long-term and continue to report success stories of their good work. One of the agency's largest funders, the Ocean Reef Community Foundation, once again granted $48,000 to support the second year of this coaching program.

Recruitment and retention of employees continues to be one of the biggest challenges being located in a rural area with high cost of living. During the last year, FKCS was able to maintain the increased pay to all employees and gave qualifying workers end-of-year bonuses. To show appreciation, a holiday party was held for staff at the administrative offices (observing safe

pandemic protocols). The agency has also continued its monthly employee newsletters and reinstated the Employee of the Month program with gift card incentives. Management is in the process of creating quantifiable metrics that will be tied to holiday bonuses at the end of the 2021 calendar year.

Efforts to reestablish the school break camps, renamed Jelsema Journey, over Spring, Summer and Winter Breaks 2020 were also positive in light of the pandemic constrictions. The Jelsema Journey camps were held as free week-long, overnight programs for at-risk youth ages 11-17 with activities, field trips, group counseling, and motivating guest speakers. The referrals for the camp were once again so high the program was at full occupancy with a large waiting list. Many of the campers did not want to go home at the end of the week because they were having such a great time, and the coaches and counselors noticed progress in youth behaviors in a short time. FKCS goal is to continue with the Jelsema Journey camps in 2021.

For the third academic year, the organization has provided free classroom space to the Monroe County School District for its Upper Keys Alternative Classroom. Each weekday, 6-9 students attend school in the building. The program provides complimentary use of its recreational facilities, meal preparation, coaches and counselors. This was enhanced by the introduction of the Jelsema Learning Center Re-boot Program, which was offered as a two-week daily program for Monroe County students, ages 10-17, assisting them with virtual school readiness, academic tutoring, counseling on conflict resolution, decision-making and life/coping skills. Transportation, meals and incentives were all offered free of charge.

FKCS once again was awarded the Basic Center Grant, in the amount of $200,000 for three years. A percentage of the staff salary is covered by this grant, a huge accomplishment of the leadership team.

**Major Changes in Personnel**

- New Residential Counselor -Erin Flannery (MSW). Erin received both her Bachelor's and Master's (BSW and MSW,) degrees in Social Work at Florida International University, focusing her efforts on adolescent populations and their families.
- New Assistant Residential Coordinator -Alana Corradi (MSW) holds a Bachelor's degree in Social Work (BSW) from Mansfield University of Pennsylvania and a Master's in Social Work (MSW) from the University of South Florida.
- New Community Outreach Worker - Diamon Dumas assists the Program Director, Jai Somers, at Project Lighthouse in all outreach efforts for the runaway, homeless and street youth in Key West, including the activities of KYAN -Keys Youth Action Network, a youth advisory board that has a seat on the Monroe County Continuum of Care.

Also of note, the Florida Keys Children's Shelter enhanced its administrative and executive board to include: 1) a new Development Director -Lynda Weinstein oversees all of our special project funding, event planning and execution, public relations, advertising, community outreach and social media, and 2) new Board Member, Ashley Arrabal, the Accounting Supervisor at

FKEC for 17 years. She is part of several organizations in the community, including Upper Keys BPW, Women of the Moose, Domestic Abuse Shelter of the Florida Keys, Leadership Monroe County XXVII, and Alpha Delta Upsilon.

## Narrative Summary

FKCS is located at 73 High Point Rd, Tavernier, FL. The agency has an eleven-member Board of Directors/Trustees with representatives from the upper, middle, and lower keys, to oversee the agency's goals, objectives and activities. The FKCS building houses the CINS/FINS shelter on the first floor and the agency's administrative offices on the second floor. The shelter provides separate female and male dormitories to children under 18 years of age that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at risk.

The program has a Senior Management team that is comprised of a Chief Executive Officer, Chief Operating Officer (COO), Financial Manager, Counseling Services Coordinator, Residential Program Coordinator, and Office Manager. At the time of the onsite QI review, there were no staff vacancies reported. The overall findings for the QI review for FKCS is summarized as follows:

Standard 1 has a total of seven indicators regarding Management Accountability. Five of the seven indicators in Standard 1 were rated satisfactory with no exceptions (1.01, 1.02, 1.03, 1.05, and 1.07) and two were rated satisfactory with exceptions (1.04 and 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 FKCS is not currently a SNAP provider. Five of the nine applicable indicators were rated satisfactory with no exceptions (2.02, 2.03, 2.04, 2.07, and 2.08), two were rated satisfactory with exceptions (2.01 and 2.06), and one was rated Limited (2.05).

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

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

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

**Standard 1:**
None of the indicators in Standard 1 had a Limited or Failed rating.

**Standard 2:**
***Indicator 2.05 – Limited***
The program was not able to demonstrate group sessions are held five times per week consistently during the review period. As a result of missing information, multiple group activities could not be validated as meeting the criteria for group sessions as follows:

- September groups: 3 out of 30 did not list duration of groups
- October groups: 4 out of 30 did not list duration of groups
- November groups: 6 out of 30 did not list duration of groups
- December groups: 19 out of 30 did not list duration of groups

Also, some groups did not appear to have a relevant topic and were just an outing activity and noted as such on the form.

**Standard 3:**
***Indicator 3.06 – Limited***

On January 16, 2021, between 3am-5am there were six (6) male bed checks not conducted by the male staff. There were also six (6) female bed checks not conducted. Staff documented in logbook on January 16, 2021 that all bed checks were conducted but it was not observed on camera surveillance. On December 31, 2020, video surveillance was also reviewed between 2am-4am and there were five (5) female bed checks that were not conducted on video. However, staff also documented in logbook on December 31, 2020 that bed checks were completed. The COO contacted the CCC to report the findings of the QI observation and the report was accepted.

**Standard 4:**
***Indicator 4.03 – Limited***

- Documentation of weekly counts of over-the-counter medications from June 1, 2020 to January 18, 2021 did not include documentation of a weekly count conducted during the week of August 16-22, 2020.
- The CEO and the RN are the identified super users of the Pyxis med-station; however, an interview with the RN indicated the CEO does not have an account which would allow him to pull reports from the Knowledge Portal and that she, the RN, is the only person who reviews the monthly reports.
- The program's medication discrepancy report noted frequent and recurring discrepancies in the amount/number of meds which were a result of users not entering a correct beginning count of medication and not returning to the computer to correct the count, thereby leaving the discrepancy unresolved, rather than resolving the discrepancy by the end of their shift, as required. An interview with the RN indicated she has repeatedly trained and retrained staff on the requirement to resolve med counts by the end of their shift, and she has posted a "cheat sheet" on the med cart with step-by-step instructions on how to resolve discrepancies; however, staff continue to leave the discrepancies unresolved. There has been no corrective action put into place other than retraining by the RN in order to correct this issue.

Florida Keys Children's Shelter- January 20-21, 2021
Lead Reviewer: Marcia Tavares

# 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 |
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| **Standard One – Management Accountability** | | | | | | | |
| **1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.01** | | | | | | **YES NO X (explain)** The provider's policy number 1.12 was last approved on 11/20/20 by the Chief Executive Officer and Chief Operations Officer. | Policy 1.12 reviewed was not updated to include requirement for suitability prescreening assessment, passing criterion, and need for explanation if staff is hired with a non-passing/low score. |
| 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 | | | | | Since January 2019, FKCS has utilized a self-created Suitability Questionnaire screening tool that is comprised of 11 questions, I of which is a bonus question, and a pass rate of 70%. The tool was used to evaluate 10 new staff hired during the review period; all ten staff met or exceeded the pass rate. | |
| 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 twelve background screening files were reviewed for ten new hires, one staff who met the criteria for 5-year background re-screening, and one intern. The ten new hire personnel and the intern had timely background screenings completed prior to their hire/start dates. | |
| Five-year re-screening completed every 5 years from initial date of hire | X | | | | | One applicable 5-year re-screening was current with valid retained prints on file with the Clearing House. | |
| Annual Affidavit of Compliance with Level 2 Screening Standards | X | | | | | The provider submitted its Annual Affidavit of Compliance with Level 2 Screening Standards on December 23, 2020 prior to the January 31, 2021 deadline. | |

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| (Form IG/BSU-006) is completed and sent to BSU by January 31st? | | | | | | | |
| Proof of E-Verify for all new employees obtained from the Department of Homeland Security | **X** | | | | | The program provided E-verify documentation for all ten new staff, verifying authorization to work. | |
| **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** The provider has comprehensive policies and procedures as follows: Code of Conduct (policy # E.1, reviewed 9/29/20); Abuse Reporting policies #1.07.01 to 1.07.03, approved 9/1/2020; and Grievance Process #3.22, approved 9/1/2020. The policies were signed and dated by the CEO and COO. | Policy 3.22 reviewed was not updated to address access to grievances and management by the program director and/or supervisor and provisions when the grievance is about the manager/supervisor. |
| 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** | | | | | The Code of Conduct (policy E.1) is a part of the agency's personnel policy and procedures and is signed and dated by each employee during their initial orientation. | |
| Child Abuse Registry telephone number is visible to youth and posted common areas of the facility | **X** | | | | | Observation during a tour of the facility revealed posted Abuse Hotline numbers at all office entrances, in the hallways of the bedrooms, dining room, and in all common areas of the shelter. | |
| Youth were informed of the Abuse and Contact Number (see youth survey results) | **X** | | | | | The Abuse Hotline contact number is included in the Resident Handbook that is given and reviewed with youth during intake. Only one youth was able to complete the survey during the review. The youth feel safe in the shelter and stated staff is respectful. Youth is familiar with the child abuse hotline number, grievance procedures and location of both. Eleven staff surveyed received child abuse training and 10 of the 11 staff have never heard staff use profanity or threat toward youth, | |
| Management takes immediate action to address any incidents of threats or abuse | **X** | | | | | No incident of threats or abuse by staff requiring management action was reported by Human Resources or the program managers interviewed during the visit. | |
| **Grievance Process** | | | | | | | |

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| Agency has a formal grievance process | X | | | | | The agency has a formal grievance process, policy # 3.22 that was approved by the CEO and COO on September 1, 2020. | |
| Locked box accessible to only management and available to youth in a common area | X | | | | | There are 2 locked grievance boxes observed to be located outside each dorm and accessible to youth. and staff. The residential coordinator has possession of the keys to the grievance boxes. | |
| 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 | | | | | Per the residential coordinator, the grievance boxes are only accessed by the residential coordinator and direct care staff do not handle the grievances. | |
| 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 | | | | | Two grievances were documented by youth since the last QI review. Both were processed properly within the 72-hour time frame. Grievances are also maintained on file by the program for a minimum of 1 year. | |
| **1.03: Incident Reporting** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.03** | | | | | | **YES X NO (explain)** The provider's policy and procedure 1.13 was approved on 9/1/2020 by the CEO and COO. | |
| 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 Central Communications Center Incidents Detail Report were reviewed indicating seven reportable residential incidents were called in to the CCC during the review period. All seven incidents were reported within the 2 hour time frame of the incident and/or staff's knowledge. | |
| The program completes follow-up communication tasks/special instructions as required by the CCC | X | | | | | Two of the seven incidents required follow up tasks. Both were documented with notes to the tasks required and outcome of the incidents reported. | |
| Incidents are documented in the program logs and on incident reporting forms | X | | | | | All seven incidents are documented on the agency's incident reporting forms. All seven incidents were recorded in the shelter logbook by staff on duty. | |

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| All incident reports are reviewed and signed by program supervisors/directors | X | | | | | All seven incidents were reviewed and signed by program supervisors. | |
| **1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.04** | | | | | | YES **NO X (explain)**<br>The provider's policies and procedures for Training Requirements #5.01 (approved 9/1/20), 5.02 (11/20/20), 5.03 (9/1/20) & 5.04 (11/20/20) were last reviewed and approved on the dates indicated by the CEO and COO. The policies do not fully meet the requirements for this indicator. | Policy 5.02 was not revised after 11/20/20 to align with the requirements of the indicator with regards to mandatory training in the first 90 days versus 120 days. The policy also does not include the Department of Justice (DOJ) Civil Rights & Federal Funds training required within 30 days of hire. |
| 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 | | | | | All 4 first year trainings files reviewed for staff hired prior to January 1, 2021 had completed the DOJ Civil Rights & Federal Funds prior to December 31, 2020. | |
| All staff receives all mandatory training during the first 90 days of employment from date of hire. | | X | | | | Reviewed four new staff training files, including one non-licensed mental health shelter staff. Three of the four staff completed all mandatory trainings required during the first 120 days, applicable to staff hired prior to January 1, 2021. | **Exception**<br>One first year staff (DOH 3/10/20) did not complete CPR/First Aid and Managing Aggressive Behavior training during the first 120 days as required. CPR/First Aid was completed 9/18/20 and MAB 9/12/20. |
| All staff completes all mandatory Florida Network and SkillPro training during the first-year employment. | X | | | | | Training files for four first year staff provided documentation for completion of all mandatory Florida Network and SkillPro training during the first-year employment. All four staff completed more than the 80 hours of training required annually, with range between 137 and 214 hours. | |

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| **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 provider had one applicable non-licensed mental health clinical shelter staff during the review period. The staff member was in compliance with the training requirements and verification of completing the training signed off by a licensed mental health professional. | |
| 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** | | | | | Staff completed eight assessments of suicide risks and a licensed staff provided the proper review and signed off on the non-licensed staff's assessments. | |
| **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** | | | | | All three in-service direct care staff files reviewed demonstrated the staff were in compliance with training requirements by completing all required topics and exceeding the required 40 hours of training annually. | |
| **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** | | | | | All seven training files reviewed were maintained in individual training files for each staff that included a training plan/log and supporting documentation. Training is maintained annually based on the individual's date of hire. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.05** | | | | | | **YES NO X (explain)** The program has multiple policies and procedures to address the requirement of Indicator: Statistical Information #1.20; Case Record Review # 3.50; Service Satisfaction Questionnaires # 3.55; Outcome Goals #1.21; Incident Reporting # 1.13; and Risk Management and Internal Quality Monitoring # 1.23. All of | The current policies have not been updated the process for conducting monthly reconciliation of NetMIS and JJIS data. |

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| | | | | | | policies and procedures were reviewed and approved by the CEO and COO 9/1/2020. | |
| 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 separately by the residential and community counseling programs. Quarterly peer record reviews were held for the quarters July-September 2020 and October-December 2020. The residential program completed a total of 21 record reviews and community counseling program completed 32 record reviews during the two quarters reviewed. | |
| The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum | X | | | | | The executive council and leadership team conducts a quarterly review of all issues regarding employee/client safety and risk management. Risk Prevention and Management (RPM) Quarterly Reports for July-September 2020 and October-December 2020 were reviewed. These reports include data for incidents, accidents and grievances and are also reviewed at monthly leadership meetings as well as monthly board meetings. | |
| The program conducts an annual review of customer satisfaction data | X | | | | | A review of the provider's Stakeholder Survey results completed in the past year included responses from youth, personnel, consumers, governance, and advisory board. The survey was conducted and submitted as part of the agency's COA re-accreditation. | |
| 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 is reviewed monthly at leadership meetings as well as staff meetings. Leadership meetings were held monthly during the past 6 months except for October 2020. Agendas and minutes for the meetings include a discussion of quality improvement, outcomes, data integrity, safety and risk management, and outreach. | |

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| The program conducts a monthly review of NetMIS data reports. | X | | | | | NetMIS outcome data is reviewed monthly and is presented at the Leadership meetings. The CEO reviews this data and activities are discussed to increase performance as needed. | |
| The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted. | X | | | | | Florida Network monthly reconciliation requests are emailed to the Counseling Services Coordinator (CSC) who is responsible for ensuring data integrity. Email correspondence between the CEO and CSC support ongoing communication upon receipt of reconciliation reports and actions taken to address deficiencies. | |
| The program has a process in place to review and improve accuracy of data entry & collection | X | | | | | Reconciliation reports are emailed to the CSC by the CEO upon receipt from the Florida Network. CSC reviews and corrects identified data. Data integrity is discussed at monthly leadership meetings. | |
| There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders. | X | | | | | A review of Agendas and minutes for the Leadership meetings and community counseling staff meetings held between July – December 2020 was conducted. The agenda and minutes for both meetings include a discussion of Florida Network data and/or data integrity and JJIS/NetMIS data reconciliation. | |
| There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process. | X | | | | | Documentation supported data collection and frequent meetings held by management to review and discuss findings and trends identified. It was also evident that this information was disseminated and communicated to staff and staff are involved in identifying and addressing areas needing improvement. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.06** | | | | | | **YES X NO (explain)**<br>The provider's policy and procedure #10.03 was last reviewed on 9/1/2020 and approved by the CEO and COO. | |
| Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle | X | | | | | Provider maintains a list of 26 staff approved to transport client(s) in agency approved vehicle. The drivers were approved after conducting motor vehicle checks. | |
| Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy | X | | | | | The Business Auto Driver Schedule prepared Roe Insurance Inc dated 1/8/2021 shows the list of approved drivers who are covered under the insurance policy. | |

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| 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 | | | | | Policy 10.03 prohibits transporting a client without maintaining at least one other passenger in the vehicle, an approved volunteer, intern, agency staff, or other youth. | |
| 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 | | | | | In the event a 3rd party is not present, the supervisor considers the client's history, evaluation, and recent behavior before giving approval for transport. The staff has appropriately documented cases where single driver transport has been approved on ten different occasions during the months of September and October 2020. A review of the program logbook supported there is documentation of approval by a supervisor for a single youth to be transported by one staff as needed. | |
| The 3rd party an approved volunteer, intern, agency staff, or other youth | X | | | | | Per policy 10.03, the 3rd party must be an approved volunteer, intern, agency staff, or other youth. The use of staff or other youth was observed on the transportation logs. | |
| 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 | | | | A review of the program's travel logs for the past six months documented name and/or initials of youth (showing number of youth), staff driver name, date, time, mileage, and location. The purpose of the trip is not noted separately on the log when it cannot be implied from location | **Exception**<br>The agency's van log does not indicate the purpose of travel as required. |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.07** | | | | | | **YES X NO (explain)**<br>The provider's policies and procedures 9.01, 9.02, & 9.03 were 9/1/2020 and approved by the CEO and COO. | |
| 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 includes minutes of the event or other verification of staff participation | X | | | | | The agency has designated staff attend the Juvenile Justice Circuit Advisory Board meetings. Two meetings were held via Zoom during the review period. Staff provided copies of the agenda and minutes for August and November 2020 and a letter from the Chief Probation Officer was provided on January 21, 2021 confirming CEO attendance to the meetings. | |

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| 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 | | | | | A list of 46 outreach activities was provided including outreach to schools, County health and human services, local community organizations, mental health provider, and interagency partners. The program has brochures of CINS/FINS and additional agency publication to distribute. There is an assigned staff who attends monthly Interagency meetings with DJJ. | |
| The program maintains written agreements with other community partners which include services provided and a comprehensive referral process. | X | | | | | The program maintains 18 written agreements with other community partners which include services provided and a comprehensive referral process. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.01** | | | | | | **YES NO X (explain)**<br>The agency has written policies 2.01 Initial Screening/ Assessment Process, 3.03 Program Services, 2.06 Orientation to the Program, and 3.22 Grievance Procedure that were last reviewed and signed on September 1, 2020 by the CEO and COO. | The agency's policy 2.01 was not revised to include the initial screening for eligibility requirement of 3 business days of referral for community counseling and immediately for all inquiries into shelter placement. |
| Rating Criteria | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| **<u>Shelter youth:</u>** Eligibility screening is completed immediately for all shelter placement inquiries. If staff on duty cannot complete the screening, an on-call supervisor is contacted and eligibility is determined within 30 minutes from initial inquiry. | X | | | | | A total of five residential files (three open and two closed) were reviewed. All files were immediately screened for eligibility during intake. | |
| **<u>Community counseling:</u>** Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form | X | | | | | A total of five community youth files (three closed and two open cases) were reviewed. All files were screened for eligibility at the time of referral. | |
| Youth and parents/guardians receive the following in writing:<br><br>a. Available service options<br><br>b. Rights and responsibilities of youth and parents/guardians | | X | | | | All five shelter youth files and one community counseling youth file confirmed receipt of available service options and rights and responsibilities via signature acknowledgement. | **Exception**<br>Four community counseling files indicated service options and rights and responsibilities information was reviewed verbally via telephone, but these documents were not provided to youth/family "in writing" as required. |

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| The following is also available to the youth and parents/guardians:<br><br>a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication)<br><br>b. Grievance procedures | X | | | | | All five shelter youth files and one community youth file were confirmed being received by guardian and youth via signature acknowledgement. The remaining four community youth files the guardian and youth did not sign but noted that they verbally received they information via telephone. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.02** | | | | | | **YES X NO (explain)**<br>The agency's policy 2.05 was last approved and signed on September 1, 2020 by the CEO and COO. | |
| 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 | | | | | A total of five residential files (three open and two closed) were reviewed. All files had a completed Needs Assessment within 72 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 | | | | | A total of five community youth files (three open and two closed) were reviewed. All files had a completed Needs Assessment within 2-3 face-to-face meeting. | |
| Needs Assessment is conducted by a bachelor's or master's level staff member | X | | | | | All ten files reviewed had Needs Assessment conducted by bachelor's or master's level staff member. | |
| Needs Assessment includes a supervisor's review signature upon completion | X | | | | | All ten files included a supervisor's review signature. | |
| **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 | | | | | One applicable residential youth was 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 | | | | | The applicable youth identified with an elevated risk of suicide was referred for Assessment of Suicide Risk under the direct supervision of a licensed mental health provider. | |

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| **Provider has a written policy and procedure that meets the requirement for Indicator 2.03** | | | | | | **YES X NO (explain)** The agency has written policies 2.02 Service Plans, 2.02.1 Education Plan, 2.03 Service Plan Implementation and Review, and 2.04 Revised Service Plans that were approved and signed on September 1, 2020 by the CEO and COO. | |
| 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 youth files reviewed had Service Plans completed within 7 working days of completion of the Needs Assessment. | |
| **Case plan service Plan includes:**<br>1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment<br>2. Service type, frequency, location<br>3. Person(s) responsible<br>4. Target date(s) for completion and Actual completion date(s)<br>5. Signature of youth, parent/ guardian, counselor, and supervisor<br>6. Date the plan was initiated | **X** | | | | | All ten files reviewed had Service Plans individualized and prioritized needs and goals identified by Needs Assessment. All of the Service Plans had the following: service type, frequency, location, person responsible, target date for completion, actual completion date, and signature of counselor and supervisor. All service plans also had initiated dates listed on the plans.<br><br>The five residential files were signed by the youth; however, due to the pandemic, none of the service plans were signed by the parent/guardian or community counseling youth. Notes were clearly documented in the files indicating the plans were reviewed with the youth/family over the phone. | |
| 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** | | | | | Seven of the ten files reviewed required Service Plans to be reviewed/updated and all seven had appropriate documentation to meet the required timeframes of the indicator. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.04** | | | | | | **YES NO X (explain)** The agency has written policies 3.01 - 24 Hour Agency Access, 3.02- Referrals, 3.03- Program Services, 3.04 - Exit Planning, Aftercare, and Follow Up, and 3.05 - Family Involvement. The policies were approved and signed on September 1, 2020 by the CEO and COO. | Policy 3.02 does not address agreements with community partners that include referral services provided and a comprehensive referral process |
| Rating Criteria | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |

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| Counselor/Case Manager is assigned | **X** | | | | | A total of 10 files were reviewed for five residential youth (three closed, two open) and five community youth (three closed, two open). All ten files had an identified counselor/case manager assigned to the case. | |
| The Counselor/Case Manager completes the following as applicable:<br>1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs<br>2. Coordinates service plan implementation<br>3. Monitors youth's/family's progress in services<br>4. Provides support for families<br>5. Monitors out-of-home placement (if necessary)<br>6. Makes referrals to the case staffing to address problems and needs of the youth/family<br>7. Accompanies youth and parent/guardian to court hearings and related appointments<br>8. Refers the youth/family for additional services when appropriate<br>9. Provides case monitoring and reviews court orders<br>10. Provides case termination notes<br>11. Provides follow-up after 30 days of exit<br>12. Provides follow-up after 60 days of exit | **X** | | | | | All ten files met the following requirements: Establishing/completing referrals based on needs and on-going assessment, coordinating service plan implementation, monitoring youth/family progress, provides support for families, provides case monitoring, provides case termination (for all six closed files), and provided 30 and 60 day follow up for all files meeting this time frame (total of four). | |
| The program maintains written agreements with other community partners that include services provided and a comprehensive referral process | **X** | | | | | Written agreements were on file with community partners to assist in the referral process for the following services: education, substance abuse, health/medical, emergency shelter, homelessness, sexual assault, recreation, law enforcement, and mental health. | |

| **Provider has a written policy and procedure that meets the requirement for Indicator 2.05** | | | | | | **YES X NO (explain)**<br>The agency has written policies: Policy 1.17 Confidentiality (General and HIPPA), 1.14 Client Case Records, and 3.50 Case Record Review. All policies identified were last approved and signed on September 1, 2020 by the CEO and COO. | |
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| 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** | | | | A total of 10 files were reviewed for five residential youth (three closed, two open) and five community youth (three closed, two open). All ten files except one shelter youth file had case notes that reflected youth and family receiving counseling services. | **Exception**<br>One residential youth file did not have any notes reflecting counseling services provided to youth within a 2-week period, despite the need for counseling services as documented on the service plan. |
| **Shelter Program** | | | | | | | |
| Shelter programs provides individual and family counseling | **X** | | | | | Five files were reviewed (3 closed, 2 open). Four of the five files had notes indicating counseling was provided to youth and family. | |
| Group counseling sessions held a minimum of five days per week | | **X** | | | | Group counseling forms were presented but some sessions did not meet the criteria for group. | **Limited Exception**<br>There was insufficient documentation to support groups were held a minimum of five times a week during the review period. |
| Group counseling sessions consist of:<br>a. Length of at least 30 minutes<br>b. Opportunity for youth engagement<br>c. Clear and relevant topic (informational/developmental/ educational)<br>d. Clear leader or facilitator | | **X** | | | | Group Counseling forms were reviewed showing documentation of groups. The group form has sections to list youth who participated, topic, facilitator, and a duration. Not all forms listed length of time for groups or provided clear and relevant topics. | **Limited Exception**<br>As a result of missing information, multiple group activities could not be validated as group counseling sessions as follows:<br>• September groups: 3 out of 30 did not list duration of groups<br>• October groups: 4 out of 30 did not list duration of groups<br>• November groups: 6 out of 30 did not list duration of groups<br>• December groups: 19 out of 30 did not list duration of groups<br>Also, some groups did not appear to have a relevant topic and were just an outing activity and noted as such on the form. |

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| **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** | | | | | Five files were reviewed (3 closed, 2 open). All five files had notes indicating interventions were provided to youth and family in many different formats. | |
| **Counseling Services** | | | | | | | |
| Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up | **X** | | | | | All five community counseling files had notes indicating counseling was provided to youth and family that focused on presenting problems, needs assessment and service plans. | |
| Maintain individual case files on all youth and adhere to all laws regarding confidentiality | **X** | | | | | All five files reviewed had confidential written on them. And all files had mentioned acknowledgement by youth and guardian regarding privacy and HIPPA. | |
| Case notes maintained for all counseling services provided and documents youth's progress | **X** | | | | | All five files provided evidence of counseling services by documentation of case notes by counselors. | |
| On-going internal process that ensures clinical reviews of case records and staff performance | **X** | | | | | The CSC conducts clinical reviews of case records on an ongoing basis and maintains monthly supervision notes of cases reviewed along with staff performance. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.06** | | | | | | **YES X NO (explain)** The agency has written policies: 3.06 - Case Staffing Committee, 3.07 - Schedule of Case Staffing Committee Meetings, 3.08 - Requesting a Case Staffing Committee Meeting, and 3.09 - Written Report from the Case Staffing Committee. All policies identified were approved and signed on September 1, 2019 by the CEO and COO. | |
| 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** | | | | | During the review period there were two (2) cases referred to case staffing that were | |

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| | | | | | | adjudicated CINS. Both referrals were initiated by staff. | |
| The youth, family and case staffing committee are contacted within a minimum of five working days<br>a. Notification to youth/family no less than 5 working days prior to staffing<br>b. Notification to committee no less than 5 working days prior to staffing | | **X** | | | | Notification to youth, family, and committee was two days prior to the scheduled staffing. | **Exception**<br>The two applicable case staffing reviewed did not provide a minimum of 5-days' notice prior to convening the case staffing meeting. |
| **Case Staffing Committee** | | | | | | | |
| **Must include:**<br>a. DJJ rep. or CINS/FINS provider<br>b. Local school district representative | **X** | | | | | Both cases reviewed had a DJJ Rep and school district representative. | |
| **Other members may include:**<br>a. State Attorney's Office<br>b. Others requested by youth/ family<br>c. Substance abuse representative<br>d. Law enforcement representative<br>e. DCF representative<br>f. Mental health representative | **X** | | | | | In both files reviewed there was no mental health representative, substance abuse representative, law enforcement representative, or DCF participants required to attend. | |
| The program has an established case staffing committee, and has regular communication with committee members | **X** | | | | | The program has a case staffing committee that includes a DJJ and school district representative. The program maintains communication with its committee members; emails reviewed shows the program provides regular communication regarding meetings. | |
| The program has an internal procedure for the case staffing process, including a schedule for committee meetings | **X** | | | | | The case staffing meeting is convened within seven working days from receipt of the written request from the parent/guardian. | |
| **As a result of the Case Staffing** | | | | | | | |
| The youth and family are provided a new or revised plan for services | | **X** | | | | A new/revised service plan was provided for one of the two applicable case staffing records. | **Exception**<br>One of the two case staffing files reviewed did not provide a new or revised service plan based on recommendations of the case staffing committee. |
| Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining | **X** | | | | | Both files had a letter provided to the youth and family that outlined the committee's recommendations and reasons. | |

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| recommendations and reasons behind the recommendations | | | | | | | |
| If applicable, the program works with the circuit court for judicial intervention for the youth/family | X | | | | | Both files had correspondence and documentation involving the court. | |
| Case Manager/Counselor completes a review summary prior to the court hearing | X | | | | | Both files had summary review prior to court. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.07** | | | | | | **YES X NO (explain)** The agency has written policies 1.14 - Client Case Records and 1.17 - Confidentiality (general and HIPPA) that were last approved and signed on September 1, 2020 by the CEO and COO. | |
| Rating Criteria | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| All records are clearly marked 'confidential'. | X | | | | | During the review there were five (5) residential files and seven (7) community counseling files reviewed. All twelve files were stamped confidential. | |
| All records are kept in a secure room or locked in a file cabinet that is marked "confidential" | X | | | | | The agency has a secure room with locked file cabinet that is marked "confidential". | |
| When in transport, all records are locked in an opaque container marked "confidential" | X | | | | | The agency has black locked boxes to keep files when they are transported out of the office. All boxes observed had combination locks built into the black boxes. | |
| All records are maintained in a neat and orderly manner so that staff can quickly and easily access information | X | | | | | All 12 cases reviewed were maintained in a neat and orderly manner with cover pages and list of the content and order of documents in each section. Progress notes are typed | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.08** | | | | | | **YES X NO (explain)** The agency has a policy and procedures # 3.61 that was last approved and signed on 11/20/2020 by the CEO and COO. | |
| **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 | X | | | | | During the review period, there was one active community counseling youth who identified as gender non-conforming. The youth's preferred name was noted in the file and the counselor | |

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| b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards | | | | | | addressed youth by preferred name and preferred pronouns. | |
| Youth in need of specialized support is referred to qualified resources (as applicable) | **X** | | | | | The counselor researched and identified a local referral to assist youth/family with gender identity support. | |
| 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** | Applicable youth is receiving community counseling services | |
| Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression | | | | | **X** | Applicable youth is receiving community counseling services | |
| 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 tour of the facility it was observed that the agency has signage placed in all common areas and in the administrative areas stating, "Everyone is Welcome Here…..Everyone Belongs".<br><br>The program has copies of the FN ZINE brochure, accessible in the day room of the shelter, providing education and information about LGBTQ. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.09** | | | | | | **YES** **NO X (explain)**<br>The agency has written policies and procedures for specialized services:, 3.13.1 – Staff Secure (11/21/20); 3.13- Domestic Violence (11/21/20); 3.13.2-Probation Respite 11/21/20); 3.13.3-DMST (9/1/20); 3.67 – FYRAC (9/1/20); 3.13.4-ICM (9/1/20). The policies were last approved and signed by the CEO and COO on the dates listed above. | Policies 3.13 and 3.13.2 do not include the revised 3 business day timeframe requirement for intake and discharge data entry into NetMIS and JJIS. |
| **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")** | | | | | | **NO** | |

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| **Staff Secure policy and procedure outlines the following:**<br>a. In-depth orientation on admission<br>b. Assessment and service planning<br>c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention<br>d. Parental involvement<br>e. Collaborative aftercare | | | **X** | | | During the review period, the provider did not serve any youth who met the criteria for Staff Secure. | |
| Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services | | | **X** | | | During the review period, the provider did not serve any youth who met the criteria for Staff Secure. | |
| **Staff Assigned:**<br>a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time<br>b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth<br>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** | | | During the review period, the provider did not serve any youth who met the criteria for Staff Secure. | |
| Agency provides a written report for any court proceedings regarding the youth's progress | | | **X** | | | During the review period, the provider did not serve any youth who met the criteria for Staff Secure. | |
| **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")** | | | | | | **NO** | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |

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| Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements | | | X | | | During the review period, the provider did not serve any youth who met the criteria for DMST. | |
| Services provided to these youth specifically designated services designed to serve DMST youth | | | X | | | During the review period, the provider did not serve any youth who met the criteria for DMST. | |
| 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 | | | During the review period, the provider did not serve any youth who met the criteria for DMST. | |
| Length of Stay:<br>a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days<br>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 | | | During the review period, the provider did not serve any youth who met the criteria for DMST. | |
| 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 | | | During the review period, the provider did not serve any youth who met the criteria for DMST. | |
| All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements | | | X | | | During the review period, the provider did not serve any youth who met the criteria for DMST. | |
| **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** | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |

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| 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 | | | | | Two (2) closed DV Respite files were reviewed for this indicator with intake and discharge prior to January 1, 2021. The two files had documentation of youth pending DV charges and had evidence of being screened by JAC/Detention and does not meet the criteria for secure detention. | |
| Data entry into NetMIS and JJIS within (3) business days of intake and discharge | | X | | | | Data entry into NetMIS was verified to be within 24 hours of intake and 72 hours of release in NetMIS and JJIS for 1 of 2 youth. | **Exception** NetMIS discharge data entry for one of 2 DV youth exceeded the 72-hour timeframe. |
| 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 | | | | | DV respite placement did not exceed 21 days for the two youth. | |
| 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 | | | | | The case plans reflected goals consistent with the issues identified regarding aggression, coping skills and effective communication in both files. | |
| All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements | X | | | | | Documentation was provided to support services were provided consistent with all other general CINS/FINS program requirements. | |
| **Probation Respite** | | | | | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")** | | | | | | **NO** | |
| **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 | | | During the review period, the provider did not serve any youth who met the criteria for Probation Respite. | |
| Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status | | | X | | | During the review period, the provider did not serve any youth who met the criteria for Probation Respite. | |

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| Data entry into NetMIS and JJIS within (3) business days of intake and discharge | | | X | | | During the review period, the provider did not serve any youth who met the criteria for Probation Respite. | |
| 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 | | | During the review period, the provider did not serve any youth who met the criteria for Probation Respite. | |
| All case management and counseling needs have been considered and addressed | | | X | | | During the review period, the provider did not serve any youth who met the criteria for Probation Respite. | |
| All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements | | | X | | | During the review period, the provider did not serve any youth who met the criteria for Probation Respite. | |
| **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")** | | | | | | **N/A** | |
| **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** | FKCS is not contracted to provide ICM services | |
| **Services for youth and family include:**<br>a. Four (4) direct contacts per month<br>b. Four (4) collateral contacts per month | | | | | **X** | | |
| **Assessments include:**<br>a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable)<br>b. An approved self-report assessment that was completed at intake<br>c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable) | | | | | **X** | | |

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| 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")** | | | | | | **NO** | |
| **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 | | | During the review period, the provider did not serve any youth who met the criteria for FYRAC. | |
| Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office | | | X | | | | |
| Intake and initial assessment sessions meets the following criteria:<br>a. Face-to-face gathering of family history and demographic information<br>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 | | | | |

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| Life Management Sessions meets the following criteria:<br>a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit<br>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 | | | | |
| Group Sessions:<br>a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence<br>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 | | | | |
| 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 | | | | |
| **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**<br>**FKCS is not a 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** | FKCS is not a SNAP Provider | |
| Needs assessment is completed at initial intake, or within two face-to-face sessions | | | | | | | |

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| SNAP Assessments<br>a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post)<br>b. Teacher Report Form (TRF) completed by the teacher (pre & post)<br>c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post)<br>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 | | | | | **X** | | |

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| in Schools group and uploaded to Dropbox | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.01** | | | | | | **YES X NO (explain)** The agency has written policy 3.14 that address Sleeping arrangements/Room Assignments; Policy 3.15 address Daily Activity Schedule; Policy 3.17 to address Participation in Religious Services; Policy 3.18 to address Residential Sleeping quarters/Bathrooms and shower facilities; Policy 3.31 to address Food Service Health Inspections/Certificate; Policy 4.01 to address Safety Inspections and Policy 4.02 to address Emergency Disaster Plan which includes evacuation egress plan. Policy last reviewed and approved by CEO and COO on 9/1/2020. | . |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| **Facility Inspection** | | **X** | | | | The Program tour was conducted on 1/20/2021 and shelter was found to be clean and organized. Furniture in the female and male bedrooms were in good condition. Program was free of insect infestation. Program grounds was clean and nicely landscaped. Program has garden area which is well maintained. No graffiti was observed. Program has an exercise area with equipment for clients to work out in the back of shelter. Program also has a basketball area for outside physical activities. Program also has bike area where they keep all donated bikes for bike riding activities. Vehicles were randomly checked during tour and were all locked and secured. Program dumpsters were covered and located in a gated area. Agency is operating with two vehicles for youth transportation, one gray mini and one gray 12 passenger van, which were both equipped with first aid kits, fire extinguishers, flashlights, glass breakers, seat belt deflator, and seat belt cutters. Program has detailed egress plan available/posted for staff and youth by posting plan behind each bedroom door and in the common areas. Program also has Abuse hotline, DJJ compliant number, and other related notices posted in the common area in the shelter. Program has BMS and orientation/rules posted in the common area in shelter. Grievance box was | **Exception**<br>A current copy of the Registered Dietician's license was not posted or provided during review.<br><br>Program does not conduct weekly inventory of chemicals as required but bi-monthly inventory. |

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| | | | | | | also observed near the entrance of youth bedroom quarters along with a box and blank grievance forms for youth to complete. Program had DCF license posted near the entrance of the facility in the lobby area. Expiration date of License is January 31, 2021. Program is also COA accreditation which expires July 31, 2024. During tour, chemical cabinet was locked with chemical inventory with the number of chemicals listed. In cabinet there were two bottles of hand soap, one bottle of fabuloso, two bottles of bleach, one can of Lysol spray, and the laundry detergent was locked in a separate storage area which there was one bottle. Program does not conduct weekly MSDS inventory but bi-monthly. Program had Group Care inspection on 1/19/2021 and there were no violations noted. Program had a Food service inspection by the State of Florida on 12/21/2020 and there were no violations noted. Program has food menus posted which are signed by the Registered Dietician on 9/23/2019. During tour, it was also observed program has posted the Nutritional alerts for youth. Refrigerators and freezer were organized and cleaned. Freezer temperature was -1F and refrigerator was at 35F degrees. Cold Food was properly stored in containers marked and labeled with names and dates. | |
| **Fire and Safety Health Hazards** | **X** | | | | | **Date of fire inspection(s) reviewed:** Program had an annual fire inspection on 1/12/2021 by the office of the Fire Chief of Islamorada and there were no violations pending on inspection.<br>Staff conducted fire drills on each shift during the period 1/1/2020 to 12/8/2020. All fire drills have been two minutes or less.<br>According to the emergency drill logs and reports, staff conducted emergency mock drills three times a month at various times. Program had inspection by Black Fire Protection on 12/23/2020 and Monroe County Fire Equipment inspection on 12/21/2020 for inspection of the sprinkler, alarm system and kitchen overhead hood. | |
| **Youth Engagement** | | | | | | | |
| a. Youth are engaged in meaningful, structured activities | **X** | | | | | All activities are posted on a monthly basis which includes weekly activities. Activities include youth participating in the farmer's market, Jacob's | |

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| (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal.<br>b. At least one hour of physical activity is provided daily.<br>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.<br>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.<br>e. Daily programming schedule is publicly posted and accessible to both staff and youth. | | | | | | aquatic center, Founders park and pool, youth group, fire explorers, pool and soccer, and movies. Program has a daily schedule that includes physical activities if weather permits. Program does provide the opportunity for clients to attend a faith-based services on Wednesdays at nearby community church called Island Christian Church. Program has included in daily schedule time for youth to complete homework and access to a variety of age-appropriate activities. Program also has a library area where all books are kept for reading purposes. At 6:30pm to 7:45pm, youth have homework time, reading time and free time while in shelter. Daily Programming is posted in the common area near the intake office. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.02** | | | | | | **YES X NO (explain)**<br>The agency has a policy and procedure #2.06 that was approved and signed on 9/1/20 by the CEO and COO. | |
| **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** | | | | | Two closed records and two open records were reviewed. It is the program's current practice to review the resident handbook with each youth at the time of intake and document orientation. | |
| **Orientation includes the following:**<br>a. Youth is given a list of contraband items<br>b. Disciplinary action is explained<br>c. Dress code explained | **X** | | | | | In all files reviewed there was a comprehensive orientation completed during the intake process that includes all items required by the indicator. Youth and parent/guardian acknowledge orientation to the program by their signature on the resident/parent handbook form; grievance process and rules are also explained. Included in the agency's handbook is the layout/map of the facility, BMS program, emergency/disaster | |

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| d. Review of access to medical and mental health services<br>e. Procedures for visitation, mail and telephone<br>f. Grievance procedure<br>g. Disaster preparedness instructions<br>h. Physical layout of the facility<br>i. Sleeping room assignment and introductions<br>j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts | | | | | | procedures, and youth is explained suicide prevention alerting staff of feelings or awareness of others having suicidal thoughts. | |
| 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 four youth files contained a completed orientation checklist covering each component of orientation topics and signed by youth and staff conducting orientation. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.03** | | | | | | **YES X NO (explain)**<br>The agency has a policy and procedure # 3.14 that was approved and signed on 9/1/20 by the CEO and COO. | |
| **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<br>b. Initial collateral contacts,<br>c. Initial interactions with and observations or the youth<br>d. Separation of younger youth from older youth,<br>e. Separation of violent youth from non-violent youth | **X** | | | | | There were four files reviewed, two open and two closed files. Program completes screening process and intake process which gathers information of youth's history, status and exposure to trauma, initial collateral contacts, observation of youth separation of younger youth from older youth, gender, history of violence, disabilities, physical size, strength, suicide risk, sexual orientation/identification, and agency observe any acute health symptoms requiring quarantine or isolation. During intake process, the CINS/FINS intake form is completed and based | |

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| f. Identification of youth susceptible to victimization<br>g. Presence of medical, mental or physical disabilities<br>h. Suicide risk<br>i. Sexual aggression and predatory behavior<br>j. Sexual orientation gender identity/ expression<br>k. Acute health symptoms requiring quarantine or isolation | | | | | | on information youth collected on history, youth is assigned a room and bed assignment. Form is signed by staff and reviewed and approved by supervisor. It was observed and reported that each room has two beds but if a youth requires a single bed it is possible in the facility. | |
| 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** | | | | | Alerts are immediately entered into the programs alert system when a youth is admitted with special needs and risks including risk of suicide, mental health, substance abuse physical health or security factors. All 4 youth files reviewed included alerts that were accurately documented in the youth's record. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.04** | | | | | | **YES NO X (explain)**<br>The agency has a policy and procedure # 3.47 that was approved and signed on 9/1/20 by the CEO and COO. | Policy 3.47 was not revised to address the requirement for oncoming supervisor and shelter counselor to review the logbook, at the beginning of their shift, all shifts since their last log entry and make a signed and dated entry and into log book indicating the dates reviewed. |
| **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** | | | | | A review of the program logbooks from November 28, 2020 to January 3,2021 was conducted. Staff highlighted all security and safety issues that could impact the youth at the program. Staff highlighted when Supervisor gave permission for staff to transport youth, discharges, intakes, staff reading of logbooks, youth returning from pass or going on pass, and outings. | |
| All entries are brief, legibly written in ink and include:<br>• Date and time of the incident, event or activity<br>• Names of youth and staff involved | **X** | | | | | All entries were brief and legibly written in ink. Logbook entries provided dates, activity/event. Staff also provided youth initials and staff signed their initials after each entry. Staff also provided a brief statement of what the youth were doing at the time of entry. | |

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| • Brief statement providing pertinent information<br>• 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 entries of errors reviewed in logbook were struck through with clear line with staff initials and date next to it. During the review of the logbooks, there were no usage of white-out observed. All entries were made in ink without any white out areas. | |
| 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** | | | | Weekly reviews of the logbook by the program director of designee was not consistent during the review period. | **Exception**<br>During the review of logbooks entries that were uploaded from January 3, 2021 through January 9, 2021, there was only two Supervisory reviews indicating supervisor reviewed logbook and video footage on 1/7/21 and 1/8/2021. For the period November 28, 2020 – January 3, 2021, there were only three entries observed in the logbook where it was reviewed by Supervisor/Program Director. |
| 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** | | | | | All direct care staff reviews of logbooks were documented at the beginning of each shift (6am-2pm; 2-10pm; and 10pm-6am) for the time frame reviewed. Staff included dates and signatures. Staff were consistent in reading logbook and documented that logbook was read on each 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** | | | | For the week of January 3-9, only two oncoming supervisory reviews of the logbook was conducted. | **Exception**<br>Effective 1/1/2021, shelter counselor and oncoming supervisor must review logbook at the beginning of their shift and that was not being done consistently by shelter Counselor or Supervisor on each shift. |
| Logbook entries include:<br>a. Supervision and resident counts<br>b. Visitation and home visits | **X** | | | | | On each day, it was reviewed that staff documents the number of youths in the facility, each staff name on each shift with their initials are written in the logbook. Staff documents visitations and passes for the youth in the logbook and it is highlighted as well. | |

| **Provider has a written policy and procedure that meets the requirement for Indicator 3.05** | | | | | | **YES X NO (explain)**<br>The agency has a policy and procedure # 3.26 that was approved and signed on 9/1/20 by the CEO and COO. | |
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| **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 detailed written description of the BMS which is explained during orientation. Parent and youth sign stating it has been explained during the intake process/orientation. Parents and youth are given a handbook which includes the BMS system and point system. New employees study the residential handbook with the BMS process during orientation. Staff document notes daily and points are logged for each youth on each shift. | |
| **Behavior Management Strategies MUST include:**<br>a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions<br>b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior<br>c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program<br>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<br>e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only | **X** | | | | | The program has three levels to their BMS system: Orientation, Level 1 and Level 2. Supervisors are trained to monitor the use of the behavioral interventions by their staff to include the expected behaviors, rewards, youth development system, social skills, and general philosophy. There were two training certificates reviewed of supervisors receiving necessary trainings to monitor program BMS system.<br><br>Behavioral interventions are applied immediately reflecting the severity of the behavior. Each BMS level has certain incentives youth can earn when that level is achieved.<br><br>Program has in place consequences or sanctions for rule violations which are directly related to the seriousness of the inappropriate behavior exhibited. Consequences are fairly applied, timely and consistent. The program's policy prohibits group discipline, room restriction, or denial of basic rights. | |

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| techniques approved by the Florida Network and DJJ are used if physical intervention is required)<br>f. Only staff discipline youth. Group discipline is not imposed<br>g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control<br>h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges | | | | | | | |
| **Program's Use of the BMS** | | | | | | | |
| All staff are trained in the theory and practice of administering BMS rewards and consequences | **X** | | | | | All staff receive training on the BMS system. Training certificates of completion were verified in the 4 new hire training files reviewed. | |
| There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences | **X** | | | | | Program supervisor monitors point cards to evaluate and provide feedback to staff during staff meetings on use of behavior management system and on youth engagement. | |
| Supervisors are trained to monitor the use of rewards and consequences by their staff | **X** | | | | | Supervisor's receipt of training in the monitoring of the BMS was verified in their training records. Program supervisor provides oversight to ensure the behavioral interventions are being used appropriately. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.06** | | | | | | **YES X NO (explain)**<br>The agency has policies and procedures #1.15- Staff Schedule and #3.46- Staff Ratios that were approved and signed on 9/1/20 by the CEO and COO. | |
| **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. | **X** | | | | | A review of the program schedules for the previous six months revealed the program maintained a minimum staffing ratio of 1:6 during wake hours and 1:12 during sleep period | |

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| • 1 staff to 6 youth during awake hours and community activities<br>• 1 staff to 12 youth during the sleep period | | | | | | | |
| All shifts must always provide a minimum of two staff present | **X** | | | | | A minimum of two staff were observed to be scheduled on all shifts for the 6-month period. Call outs were crossed off the schedule with the name of on call staff written in ink. | |
| 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** | | | | | Staff listed on the shelter schedule were verified to have valid prints in the clearinghouse and hold current position titles of direct care staff. | |
| The staff schedule is provided to staff or posted in a place visible to staff | **X** | | | | | The residential coordinator produces a staffing schedule which meets the requirements of twenty-four-hour awake supervision and the schedule is posted in the staff room. During the tour of the facility, the staff schedule was observed posted in the control room/staff office. | |
| 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 maintains a roster with contact numbers of staff to call to ensure operation within the required staff-to-youth supervision. No vacancies were reported at the program at the time of the annual compliance review. | |
| 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** | | | | A review of the video surveillance system was completed for a total of three randomly selected days and all were reviewed for two hours during the 10pm-6am shift. During review of the video surveillance on January 18, 2021, it was observed during 1am-3am all bed checks were conducted every 15 minutes for the female and male rooms. Staff documented in logbook on January 16, 2021 that all bed checks were conducted but it was not observed on camera surveillance. when there was none observed on camera. On January 16, 2021, during 3am-5am there were six (6) male bed checks not conducted by the male staff. There were also six (6) female bed checks not conducted. On December 31, 2020, video surveillance was also reviewed during 2am-4am and there were five (5) female bed checks that were not conducted. | **Limited Exception:**<br>On January 16, 2021, during 3am-5am there were six (6) male bed checks not conducted by the male staff. There were also six (6) female bed checks not conducted. Staff documented in logbook on January 16, 2021 that all bed checks were conducted but it was not observed on camera surveillance.<br><br>On December 31, 2020, video surveillance was also reviewed during 2am-4am and there were five (5) female bed checks that were not conducted on video. However, staff also documented in logbook on |

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| | | | | | | | December 31, 2020 that bed checks were completed. |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.07** | | | | | | **YES** **NO X (explain)**<br>The agency has a policy and procedures #4.23 that were approved and signed on 9/1/20 by the CEO and COO. | The provider's policy #4.23 was not revised to address: 1) granting of video recording requests within 24-72 hours of the request by funder or for the purpose of investigating an incident, and 2) initiating camera service order/requests within 24 hours of discovery of camera malfunctioning. |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| **Surveillance System** | | | | | | | |
| The agency, at a minimum, shall demonstrate:<br>a. A written notice that is conspicuously posted on the premises for the purpose of security<br>b. System can capture and retain video photographic images which must be stored for a minimum of 30 days<br>c. System can record date, time, and location; maintain resolution that enables facial recognition<br>d. Back-up capabilities consist of cameras' ability to operate during a power outage<br>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.<br>f. All cameras are visible | **X** | | | | | During tour of the shelter program, there was a written notice that was posted near the entrance of the facility notifying the public that program was under surveillance for security. Program has cameras located in the interior and exterior of the facility. These cameras capture footage of classroom area, kitchen, lobby, youth common area, intake office, basketball court, the back of the facility, dumpster area, parking lot, front entrance, level 2 room, medical room, and alternative class. All cameras are visible in the facility. Program does not have cameras in the youth sleeping quarters nor in the youth bathrooms. During the review of the video surveillance, it was demonstrated that the system can retain and capture video photographic images for more than 30 days. The surveillance was able to be stored up to November 30, 2020 approximately 55 days of photos/images. Video surveillance displayed dates, times, and maintained resolution that enables facial recognition. Program has a generator and battery backup if there are any outages. | |
| A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)? | **X** | | | | | Program has COO and Residential Coordinator designated to manage, control, and audit the use and security of monitoring cameras, DVR, | |

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| | | | | | | computers used to store images, computer diskettes, and all other video records. | |
| Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.<br><br>The reviews assess the activities of the facility and include a review of random sample of overnight shifts | **X** | | | | | There is a log of supervisory checks/camera reviews from 7/30/20 through January 8, 2021. All checks reviewed for the period demonstrate supervisory checks a minimum of every 14 days with only one missing between 9/16/2020 and 10/9/2020. | |
| Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident | **X** | | | | | | |
| 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** | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.01** | | | | | | **YES X NO (explain)**<br>Policy and procedures #4.01 address the program's initial screening and assessment process which was last reviewed and approved on 9/1/2020 by the CEO and COO. | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| **Preliminary Healthcare Screening** | | | | | | | |
| **Screening includes :**<br>a. Current medications<br>b. Existing (acute and chronic) medical conditions<br>c. Allergies<br>d. Recent injuries or illnesses<br>e. Presence of pain or other physical distress<br>f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. | **X** | | | | | Four youth records were reviewed, and each documented completion of a healthcare screening on the date of admission which included all required screening elements. All four screenings documented observation for evidence of illness, injury, pain, physical distress, movement difficulties, scars, tattoos and piercings. Youth are also screened for symptoms requiring quarantine or isolation. | |

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| g. Observation for presence of scars, tattoos, or other skin markings<br>h. Acute health symptoms requiring quarantine or isolation | | | | | | | |
| **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** | | | | | One of the four youth records reviewed indicated the youth had previously been diagnosed with ADHD for which the youth was on medication at the time of admission; however, no additional chronic medical conditions were identified which required a new referral or follow-up care. | |
| When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments | **X** | | | | | None of the four records indicated the parent/guardian needed to be involved in healthcare services while the youth was in the program. | |
| All medical referrals are documented on a daily log. | **X** | | | | | None of the four youth were identified with a chronic medication condition which required a referral for medical care. The provider documents medical referrals on an episodic daily log and 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 agency's policy states the program will work with the youth's parent/guardian and the provider's medical consultant, if needed, to ensure the youth receives proper medical care and follow-up. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.02** | | | | | | **YES X NO (explain)**<br>Policy and procedures #4.14 was last reviewed and approved on 9/1/2020 by the CEO and COO. | |
| **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** | | | | | Three applicable youth records were reviewed, and each documented the completion of suicide risk screening during the initial intake and screening. Each screening was reviewed and signed by the supervisor and documented in the youth's case record. | |

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| The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services | X | | | | | Provider uses the Suicide Probability Scale (SPS) assessment of suicide risk tool that was 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 three youth were placed on precautionary sight and sound supervision based on the results of the CINS/FINS suicide screening results. | |
| Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals | X | | | | | The three youth records validated staff documented each youth's behavior at least every thirty minutes on the Suicide Precautions Observation Log as required. | |
| 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 | | | | | Three of three applicable youth were assessed by a master's level clinician working under the supervision of a licensed mental health counselor (LMHC). Each youth's supervision level was not changed or reduced to standard supervision until after the LMHC reviewed the completed Assessment of Suicide Risk (ASR). | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.03** | | | | | | **YES X NO (explain)** Policy and procedure # 3.41 was last approved on 9/1/2020 and signed by the CEO and COO. | |
| **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)<br>b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management<br>c. Oral medications are stored separately from injectable epi-pen and topical medications<br>d. Medications requiring refrigeration are stored in a secure refrigerator that is used | X | | | | | The program stores all medications in a Pyxis Med-Station 4000 Medication Cabinet which is inaccessible to youth. Pyxis Med-Station is stored in a locked room in accordance with guidelines in FS 499.0121 and medication management policy. Oral medications are stored separately from injectable epi-pen and topical medications. The program maintains a dedicated locked medical refrigerator which is utilized only for storage of medication. A posting on the refrigerator indicates the refrigerator is to be maintained at temperature range of 38-46 degrees Fahrenheit. | |

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| only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.)<br>e. Narcotics and controlled medications are stored in the Med-Station | | | | | | | |
| **Medication Distribution** | | | | | | | |
| a. Agency maintains a minimum of 2 Super Users for the Med-Station<br>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)<br>c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff<br>d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual<br>e. When nurse is on duty, medication processes are conducted by the nurse<br>f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy<br>g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens<br>h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse | **X** | | | | | The program indicated the CEO and the RN are the designated Pyxis Med-Station super users; however, an interview with the RN indicated the CEO does not have an account which would allow him access to Knowledge Portal reports. It was not clear what other restrictions may limit the CEO's Super User account.<br><br>An interview with the registered nurse (RN) indicated all eighteen direct care staff have access to the secured medications and each has completed medication administration and EpiPen training with the RN. Authorized staff use a Medication Distribution Log to document distribution of medication.<br>The program's policy and procedures require staff to verify medications by contacting the pharmacy by telephone to verify the prescription is current, and valid.<br><br>When the RN is on-site, the RN completed all medication processes.<br><br>The program's policy prohibits the admission of youth with currently prescribed injectable medications, with the exception of Epi-pen auto injectors. | |
| **Medication Inventory** | | | | | | | |

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| 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<br>b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory<br>c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly | | **X** | | | | Trained staff complete an inventory every shift of all the controlled substances. For controlled substances, the perpetual running balance is indicated on the shift-to-shift count. This is completed by two staff members and is documented on the youth's Medication Distribution Log (MDL). Shift to shift count documentation were reviewed for 3 medication records reviewed.<br><br>Over-the-counter medications that are accessed regularly are inventoried weekly on a perpetual log that is reviewed and signed by the RN. A perpetual inventory is maintained on the youth's MDL each time a medication is given.<br><br>Syringes and sharps are counted weekly and are kept in the Med-station.<br><br>Program provided documentation of weekly counts of over the counter (OTC) medications from June 1, 2020 to January 18, 2021 did not include documentation of a weekly count conducted during the week of August 16-22, 2020. | **Exception**<br>Documentation of weekly counts of OTC medications from June 1, 2020 to January 18, 2021 did not include documentation of a weekly count conducted during the week of August 16-22, 2020. |
| There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports. | | **X** | | | | The program provided documentation to indicate reports were pulled from the Knowledge Portal at least monthly since May 2020 to include the discrepancy audit summary, summary by transaction type, profile overrides, user summaries, cancelled transactions by station and by user, and discrepancies by station and by user. An interview with the RN revealed the nurse is the only person who reviews the reports from the Knowledge Portal. | **Exception**<br>The CEO and the RN are the identified super users; however, an interview with the RN indicated the CEO does not have an account which would allow him to pull reports from the Knowledge Portal and that she, the RN, is the only person who reviews the monthly reports. |
| Medication discrepancies are cleared after each shift. | | **X** | | | | The program provided a medication discrepancy report covering the dates of June 1, 2020 through November 23, 2020, which noted frequent and recurring discrepancies in the amount/number of meds which were a result of users not entering a correct beginning count of medication and leaving the discrepancy unresolved, rather than resolving the discrepancy by the end of their shift, as required. | **Limited Exception**<br>The program provided a medication discrepancy report covering the dates of June 1, 2020 through November 23, 2020, which noted frequent and recurring discrepancies in the amount/number of meds which were a result of users not entering a correct beginning count of medication and leaving the discrepancy unresolved, rather than resolving the |

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| | | | | | | | discrepancy by the end of their shift, as required. The program's Risk Prevention and Management Quarterly Report indicated the shelter reported no medication errors during the months of October, November, and December 2020; however, an interview with the nurse confirmed the program continued to have "a lot" of medication discrepancies which were not resolved by the end of each shift as required. A request made to the RN for the discrepancy report for November 24, 2020 through January 20, 2021 was confirmed but not received prior to conclusion of QI visit. A second request was made post-review and report was received showing four additional discrepancies, three of which were user error entering counts. Two of the four discrepancies were not cleared during the shift. An interview with the RN indicated she has repeatedly trained, and retrained, staff on the requirement to resolve medication counts by the end of their shift. Additionally, the RN posted a "cheat sheet" on the medication cart with step-by-step instructions on how to resolve discrepancies; however, staff continue to leave the discrepancies unresolved. There has been no corrective action put into place other than retraining by the RN in an attempt to correct this issue. |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.04** | | | | | | **YES X NO (explain)**<br>Policy 7.03 was last reviewed last reviewed and approved on 9/1/20. | |
| **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 applicable records were reviewed and all four were found to document each youth's medical or mental health condition or food | |

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| | | | | | | allergy. Each youth was appropriately placed on the program's alert system. | |
| Alert system includes precautions concerning prescribed medications, medical/mental health conditions | X | | | | | The program maintains a daily medical and mental health alert system to ensure information concerning a youth's medication condition, allergies, common side effects of prescribed medication, foods and medications which are contraindicated, or other pertinent mental health treatment information is communicated to all staff. | |
| Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems | X | | | | | A review of staff training records indicated staff are provided sufficient information and instruction to recognize and respond to the need for emergency care for medical and/or 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 | | | | | Medical alert codes are placed on the front of the youth file chart and on the roster board in the monitoring station. Food allergies are also documented on the clipboard in the kitchen. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.05** | | | | | | **YES X NO (explain)**<br>Policy and procedures 7.03 Medical was last reviewed and approved on 9/1/20 by the CEO and COO. | |
| 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<br>b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file | X | | | | | Three applicable youth records were reviewed for off-site emergency medical care and each had an incident report called into the Department's Central Communications Center (CCC) for the emergency care. The program was able to provide documentation of discharge instructions for all three youth records. The program maintains an Off-Site Emergency Care Log on which parent notification was handwritten in all three reviewed instances. | |

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| c. Youth's parent/guardian was notified<br>d. A daily log is maintained for emergency care provided | | | | | | | |
| All staff are trained on emergency medical procedures | **X** | | | | | All reviewed staff training records validated staff maintained current certification in first aid and CPR. Additionally, reviewed documentation indicated all staff participated in emergency drills. | |
| The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s) | **X** | | | | | During tour of facility, knife-for-life and wire cutters are located in the monitoring station. | |
| First aid kit/supplies are fully equipped and inventoried | **X** | | | | | During tour of facility, the first aid kits were in every van and in the medication room. The medication room houses a first aid cabinet on the wall and a portable first aid kit. | |