Florida Network for Youth and Family Services
Compliance Monitoring Report for

Family Resources - Clearwater
1615 Union Street
Clearwater, FL 33755

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Family Resources - Clearwater for the FY 2020-2021 at its program office located at 1615 Union Street, Clearwater, 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. Family Resources - Clearwater 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 Ashley Davies, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from Family Resources - Clearwater present for the entrance interview were: Beth Davis, Chief Executive Officer; Elizabeth Polifrone, Community Services Supervisor; and Erik Kline, Residential Supervisor. The last onsite QI visit was conducted October 24 – 25, 2019.

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

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

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 01-20-2021

Agency Name: Family Resources - Clearwater	**Monitor Name: Ashley Davies, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1615 Union St., Clearwater, FL**
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 a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The program currently has at least two staff members certified as DJJ QI Peer reviewers.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency provided a list of five additional contracts for FY2020 - 2021 for the shelter and for the Family Counseling program. The list includes: the funder, service provided, and contract start and end dates. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements	**No recommendation or Corrective Action.**

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
						reviewed had current contract/agreement dates.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: General Liability through Alliance of Nonprofits for Ins. RRG, for limits of coverage $1,000,000 each $3,000,000 aggregate and medical expenses of $20,000 for any one person, effective 6/01/20 – 6/01/21. Workers Compensation through Star Insurance Co with limits of $2,000,000 each/aggregate, effective 6/1/20 – 6/1/21. Automobile insurance through Alliance of Nonprofits for Ins. RRG with an umbrella policy through Alliance of Nonprofits for Ins. RRG for combined limits of $1,000,000 effective for 6/1/20 – 6/1/21. Directors and Officers Liability insurance through Alliance of Nonprofits for Ins. RRG for a limit of	**No recommendation or Corrective Action.**

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						liability of $1,000,00/$2,000,000 each/aggregate. Policy effective for 6/1/2020– 6/1/2021. Florida Network is listed on the Worker's Compensation certificate as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	**N/A –** During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in Section F-Financial Management of the Administrative Standard Operating Manual. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. Procedures are included for general ledger, payroll, petty cash, computer backup, and other relevant financial processes.	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						Polices were last reviewed in 2020 by the Chief Executive Officer.	
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. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program and non-residential program.	**No recommendation or Corrective Action.**
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: No change in practice was reported for the agency since the last onsite program review in October 2019. Reviewed petty cash Policy and Procedure was conducted. The Petty Cash fund does not exceed the established minimum. Petty cash is stored in a secure locked location in the building. The Residential Supervisor reported all receipts are submitted to finance at the main office for reimbursement as needed. Reimbursement comes in the form of a check made out to the Residential	**No recommendation or Corrective Action.**

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						Supervisor, who will then cash it and place money in petty cash box.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation and Observation: Reviewed Bank Statements and Bank Reconciliations for the past six months for one account held with SunTrust. Financial Statements are reported on a monthly basis and were found to be current. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month. Checks disbursed over $750 are signed by two individuals with signing authority. Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files.	**No recommendation or Corrective Action.**
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency provided documentation for the last six months of payment of payroll taxes. Payroll taxes are paid weekly via electronic payment through the IRS. Electronic print out documents Tax form 941 was completed.	**No recommendation or Corrective Action.**
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a Budget-to-Actual report for the current fiscal year. A review of these documents was conducted. Report shows program budget and actual with YTD actual, budget, variance, and %. Variances in budget are monitored on a regular basis and approved by management.	**No recommendation or Corrective Action.**
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2020 and 2019 was completed by Assurance Dimensions. A separate Management Letter requiring a Corrective Action Plan was	**No recommendation or Corrective Action.**

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	Explain Rating					**Ratings Based Upon:**	**Notes**
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**						not issued by the auditor. A copy of the audit was submitted to the FNYFS.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Policies and procedures for Confidentiality/Release of Information, System Backup, and Disaster Recovery were reviewed. A daily back-up is performed on all information saved on various servers throughout the agency. Policies were last reviewed in 2020 by the Chief Executive Officer.	**No recommendation or Corrective Action.**

CONCLUSION

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

SUMMARY OF RECOMMENDATIONS

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

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources - Clearwater
CINS/FINS Program

January 20 – 21, 2021

Compliance Monitoring Services Provided by

FOREFRONT

Family Resources Clearwater – January 20 – 21, 2021
Lead Reviewer: Ashley Davies

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	

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health /Health Services

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

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

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

Rating Definitions

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

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

Reviewer

Members

Ashley Davies - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services

Sebastian Roth – Youth and Family Services

Mark Shearon – Anchorage Children's Home

Brenda Comadore – Department of Juvenile Justice

Vincent Lisbon – Bethel Community Foundation, Inc.

Quality Improvement Review

Family Resources Clearwater – January 20 – 21, 2021
Lead Reviewer: Ashley Davies

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2020/Jan 2021).

Persons Interviewed

- ☐ Chief Executive Officer
- ☐ Chief Financial Officer
- ☒ Chief Operating Officer
- ☐ Executive Director
- ☒ Program Director
- ☐ Program Manager
- ☐ Program Coordinator
- ☒ Clinical Director
- ☒ Counselor Licensed
- ☐ Case Manager
- ☐ Counselor Non-Licensed
- ☐ Advocate
- ☐ Direct – Care Full time
- ☐ Direct – Part time
- ☐ Direct – Care On-Call
- ☐ Intern
- ☐ Volunteer
- ☒ Human Resources
- ☐ Nurse – Full time
- ☒ Nurse – Part time

0 # Case Managers
1 # Program Supervisors
0 # Food Service Personnel
1 # Healthcare Staff
0 # Maintenance Personnel
0 # 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
- ☐ List of Supplemental Contracts
- ☐ Vehicle Inspection Reports
- ☐ Visitation Logs
- ☒ Youth Handbook

5 # Health Records
5 # MH/SA Records
0 # Personnel /Volunteer Records
7 # Training Records
8 # Youth Records (Closed)
2 # Youth Records (Open)
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**.

Quality Improvement Review

Family Resources Clearwater – January 20 – 21, 2021
Lead Reviewer: Ashley Davies

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

The community counseling has had one counselor leave in the past year and was able to hire a new staff to fill that position in a timely manner. Both program counselors are registered interns working towards their Licensed Mental Health Counselor and Licensed Clinical Social Worker. The program has been working with local universities and currently has an MSW intern from the University of South Florida completing their internship in the program. The program is currently accommodating telehealth and in person counseling sessions. The program has been implementing the “Success Shop”, focusing on anger management, impulse control, improved school performance, and many other topics. This group has been receiving positive feedback from youth, parents, and referral sources. The program will be implementing a teen girl group focusing on healthy body image, self-esteem, and healthy relationships/communication. The community counseling program continues to receive steady referrals for services and the counselors have been active with continued outreach within the community.

Narrative Summary

Family Resources, Inc. is managed by the Chief Executive Officer who oversees the Vice President of Residential Services and the Vice President of Community Based Services. Family Resources Clearwater provides residential and non-residential counseling and case management services across one county, Pinellas, in circuit 6. Day-to-day activities at Family Resources Clearwater youth shelter are managed by a Residential Supervisor. The community counseling program is managed by a Community Services Supervisor who is a Licensed Clinical Social Worker (LCSW).

The overall findings for the QI Review for Family Resources, Inc. (Clearwater) are summarized as follows:

Standard 1: This standard has a total of seven indicators regarding management accountability. All seven indicators were rated satisfactory with no exceptions noted.

Standard 2: This standard has a total of ten indicators that relate to intervention and case management. Nine of the ten indicators were rated satisfactory with one exception noted in 2.02 Needs Assessments. The exception in 2.02 was due to one Needs Assessments not being signed by a supervisor. Indicator 2.10 Stop Now and Plan (SNAP) was rated not applicable as the program does not provide SNAP services.

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

Standard 4: This standard has a total of five indicators regarding mental health and health services. All five indicators were rated satisfactory with no exceptions noted.

Quality Improvement Review

Family Resources Clearwater – January 20 – 21, 2021
Lead Reviewer: Ashley Davies

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon Document Source For example: Interview/Surveys, Observation, and/or Type of Documentation	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						**YES** **NO (explain) X** The agency has a policy in place titled 1.01 Background of Employees and Volunteers. The policy was last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
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**					A total of six new staff were hired since the last onsite QI review. All six staff met the criteria for a pre-screening assessment. The agency uses the Berke Assessment and completed the screening prior to hire for the six staff. One of the six staff had a low score on the Berke Assessment and the agency provided an explanation as to why the staff was hired with the low score.	

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 six new staff were hired since the last on-site QI review. All six staff were background screened prior to hire. There were no volunteers, interns, or contractors used since the last QI review.	
Five-year re-screening completed every 5 years from initial date of hire			X			There were no staff applicable for a five-year re-screening during this review cycle.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					The agency submitted the Annual Affidavit of Compliance with Level 2 Screening via email to the Background Screening Unit on 01/06/2021.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Documentation of approval of E-Verify work eligibility was provided for all six new staff hired.	
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 agency has a policy in place titled 1.02 Provision of an Abuse Free Environment. The policy was last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
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 program has a code of conduct that all staff sign at hire prohibiting the use of physical abuse, profanity, threats, or intimidation. All six newly hired staff had evidence this code of conduct was signed at hire and was maintained in their personnel files.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					Child Abuse telephone number was observed during the virtual tour to be posted on a bulletin board in the dayroom of the shelter and also in the lobby of the shelter.	

Youth were informed of the Abuse and Contact Number (see youth survey results)	X					A review of five residential files confirmed youth were informed of the Abuse Hotline number during orientation. The youth initialed and signed the orientation checklist documenting a review of the Abuse Hotline information.	
Management takes immediate action to address any incidents of threats or abuse			X			The program reported there were no incidents of abuse or threats reported during the review period needing management action.	
Grievance Process							
Agency has a formal grievance process	X					A review of the program's policy confirmed the agency has a formal grievance process in place.	
Locked box accessible to only management and available to youth in a common area	X					During the virtual tour it was observed that the program has an accessible grievance box that is locked and located in the dayroom. The Residential Supervisor has a key to the box, and it is checked daily. The box was opened during the tour and was empty.	
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					There were two grievances filed since the last QI review. Both grievances were resolved and signed by the Residential Supervisor.	
72-hour resolution requirement by management. If this does NOT occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution.	X					There were two grievances filed since the last QI review. One grievance was addressed and resolved the same day it was filed and the second grievance was addressed and resolved within 48 hours.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES X NO (explain)** The agency has a policy in place titled 1.03 Incident Reporting. The policy was last reviewed in July 2019 by the Chief Executive Officer.	
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	X					There were eighteen CCC incidents in the last six months reported by the agency. All eighteen incidents were reported within the two-hour required time frame.	

than two hours after any reportable incident occurred or within two hours of the program learning of the incident							
The program completes follow-up communication tasks/special instructions as required by the CCC	**X**					All CCC incidents that required followed up documented it was completed and the report was successfully closed.	
Incidents are documented in the program logs and on incident reporting forms	**X**					All eighteen incidents were documented on agency incident reporting forms. A sample of six incidents were reviewed for documentation in the program's logbook. All six randomly chosen incidents were documented in the logbook.	
All incident reports are reviewed and signed by program supervisors/directors	**X**					All reports were reviewed and signed by the program supervisor and directors.	
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						**YES NO (explain) X** The agency has a policy in place titled 1.04 Training Requirements. The policy was last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*	**X**					There was a total of seven staff training files reviewed. All seven staff were hired prior to the January 1, 2021 and had the DOJ Civil Rights and Federal Funds training completed prior to December 31, 2020.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.	X					There were three staff training files reviewed for first year training requirements. All three staff documented all required trainings were completed in the first 90 days.	
All staff completes all mandatory Florida Network and SkillPro training during the first-year employment.	X					There were three staff training files reviewed for first year training requirements. One staff documented 117 of the 80 required training hours and all required trainings with approximately three weeks left to receive additional trainings. The second staff documented 62 of the required 80 training hours and all required trainings with approximately seven months left to receive with additional required training hours. The last staff documented 159 of the 80 required training hours. This staff was missing two required trainings; however, still had approximately nine months to receive these two trainings.	
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	There were no non-licensed clinical staff requiring this training during this review period.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).					X	There were no non-licensed clinical staff requiring this training during this review period.	
In-Service Direct Care Staff							

Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	X					There were four staff training files reviewed for in-service training requirements. All four staff documented over the required 40 hours of annual training with 76, 114.5, 58.5 and 151 hours for the last completed training cycle. All four staff documented all required trainings were completed.	
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 contained a spreadsheet documenting all trainings, date completed, and hours. Also, training files included any related documentation such as training certificates, sign-in sheets, and training worksheets.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES NO (explain) X** The agency has a policy in place titled 1.05 Analyzing and Reporting Information. The policy was last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
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					The agency reviews case records monthly. These monthly reports were provided for the last six months.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					Incidents, accidents, and grievances are reviewed quarterly by the Risk Management Committee and Impact Committee.	
The program conducts an annual review of customer satisfaction data	X					Customer satisfaction data is reviewed quarterly by the Impact Committee.	
The program conducts an annual review of outcome data and (if applicable) there is evidence of	X					An annual review of outcome data is completed by the agency's Data Administrator. The Data Administrator	

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.						communicates with the Florida Network via email to complete annual reconciliations. The Data Administrator sends email to the Administrative Assistants of each program with information that needs to be corrected. Once the Administrative Assistants complete the corrections the Data Administrator submits the corrections to the Florida Network. This process was just completed in January 2021.	
The program conducts a monthly review of NetMIS data reports.	**X**					NetMIS data reports are reviewed twice a month by the agency's Data Administrator.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	**X**					NetMIS data reports are reviewed twice a month by the agency's Data Administrator. The reports are then sent out to the Administrative Assistant for each program who will then send the report to any staff responsible for any discrepancies to fix.	
The program has a process in place to review and improve accuracy of data entry & collection	**X**					The NetMIS data reports are reviewed at monthly supervisors' meetings and then at the monthly staff meetings to see if there is anything the whole group is having trouble with.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**X**					Information from all the quarterly committee meetings is summarized into a quarterly Continuous Quality Improvement (CQI) Analysis report. This report is then sent to each program and is reviewed by management and then reviewed with all staff at the monthly staff meeting.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**X**					There are three committees that meet quarterly, the Risk Management Committee, the Impact Committee, and the Staff Development Committee. Each committee produces a quarterly report that identifies all strengths and weakness as well as improvements that need to be implemented or modified for that committees' specific areas of review. These findings are summarized into a quarterly CQI Analysis report that is reviewed with all staff at each program operated by the agency.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES X NO (explain)** The agency has a policy in place titled 1.10 Transportation Policy. The policy was last reviewed in July 2019 by the Chief Executive Officer.	

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Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The program provided a list of staff approved to transport youth.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					There was documentation all drivers had a valid Florida driver's license and are covered under the agency's insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	X					The programs policy titled 1.10 Transportation prohibits transporting a youth without another passenger in the vehicle. There are provisions in place in case a 3rd party is not present in the vehicle.	
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					Transportation Logs and logbook entries were reviewed for the last six months. There was documentation for all single client transport of supervisor approval, prior to the transport taking place, documented on the Transportation Logs and also in the logbook.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The 3rd party presence on transports, reviewed for the last six months, was either an agency staff member or another youth.	
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					Transportation Logs were reviewed for the last six months and documented the date, time, mileage, number of passengers, destination, drivers' initials, and supervisor approval if required. All Transportation Logs were filled out in their entirety.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES** **NO (explain) X** The agency has a policy in place titled 1.11 Outreach. The policy was last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	**X**					The agency provided verification of attendance to meetings with the Homeless Leadership Board, Pinellas Juvenile Assessment Center On-Site Partner's Meeting and DJJ's Circuit 6 Coordinator Meeting.	
Outreach and prevention services are provided by designated staff and include increasing community awareness, offering informational and educational CINS/FINS services to youth and families.	**X**					The program provided documentation of 58 different outreach activities conducted during the last six months. The outreach activities were conducted at local schools and community events.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**X**					The program has nineteen interagency agreements with local schools, mental health providers, hospitals, and sheriff's office. The agreements were all current and included services provided and a referral process.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES NO (explain) X** The agency has a policy in place titled 2.01 Eligibility Screening and Intake Assessment. The policy was last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries. If staff on duty cannot complete the screening, an on-call supervisor is contacted and eligibility is determined within 30 minutes from initial inquiry.	**X**					There were five shelter files reviewed, all were closed. All five files documented an eligibility screening was completed immediately.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	**X**					There were five community counseling files reviewed, two open and three closed. All five files documented an eligibility screening was completed within three days of the referral.	

Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**X**					All ten files documented the youth and parent/guardian received, in writing, available services options, rights and responsibilities, and brochure.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**X**					All ten files documented the youth and parent/guardian were provided information on possible actions occurring through involvement with CINS/FINS services and the grievance procedure.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES X NO (explain)** The agency has a policy in place titled 2.02 Needs Assessment. The policy was last reviewed in July 2019 by the Chief Executive Officer.	
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**					There were five shelter files reviewed, all were closed. All five files documented the Needs Assessment was initiated 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**					There were five community counseling files reviewed, two open and three closed. All five files documented the Needs Assessment was completed within two to three face-to-face contacts.	
Needs Assessment is conducted by a bachelor's or master's level staff member	**X**					All ten Needs Assessments were completed by a bachelor's or master's level staff member.	
Needs Assessment includes a supervisor's review signature upon completion		**X**				Nine out of the ten Needs Assessments included a supervisor's signature.	**Exception:** One shelter file reviewed did not contain a supervisor's signature on the Needs Assessment.

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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**					In two of the shelter files the youth 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**					Both youth received an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES X NO (explain)** The agency has a policy in place titled 2.03 Case/Service Plans. The policy was last reviewed in July 2019 by the Chief Executive Officer.	
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**					There were ten files reviewed, five shelter files reviewed, all closed, and five community counseling files, two open and three closed. All ten files had a Service Plan developed within seven working days of the Needs Assessment.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**X**					All ten Service Plans reviewed included individualized and prioritized needs and goals identified by the Needs Assessment, service type, frequency and location, persons responsible, and target dates for completion. Of the ten files reviewed, seven files include actual goal completion dates while two community counseling cases that are still open, and one shelter file that was just closed the day prior to the review and had yet to be updated. All ten Service Plans had the signature of the counselor and supervisor. Eight of the ten Service Plans had the signature of the youth. Two community counseling files documented the plan was reviewed virtually with the youth. Five of the ten Service Plans had the signature of the parent. Three shelter files and two community counseling files were reviewed virtually with the parent.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**X**					There were four community counseling files applicable for 30 day reviews. All of the 30 day reviews in these four files were completed as required. The remaining	

						six files reviewed were not applicable for 30 day reviews due to not being in the program long enough.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES NO (explain) X** The agency has a policy in place titled 2.04 Case Management and Service Delivery. The policy was last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Counselor/Case Manager is assigned	**X**					There were ten files reviewed, five shelter files reviewed, all closed, and five community counseling files, two open and three closed. All ten files had a counselor assigned.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate	**X**					All ten files establish referral needs and coordinated referrals to services based upon the ongoing assessment of the youth's/family's problems and needs, coordinated service plan implementation, monitored youth's/family's progress in service, and provided support to families. Five out of ten files were applicable and documented monitoring out-of-home placement. No files were applicable for referrals to case staffing committee or accompanying youth/guardian to court hearings and related appointments. Six out of ten files were applicable and referred the youth/family for additional services. All ten files provided case monitoring and reviews. All eight applicable files provided case termination documentation. There were seven files applicable for providing follow-up after 30 and 60 days of exit. All follow-up calls were completed as required.	

9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit							
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**X**					The program has written agreements with Camelot Community Care, Inc., Bay Area Youth Services, Inc., Central Florida Behavioral Health Network, Inc., Pinellas County Schools, Bethel Community Foundation, Inc., The Department of Juvenile Justice, and The Department of Children and Families Substance Abuse and Mental Health. Agreements included services provided and a comprehensive referral process.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES NO (explain) X** The agency has a policy in place titled 2.05 Counseling Services. The policy was last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
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**					There were ten files reviewed, five shelter files reviewed, all closed, and five community counseling files, two open and three closed. Service plans and case notes maintained demonstrated all ten youth received counseling services to address needs identified during the assessment process.	
Shelter Program							
Shelter programs provides individual and family counseling	**X**					All five shelter files reviewed demonstrated individual and/or family counseling was offered.	
Group counseling sessions held a minimum of five days per week	**X**					All five shelter files reviewed documented group sessions at least five days per week.	
Group counseling sessions consist of: a. Length of at least 30 minutes	**X**					All groups reviewed were at least 30 minutes in length, had an opportunity for engagement, had a clear and relevant topic, and had a clear leader.	

b. Opportunity for youth engagement c. Clear and relevant topic (informational/developmental/ educational) d. Clear leader or facilitator							
Community Counseling							
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, or the local provider's counseling office.	**X**					All five community counseling files reviewed documented therapeutic services were provided by agency staff and were documented in the case notes. Referral needs were established and provided to all five youth.	
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 ten files reviewed documented coordination between presenting problems, the needs assessment, service plan, service plan reviews, case management, and follow-up.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**X**					An individual youth file was maintained for all ten youth files reviewed.	
Case notes maintained for all counseling services provided and documents youth's progress	**X**					All ten youth files included case notes that documented services provided including counseling and the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	**X**					A sample of case records are reviewed monthly. A supervisor also signs all screening, assessment, and treatment paperwork in each file to ensure staff performance is adequate.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES X NO (explain)** The agency has a policy in place titled 2.06 Adjudication/Petition Process. The policy was last reviewed in July 2019 by the Chief Executive Officer.	
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**					There were seven case staffings reviewed. Three of the staffings were initiated by the parent and were held within seven days.	
The youth, family and case staffing committee are contacted within a minimum of five working days a. Notification to youth/family no less than 5 working days prior to staffing b. Notification to committee no less than 5 working days prior to staffing	**X**					All seven staffings documented the family and case staffing committee were notified of the staffing at least five days prior.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**X**					All seven staffings included a DJJ representative, the CINS/FINS provider, and a school representative.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**X**					There were other members present at the staffings as needed or requested.	
The program has an established case staffing committee, and has regular communication with committee members	**X**					The program has an established committee that meets on a regular basis.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**X**					The program has policy 2.06 Adjudication/Petition Process in place and has a committee that meets on a regular basis.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	**X**					In all seven cases the youth and family were provided a revised plan for services.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and	**X**					In all seven cases a written report was provided to the parent on the day of the staffing outlining recommendations and reasons for the recommendations.	

reasons behind the recommendations							
If applicable, the program works with the circuit court for judicial intervention for the youth/family					**X**	None of the seven files reviewed were applicable for judicial intervention.	
Case Manager/Counselor completes a review summary prior to the court hearing					**X**	None of the seven files reviewed were applicable for judicial intervention.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES X NO (explain)** The agency has a policy in place titled 2.07 Youth Records. The policy was last reviewed in July 2019 by the Chief Executive Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All records are clearly marked 'confidential'.	**X**					All ten youth files reviewed were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**X**					All files were maintained in a secure file, in a locked file cabinet that was marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	**X**					The program had an opaque container that was marked confidential that is used to transport files.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**X**					All files were maintained in a consistent manner and were neat and orderly making information easy to access.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES X NO (explain)** The agency has a policy in place titled 5.08 Sexual Orientation, Gender Identity & Gender Expression. The policy was last reviewed in July 2019 by the Chief Executive Officer.	
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**			There have been no youth who have fallen under the requirements of this indicator since the last on-site Quality Improvement review.	

b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards							
Youth in need of specialized support is referred to qualified resources (as applicable)			**X**			There have been no youth who have fallen under the requirements of this indicator since the last on-site Quality Improvement review.	
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**			There have been no youth who have fallen under the requirements of this indicator since the last on-site Quality Improvement review.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			**X**			There have been no youth who have fallen under the requirements of this indicator since the last on-site Quality Improvement review.	
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**					A virtual tour of the facility showed signage posted in the lobby area, offices, and dayroom of the facility.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES NO (explain) X** The agency has a policy in place titled 3.07 Special Populations. The policy was last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The provider has not served any youth meeting the criteria for staff secure since the last QI review.	
Staff Secure policy and procedure outlines the following:	**X**					The program's policy titled 3.07 Special Populations covers all requirements for staff secure services.	

a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare							
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services			**X**				
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift			**X**				
Agency provides a written report for any court proceedings regarding the youth's progress			**X**				
Domestic Minor Sex Trafficking (DMST)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The provider has not served any youth meeting the criteria for DMST since the last QI review.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements			**X**				
Services provided to these youth specifically designated services designed to serve DMST youth			**X**				
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**				
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)			**X**				
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**				
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements			**X**				
Domestic Violence							

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Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES** **X**	**NO**	**N/A**				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	**X**					There were three closed files reviewed. All three files had a face sheet indicating a pending DV charge and all three were screened by the JAC and did not meet criteria for secure detention.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**X**					All three files had evidence of data entry at intake and release.	
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**					None of the files exceed 21 days in the program.	
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	**X**					All three files had Service Plans that focused on anger management and family coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**X**					All three youth received all other general CINS/FINS required services.	
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**	**YES** **X**	**NO**	**N/A**				

rating "No eligible items for review")							
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**					There were two closed probation respite files reviewed. Both files had referrals submitted to and approved by the Florida Network.	
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	**X**					Both referrals came from DJJ Probation and both youth referred were on probation.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**X**					Both files had evidence of data entry at intake and release.	
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**					Both youth were in the program between 14 to 30 days. Neither youth stayed in the program beyond 30 days.	
All case management and counseling needs have been considered and addressed	**X**					Both files documented all case management and counseling needs identified were addressed.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**X**					Both youth received all other general CINS/FINS required services.	
Intensive Case Management (ICM)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO**	**N/A X**			The provider is not contracted to provide ICM services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth receiving services was court ordered or referred by case staffing committee					**X**		

Services for youth and family include: a. Four (4) direct contacts per month b. Four (4) collateral contacts per month					**X**		
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable) b. An approved self-report assessment that was completed at intake c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)					**X**		
Case plan demonstrates a strength-based, trauma-informed focus					**X**		
Agency has evidence that ICMS has a strength-based perspective in one or more of the following areas; engaging the family, advocating on their behalf, initiating change agent activities, helping to access supports in the community, teaching problem solving skills, modeling productive behaviors, and/or successful completion of youth and family developmental milestones					**X**		
Family and Youth Respite Aftercare Services (FYRAC)– Non-residential Only							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The provider has not served any youth meeting the criteria for FYRAC since the last QI review.	

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Lead Reviewer: Ashley Davies

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				
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: a. Face-to-face gathering of family history and demographic information b. Includes development of the service plan and is documented through signature of the youth and his/her parent/guardian as well as orientation to the program			X				
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning			X				
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence			X				

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							
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** The agency does not provide SNAP services at this location.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
SNAP Clinical Groups							
Youth are screened to determine eligibility of services					**X**		
Needs assessment is completed at initial intake, or within two face-to-face sessions					**X**		
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post) d. Prevention Assessment Tool (PAT) (pre & post)					**X**		
SNAP discharge report summary					**X**		

SNAP Boys/SNAP Girls **Parent** Group Evaluation Form					**X**		
SNAP Boys/SNAP Girls **Child** Group Evaluation Form					**X**		
SNAP in Schools							
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Weekly attendance sheet with youth names and/or identifying number completed with signatures of teacher and facilitator(s) (For a total of 13 attendance sheets)					**X**		
"Class Goal" sheet					**X**		
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.					**X**		
Pre and Post Evaluations					**X**		
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox					**X**		
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES X NO (explain)** The agency has a policy in place titled 3.01 Shelter Environment. The policy was last reviewed in July 2019 by the Chief Executive Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Facility Inspection	**X**					A virtual tour of the facility revealed furnishings were in good repair. The program was free of insect infestation. Grounds were landscaped and maintained. Bathrooms were clean and functional. No graffiti was observed. Lighting was adequate. Exterior areas were free of debris and grounds were free of hazards. Dumpster and garbage cans were covered. Doors are secure with key access required. Egress plans were posted in several locations. The client rules, abuse hotline information, and DJJ incident reporting information is posted in the staff area/youth group room. Blank grievance forms are available on the wall of the youth group room underneath the locked grievance mailbox. The program has one twelve-person passenger van which is equipped with major safety equipment as required. The key ring has a seat belt cutter and a window punch which also serves as an airbag deflator. Interior areas did not contain contraband and were free of hazardous items. Chemicals were stored behind locks and inventories and MSDS were maintained. The washers and dryers were operational and clean of lint. Current DCF license is displayed. Each youth has their own individual bed with clean, covered mattress, pillow, and sufficient linens. The program has lockers in a closet which can be locked and serve as a safe place for youth to keep their personal belongings.	
Fire and Safety Health Hazards	**X**					The annual fire inspection was completed on September 30, 2020. The program required a re-inspection due to the emergency action plan not containing the required procedures. A re-inspection was completed on October 15, 2020 and noted the emergency action plan was updated with the required procedures and the program received a satisfactory rating. Fire safety equipment inspections were completed on April 24 and August 6, 2020 documenting satisfactory compliance. At least one fire drill was completed monthly on each shift since June 2020. Mock emergency drills were completed at least monthly since June 2020. Residential Group Care and Food Service inspection was completed on September 29, 2020. Menus were posted and signed by a	

						licensed dietician. Cold food is properly stored, marked, and labeled, and dry storage/pantry areas are clean. Refrigerators/freezers are clean, and temperatures are maintained.	
Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**X**					The program has an activity schedule for weekdays and weekends. Each weekday youth are engaged in activity from 5:40 a.m. to 10:00 p.m. and from 8:30 am to 11:00 p.m. on weekends. The schedule indicates one hour of recreation/physical activity is provided daily and non-punitive activities are available if youth do not want to participate in a faith-based activity. The schedule includes over an hour of time for youth to complete homework or read approved books. The daily schedule is posted in the program's main group/living area.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES X NO (explain)** The agency has a policy in place titled 3.02 Program Orientation. The policy was last reviewed in July 2019 by the Chief Executive Officer.	
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**					There were five closed shelter files reviewed. A Youth Orientation Checklist was observed in all five files reviewed and completed on the day of admission. All five files documented the youth received a handbook.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**X**					The Youth Orientation Checklist was completed in all five files reviewed and documented all required topics were covered.	
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**					The Youth Orientation Checklist was completed in all five files reviewed and signed and dated by the youth and staff.	

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Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES NO (explain) X** The agency has a policy in place titled 3.03 Youth Room Assignment. The policy was last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Sexual orientation gender identity/ expression k. Acute health symptoms requiring quarantine or isolation	**X**					There were five closed shelter files reviewed. The program utilizes the Residential CINS/FINS Intake Form to document the initial classification process and room assignment. All five files included this form completed in its entirety and signed by a staff member and supervisor. This form documents all required elements.	
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,	**X**					Alerts for all five youth were documented on all screening and admission forms in the files. The applicable color-coded dots were all placed on the youth's file.	

substance abuse, physical health or security risk factors							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES NO (explain) X** The agency has a policy in place titled 3.04 Log Book. The policy was last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**X**					Logbook entries were reviewed for the first week of July 2020, the second week of August 2020, the third week of September 2020, the fourth week of October 2020, the first week of November 2020, and the second week of December 2020. Entries that impacted the safety and security of the youth or program were observed highlighted.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**X**					All entries were brief and legible, included the date and time of the event, included names of youth and staff involved, provided a brief statement, and included the name and signature of the 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**					Errors were observed struck through with a single line and initialed.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in	**X**					The Program Director reviewed the logbook every week and made a note stating dates reviewed with any recommendations.	

the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry							
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 staff were constantly reviewing the logbook for the previous two shifts. Staff would make a note in the logbook indicating the dates reviewed.	
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**					The on-coming supervisor was documenting a review of previous shifts in the logbook.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**X**					Entries were observed for counts, visitation, and home visits.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES NO (explain) X** The agency has a policy in place titled 3.05 Behavior Management Strategies. The policy was last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program has a detailed written description of the BMS, and it is explained during program orientation	**X**					The written description of the BMS is included in each youth's handbook and it is described as the SafePlace2B Behavior Management System (BMS) and Advancing Youth Development (AYD). All five shelter files reviewed confirmed each youth received this handbook during orientation.	
Behavior Management Strategies MUST include:	**X**					AYD is based on the principle that youth need to fully be involved in the processes that affect them. This also means they need opportunities to plan, evaluate	

a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep,						and communicate with adults. When this happens, youth feel a sense of belonging, membership, empowerment, and contribution. The BMS is a level system which helps the youth gain more rewards during their stay. Youth are graded each day in their ability to meet expectations in seven areas: 1. Morning chores and hygiene 2. School Attendance 3. Group Attendance 4. After Dinner Chores 5. Bedtime Hygiene 6. Respect 7. Safety Each day youth earn shelter dollars based on their level at the end of the day. Three dollars a day can be earned on leadership level, and two dollars a day for each day on citizenship level. No dollars can be earned on the orientation or ownership level. Each Friday youth can purchase items from the shelter store. The BMS has four levels: Leadership, Citizenship, Orientation, and Ownership. Rewards commensurate with the level of performance. On the ownership level, consequences are given as well as information on how to get back to the citizenship level. After twenty-four hours on ownership, an ownership paper, which describes the incident, will be given to the program supervisor or the case manager and they will decide what assignment will be given to youth prior to earning back their citizenship level. When youth are on the ownership level, they do not gain incentives until they regain citizenship level. At no time does the program take earned shelter dollars from youth as a consequence, nor does the program utilizes room restriction, restraint, or group punishment. The program does not deny youth meals, snacks, clothing, sleep, exercise, services, or correspondence privileges as a means of discipline. Levels youth have achieved are documented on the program youth information board so each youth can see. A Behavior Grading Sheet is completed for each youth, every day	

services, exercise, or correspondence privileges						and at the end of the day the total number of shelter dollars earned are documented. All grading sheets are maintained by staff in a binder on the unit. The program has a six-step approach for processing violation of programmatic values. Each step allows an opportunity for the youth to explain their perspective of the event, assist in taking responsibility and participate in suggesting appropriate consequences.	
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	**X**					A review of seven staff training files was conducted and each staff was trained in the theory and practice of administering BMS rewards and consequences.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**X**					The supervisor monitors each staff's use of the BMS and provides feedback as needed. The BMS is also discussed during staff meetings to ensure all staff are using it consistently.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**X**					The supervisors are trained to monitor the use of interventions by their staff to include the use of point-based and level-based interventions.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES NO (explain) X** The agency has a policy in place titled 3.06 Staffing and Youth Supervision. The policy was last reviewed in August 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**X**					There were five random samples of video surveillance reviewed, December 26, 2020 from 12am – 1am, January 1, 2021 from 2am – 3am, January 6, 2021 from 4am – 5am, January 9, 2021 from 11:30pm to 12:30am, and January 14, 2021 from 1am to 2am. A review of the above video surveillance sample, staff schedules, and log book entries documented required staffing ratios were met for awake hours and sleeping hours.	

All shifts must always provide a minimum of two staff present	X					The random sample above and staff schedules reviewed for the last six months documented at least two staff were present on all shifts.	
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					All staff that were included in staff-to-youth ratios had an eligible background screening completed and had been appropriately trained.	
The staff schedule is provided to staff or posted in a place visible to staff	X					During the virtual tour, the schedule was observed posted in the intake area of the shelter.	
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					A staff overtime rotation book including staff home phone numbers and was located in the intake office.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	X					A review of the video surveillance system for the five random samples listed above showed consistent fifteen-minute checks by staff. These checks were done by opening the door and looking inside. The log book and accountability forms also confirmed staff were constantly observing the youth every fifteen minutes and documenting observations in real time.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES** **NO (explain) X** The agency has a policy in place titled 4.13 Video Surveillance System. The policy was last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security	X					Observed cameras and written notices during the virtual tour. System can capture and retain video images for up to forty-five days. A review of random samples of overnight video surveillance revealed system records date, time, and location, and enables facial recognition. Cameras have back-up capabilities	

b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible						in case of power outage. All cameras were visible, and no cameras were located in the bathrooms or sleeping rooms.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**X**					The programs maintains a list of staff who can access the video surveillance system. The list consisted of only supervisory staff.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**X**					Supervisory reviews were conducted at least every 14 days for the last 6 months and documented in the log book. The reviews included a random sample of overnight shifts and assessed the activities of the facility.	
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**					The program has procedures in place in policy 4.13 Video Surveillance System to handle requests of video recordings within 24 – 72 hours.	

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			Due to the program's QI review occurring in January 2021 the program had not yet implemented this requirement in policy or practice, that was released from the Florida Network on January 1, 2021.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES NO (explain) X** The agency has a policy in place titled 4.01 Healthcare Admission Screening. The policy was last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Preliminary Healthcare Screening							
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	X					There were five closed shelter files reviewed. The health screening section of the CINS/FINS Intake Form was completed in all five files and included all required elements. The program had implemented procedures to take the youths temperatures at intake and screen youth for COVID-19 related symptoms. All health screenings were reviewed by a Registered Nurse (RN) within five business days.	
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			None of the five youth presented with chronic conditions requiring a referral to ensure medical care.	

When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments			X			None of the youth required follow-up medical appointments.	
All medical referrals are documented on a daily log.	X					Any medical referrals are documented in the log book and the Episodic Care Log.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	X					There are procedures in place to involve the parent in any follow-up medical care or referrals needed.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES X NO (explain)** The agency has a policy in place titled 4.02A Comprehensive Master Plan for Suicide Prevention and Response. The policy was last reviewed in October 2019 by the Chief Executive Officer.	
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					There were five closed shelter files reviewed. All five files contained a suicide risk screening completed during the initial intake screening process that was signed by a supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The program's suicide risk assessment tool was reviewed, and it was reported it had been previously 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					Three out of the five youth were placed on sight-and-sound supervision until assessed by a mental health professional. An Assessment of Suicide Risk (ASR) was completed by a licensed professional or non-licensed professional under the direct supervision of the licensed professional.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					In all three files the observation logs documented the youth were monitored at least every thirty minutes while on sight-and-sound supervision.	

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					All three youth were removed from sight-and-sound supervision after an ASR was completed by or reviewed with the licensed professional.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES NO (explain) X** The agency has three policies in place titled 4.03 Medications, 4.03A Medication Management and Distribution, and 4.03B Medication Disposal to address the requirements of this indictor. These policies were last reviewed in July 2019 by the Chief Executive Officer. Due to the QI review occurring in January 2021 the program did not have time to update policies and procedures to reflect any changes and new requirements released by the Florida Network on January 1, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees	X					A virtual tour of the Pyxis Med-Station and medical room was completed. The Pyxis Med-Station is located in a locked room and is inaccessible to youth. All medications are stored in the Pyxis Med-Station 4000 medication cabinet. Oral medications are stored separately from topical medications in the locked medical cabinet. There is a secure refrigerator used only for medical purposes and maintained at 36 degrees F. The temperature of the refrigerator is checked weekly by the RN. All narcotic and controlled medications are stored in the Pyxis Med-Station 4000 medication cabinet.	

F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med-Station							
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	**X**					A list of Super Users was provided, and a list of designated staff delineated to have access to secured medication. The program has four Super Users for the Med-Station. A review of three youth files supported they took medication while in the program. All three files contained a Medication Distribution Log (MDL) completed as required. Staff verify medication either by the Registered Nurse (RN) or by calling the pharmacy. The RN distributes all medications when on-site. Trained direct care staff distribute medication when the nurse is not on-site. All medication in the three files reviewed was distributed as required. All staff have training in the use of epi-pens by the RN.	
Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is	**X**					All controlled substances are counted shift-to-shift with two staff members present and documented on the youth's MDL. A perpetual inventory with running	

maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly						balances is also maintained on the MDL's for all medications. All medications stored in the Med-Station, including all over-the-counter (OTC) medications, are inventoried weekly by the RN. Razors are secured in a locked box and are inventoried weekly and as used.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	**X**					The RN runs weekly and monthly reports via the knowledge portal.	
Medication discrepancies are cleared after each shift.	**X**					At the time of the review there were no open discrepancies. The RN reported all discrepancies are cleared out at the end of shift. The RN also runs a weekly discrepancy report via the Knowledge Portal.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES X NO (explain)** The agency has a policy in place titled 4.04 Medical and Mental Health Alert Process. The policy was last reviewed in July 2019 by the Chief Executive Officer.	
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**					There were five closed shelter files reviewed. All five files documented the youth had alerts had were placed in the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**X**					In all five files reviewed precautions concerning prescribed medications and medical/mental health conditions were documented on intake and screening forms and on the youth's MDL's.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**X**					In all five files the alerts included sufficient information concerning the youth's medical condition, allergies, common side effects to medications, food and medications that are contraindicated, and other pertinent mental health treatment information, documented on the youth's screening forms, assessments, and MDL's.	

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**					Alerts are documented on all intake and screening forms in the youth's file and then the applicable color-coded stickers are placed on the spine of the youth's file. The alerts are then documented on a dry erase board in the shelter. The alert system includes precautions concerning prescribed medications and medical/mental health conditions. Staff can find this information documented in the youth's file and on the youth's individual MDL's.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES X NO (explain)** The agency has a policy in place titled 4.05 Episodic/Emergency Care. The policy was last reviewed in July 2019 by the Chief Executive Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Off-site Emergency Services							
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**X**					There were three closed shelter files reviewed for off-site emergency medical or dental care. All three incidents were reported to the CCC and an incident report was completed. One of the three files was applicable for receipt of medical services/discharge instructions and was found documented in the youth's file. The remaining two files had one youth who did not return to the program and the other youth who was picked up by his father for transport to a medical facility. However, the youth's father stated that the youth appeared fine after he picked him up therefore, he did not take the youth to a medical facility but kept youth overnight and returned him to the program the next day. In all three cases the youth's parent was notified and the incident was documented on the daily episodic care log.	
All staff are trained on emergency medical procedures	**X**					There were seven staff training files reviewed and the staff were trained in first aid, CPR, and emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**X**					The knife-for-life and wire cutters are located in a cabinet in the dayroom. These were observed on the virtual tour.	

First aid kit/supplies are fully equipped and inventoried	**X**					First aid kits were observed on the virtual tour to be located in the dayroom and the vehicles. The first aid kits are inventoried weekly by the RN.	